1 # INSURANCE RELATED MODIFICATIONS
2 2017 GENERAL SESSION
3 STATE OF UTAH
4

5 **LONG TITLE**
6 **General Description:**
7 This bill modifies provisions related to insurance.
8 **Highlighted Provisions:**
9 This bill:
10 ▸ amends the definition provision;
11 ▸ modifies enforcement penalties and procedures;
12 ▸ replaces the term "health benefit product" with "health benefit plan";
13 ▸ clarifies that rules are made under Title 63G, Chapter 3, Utah Administrative
14 Rulemaking Act;
15 ▸ requires licensees who are foreign insurers to provide contact information and
16 maintain certain records;
17 ▸ modifies due date of insurer holding company filing;
18 ▸ enacts the Risk Management and Own Risk and Solvency Assessment Act,
19 including:
20 • providing the scope of the chapter;
21 • defining terms;
22 • requiring a risk management framework;
23 • requiring an own risk and solvency assessment;
24 • providing for a summary report and its contents;
25 • providing for exemptions;
26 • addressing confidentiality;
27 • establishing sanctions; and
28 • providing a severability clause;
29 ▸ addresses risk based capital provisions;
30 ▸ addresses association groups;
31 ▸ modifies accident and health insurance standards;
32 ▸ moves provision for when a child of a group member may be denied eligibility;

33 ▸ addresses when a person is required to provide information concerning an employer
34 self-insured employee welfare benefit plan;
35 ▸ moves provisions related to alcohol and drug dependency treatment;
36 ▸ addresses groups eligible for group or blanket insurance;
37 ▸ modifies provision related to requirements for notice of termination;
38 ▸ amends definitions under the Unclaimed Life Insurance and Annuity Benefits Act;
39 ▸ provides for the assessment of forfeitures;
40 ▸ provides for notice to a producer of the termination of appointment;
41 ▸ addresses when an insurer contracts with a licensee;
42 ▸ imposes requirements related to flood insurance;
43 ▸ addresses licensed compensation;
44 ▸ provides for notice to a designee when an agency terminates the designation,
45 including navigator agencies;
46 ▸ addresses contracts with agencies;
47 ▸ addresses contracts with individual title insurance producer or an agency title
48 insurance producer;
49 ▸ requires certain record keeping requirements;
50 ▸ addresses reports from organizations licensed as adjusters;
51 ▸ modifies provisions related to captive insurers, including:
52 • amending definitions;
53 • addressing permissive areas of insurance;
54 • addressing capital issues;
55 • modifying provisions required for formation;
56 • including pool captive insurance companies under investment requirements;
57 • providing that captive insurance companies may cede risks to certain insurers;
58 • addressing rating organizations;
59 • addressing contributions to guaranty of insolvency funds; and
60 • repealing provisions related to an association captive or industrial insured
61 group;
62 ▸ amends board of directors provisions under the Defined Contribution Risk Adjuster
63 Act;

64 ‣ imposes record retention requirements under the Continuing Care Provider Act; and
65 ‣ makes technical and conforming amendments.
66 **Money Appropriated in this Bill:**
67 None
68 **Other Special Clauses:**
69 None
70 **Utah Code Sections Affected:**
71 AMENDS:
72 **31A-1-301**, as last amended by Laws of Utah 2016, Chapter 138
73 **31A-2-308**, as last amended by Laws of Utah 2012, Chapter 253
74 **31A-8-402.3**, as last amended by Laws of Utah 2014, Chapters 290, 300, and 425
75 **31A-8-402.5**, as last amended by Laws of Utah 2003, Chapter 252
76 **31A-16-105**, as last amended by Laws of Utah 2015, Chapter 244
77 **31A-17-404**, as last amended by Laws of Utah 2016, Chapter 138
78 **31A-17-603**, as last amended by Laws of Utah 2013, Chapter 319
79 **31A-22-505**, as enacted by Laws of Utah 1985, Chapter 242
80 **31A-22-605**, as last amended by Laws of Utah 2005, Chapter 78
81 **31A-22-610.5**, as last amended by Laws of Utah 2011, Chapter 297
82 **31A-22-614.5**, as last amended by Laws of Utah 2011, Chapter 284
83 **31A-22-701**, as last amended by Laws of Utah 2011, Chapter 284
84 **31A-22-716**, as last amended by Laws of Utah 2011, Chapters 284 and 297
85 **31A-22-721**, as last amended by Laws of Utah 2014, Chapters 290, 300, and 425
86 **31A-22-1902**, as enacted by Laws of Utah 2015, Chapter 259
87 **31A-23a-111**, as last amended by Laws of Utah 2016, Chapter 138
88 **31A-23a-115**, as last amended by Laws of Utah 2009, Chapter 349
89 **31A-23a-203**, as last amended by Laws of Utah 2014, Chapters 290 and 300
90 **31A-23a-302**, as last amended by Laws of Utah 2012, Chapter 253
91 **31A-23a-407**, as last amended by Laws of Utah 2016, Chapter 314
92 **31A-23a-412**, as last amended by Laws of Utah 2012, Chapter 253
93 **31A-23a-501**, as last amended by Laws of Utah 2016, Chapter 138

94 **31A-23b-102**, as last amended by Laws of Utah 2014, Chapters 290 and 300
95 **31A-23b-202.5**, as enacted by Laws of Utah 2014, Chapter 425
96 **31A-23b-209**, as enacted by Laws of Utah 2013, Chapter 341
97 **31A-23b-210**, as enacted by Laws of Utah 2013, Chapter 341
98 **31A-23b-401**, as last amended by Laws of Utah 2016, Chapter 138
99 **31A-26-209**, as last amended by Laws of Utah 2004, Chapter 173
100 **31A-26-210**, as last amended by Laws of Utah 2009, Chapter 349
101 **31A-26-213**, as last amended by Laws of Utah 2016, Chapter 138
102 **31A-30-103**, as last amended by Laws of Utah 2014, Chapters 290, 300, and 425
103 **31A-30-106**, as last amended by Laws of Utah 2014, Chapters 290 and 300
104 **31A-30-106.1**, as last amended by Laws of Utah 2012, Chapter 279
105 **31A-30-107**, as last amended by Laws of Utah 2014, Chapters 290, 300, and 425
106 **31A-30-107.1**, as last amended by Laws of Utah 2003, Chapter 252
107 **31A-37-102**, as last amended by Laws of Utah 2016, Chapter 138
108 **31A-37-106**, as last amended by Laws of Utah 2015, Chapter 244
109 **31A-37-202**, as last amended by Laws of Utah 2015, Chapter 244
110 **31A-37-204**, as last amended by Laws of Utah 2016, Chapter 138
111 **31A-37-301**, as last amended by Laws of Utah 2016, Chapter 348
112 **31A-37-302**, as last amended by Laws of Utah 2015, Chapter 244
113 **31A-37-303**, as last amended by Laws of Utah 2016, Chapter 138
114 **31A-37-304**, as enacted by Laws of Utah 2003, Chapter 251
115 **31A-37-305**, as enacted by Laws of Utah 2003, Chapter 251
116 **31A-42-201**, as last amended by Laws of Utah 2010, Chapters 10 and 68
117 **31A-44-603**, as enacted by Laws of Utah 2016, Chapter 270
118 **53-2a-1102**, as last amended by Laws of Utah 2015, Chapter 408
119 **63G-2-302**, as last amended by Laws of Utah 2016, Chapter 410
120 ENACTS:
121 **31A-14-205.5**, Utah Code Annotated 1953
122 **31A-16a-101**, Utah Code Annotated 1953
123 **31A-16a-102**, Utah Code Annotated 1953
124 **31A-16a-103**, Utah Code Annotated 1953

125 **31A-16a-104**, Utah Code Annotated 1953
126 **31A-16a-105**, Utah Code Annotated 1953
127 **31A-16a-106**, Utah Code Annotated 1953
128 **31A-16a-107**, Utah Code Annotated 1953
129 **31A-16a-108**, Utah Code Annotated 1953
130 **31A-16a-109**, Utah Code Annotated 1953
131 **31A-16a-110**, Utah Code Annotated 1953
132 **31A-22-645**, Utah Code Annotated 1953
133 REPEALS:
134 **31A-22-715**, as last amended by Laws of Utah 2016, Chapter 138
135 **31A-22-718**, as enacted by Laws of Utah 1995, Chapter 344
136 **31A-37-306**, as last amended by Laws of Utah 2015, Chapter 244
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138 *Be it enacted by the Legislature of the state of Utah:*
139 Section 1. Section **31A-1-301** is amended to read:
140 **31A-1-301. Definitions.**
141 As used in this title, unless otherwise specified:
142 (1) (a) "Accident and health insurance" means insurance to provide protection against
143 economic losses resulting from:
144 (i) a medical condition including:
145 (A) a medical care expense; or
146 (B) the risk of disability;
147 (ii) accident; or
148 (iii) sickness.
149 (b) "Accident and health insurance":
150 (i) includes a contract with disability contingencies including:
151 (A) an income replacement contract;
152 (B) a health care contract;
153 (C) an expense reimbursement contract;
154 (D) a credit accident and health contract;

155 (E) a continuing care contract; and
156 (F) a long-term care contract; and
157 (ii) may provide:
158 (A) hospital coverage;
159 (B) surgical coverage;
160 (C) medical coverage;
161 (D) loss of income coverage;
162 (E) prescription drug coverage;
163 (F) dental coverage; or
164 (G) vision coverage.
165 (c) "Accident and health insurance" does not include workers' compensation insurance.
166 (2) "Actuary" is as defined by the commissioner by rule, made in accordance with Title
167 63G, Chapter 3, Utah Administrative Rulemaking Act.
168 (3) "Administrator" is defined in Subsection [~~(166)~~] (167).
169 (4) "Adult" means an individual who has attained the age of at least 18 years.
170 (5) "Affiliate" means a person who controls, is controlled by, or is under common
171 control with, another person. A corporation is an affiliate of another corporation, regardless of
172 ownership, if substantially the same group of individuals manage the corporations.
173 (6) "Agency" means:
174 (a) a person other than an individual, including a sole proprietorship by which an
175 individual does business under an assumed name; and
176 (b) an insurance organization licensed or required to be licensed under Section
177 31A-23a-301, 31A-25-207, or 31A-26-209.
178 (7) "Alien insurer" means an insurer domiciled outside the United States.
179 (8) "Amendment" means an endorsement to an insurance policy or certificate.
180 (9) "Annuity" means an agreement to make periodical payments for a period certain or
181 over the lifetime of one or more individuals if the making or continuance of all or some of the
182 series of the payments, or the amount of the payment, is dependent upon the continuance of
183 human life.
184 (10) "Application" means a document:
185 (a) (i) completed by an applicant to provide information about the risk to be insured;

186 and
187 (ii) that contains information that is used by the insurer to evaluate risk and decide
188 whether to:
189 (A) insure the risk under:
190 (I) the coverage as originally offered; or
191 (II) a modification of the coverage as originally offered; or
192 (B) decline to insure the risk; or
193 (b) used by the insurer to gather information from the applicant before issuance of an
194 annuity contract.
195 (11) "Articles" or "articles of incorporation" means:
196 (a) the original articles;
197 (b) a special law;
198 (c) a charter;
199 (d) an amendment;
200 (e) restated articles;
201 (f) articles of merger or consolidation;
202 (g) a trust instrument;
203 (h) another constitutive document for a trust or other entity that is not a corporation;
204 and
205 (i) an amendment to an item listed in Subsections (11)(a) through (h).
206 (12) "Bail bond insurance" means a guarantee that a person will attend court when
207 required, up to and including surrender of the person in execution of a sentence imposed under
208 Subsection 77-20-7(1), as a condition to the release of that person from confinement.
209 (13) "Binder" means the same as that term is defined in Section 31A-21-102.
210 (14) "Blanket insurance policy" means a group policy covering a defined class of
211 persons:
212 (a) without individual underwriting or application; and
213 (b) that is determined by definition without designating each person covered.
214 (15) "Board," "board of trustees," or "board of directors" means the group of persons
215 with responsibility over, or management of, a corporation, however designated.
216 (16) "Bona fide office" means a physical office in this state:

217 (a) that is open to the public;
218 (b) that is staffed during regular business hours on regular business days; and
219 (c) at which the public may appear in person to obtain services.
220 (17) "Business entity" means:
221 (a) a corporation;
222 (b) an association;
223 (c) a partnership;
224 (d) a limited liability company;
225 (e) a limited liability partnership; or
226 (f) another legal entity.
227 (18) "Business of insurance" is defined in Subsection (89).
228 (19) "Business plan" means the information required to be supplied to the
229 commissioner under Subsections 31A-5-204(2)(i) and (j), including the information required
230 when these subsections apply by reference under:
231 (a) Section 31A-7-201;
232 (b) Section 31A-8-205; or
233 (c) Subsection 31A-9-205(2).
234 (20) (a) "Bylaws" means the rules adopted for the regulation or management of a
235 corporation's affairs, however designated.
236 (b) "Bylaws" includes comparable rules for a trust or other entity that is not a
237 corporation.
238 (21) "Captive insurance company" means:
239 (a) an insurer:
240 (i) owned by another organization; and
241 (ii) whose exclusive purpose is to insure risks of the parent organization and an
242 affiliated company; or
243 (b) in the case of a group or association, an insurer:
244 (i) owned by the insureds; and
245 (ii) whose exclusive purpose is to insure risks of:
246 (A) a member organization;
247 (B) a group member; or

248 (C) an affiliate of:
249 (I) a member organization; or
250 (II) a group member.
251 (22) "Casualty insurance" means liability insurance.
252 (23) "Certificate" means evidence of insurance given to:
253 (a) an insured under a group insurance policy; or
254 (b) a third party.
255 (24) "Certificate of authority" is included within the term "license."
256 (25) "Claim," unless the context otherwise requires, means a request or demand on an
257 insurer for payment of a benefit according to the terms of an insurance policy.
258 (26) "Claims-made coverage" means an insurance contract or provision limiting
259 coverage under a policy insuring against legal liability to claims that are first made against the
260 insured while the policy is in force.
261 (27) (a) "Commissioner" or "commissioner of insurance" means Utah's insurance
262 commissioner.
263 (b) When appropriate, the terms listed in Subsection (27)(a) apply to the equivalent
264 supervisory official of another jurisdiction.
265 (28) (a) "Continuing care insurance" means insurance that:
266 (i) provides board and lodging;
267 (ii) provides one or more of the following:
268 (A) a personal service;
269 (B) a nursing service;
270 (C) a medical service; or
271 (D) any other health-related service; and
272 (iii) provides the coverage described in this Subsection (28)(a) under an agreement
273 effective:
274 (A) for the life of the insured; or
275 (B) for a period in excess of one year.
276 (b) Insurance is continuing care insurance regardless of whether or not the board and
277 lodging are provided at the same location as a service described in Subsection (28)(a)(ii).
278 (29) (a) "Control," "controlling," "controlled," or "under common control" means the

279 direct or indirect possession of the power to direct or cause the direction of the management
280 and policies of a person. This control may be:
281 (i) by contract;
282 (ii) by common management;
283 (iii) through the ownership of voting securities; or
284 (iv) by a means other than those described in Subsections (29)(a)(i) through (iii).
285 (b) There is no presumption that an individual holding an official position with another
286 person controls that person solely by reason of the position.
287 (c) A person having a contract or arrangement giving control is considered to have
288 control despite the illegality or invalidity of the contract or arrangement.
289 (d) There is a rebuttable presumption of control in a person who directly or indirectly
290 owns, controls, holds with the power to vote, or holds proxies to vote 10% or more of the
291 voting securities of another person.
292 (30) "Controlled insurer" means a licensed insurer that is either directly or indirectly
293 controlled by a producer.
294 (31) "Controlling person" means a person that directly or indirectly has the power to
295 direct or cause to be directed, the management, control, or activities of a reinsurance
296 intermediary.
297 (32) "Controlling producer" means a producer who directly or indirectly controls an
298 insurer.
299 (33) (a) "Corporation" means an insurance corporation, except when referring to:
300 (i) a corporation doing business:
301 (A) as:
302 (I) an insurance producer;
303 (II) a surplus lines producer;
304 (III) a limited line producer;
305 (IV) a consultant;
306 (V) a managing general agent;
307 (VI) a reinsurance intermediary;
308 (VII) a third party administrator; or
309 (VIII) an adjuster; and

310 (B) under:
311 (I) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and
312 Reinsurance Intermediaries;
313 (II) Chapter 25, Third Party Administrators; or
314 (III) Chapter 26, Insurance Adjusters; or
315 (ii) a noninsurer that is part of a holding company system under Chapter 16, Insurance
316 Holding Companies.
317 (b) "Stock corporation" means a stock insurance corporation.
318 (c) "Mutual" or "mutual corporation" means a mutual insurance corporation.
319 (34) (a) "Creditable coverage" has the same meaning as provided in federal regulations
320 adopted pursuant to the Health Insurance Portability and Accountability Act.
321 (b) "Creditable coverage" includes coverage that is offered through a public health plan
322 such as:
323 (i) the Primary Care Network Program under a Medicaid primary care network
324 demonstration waiver obtained subject to Section 26-18-3;
325 (ii) the Children's Health Insurance Program under Section 26-40-106; or
326 (iii) the Ryan White Program Comprehensive AIDS Resources Emergency Act, Pub. L.
327 No. 101-381, and Ryan White HIV/AIDS Treatment Modernization Act of 2006, Pub. L. No.
328 109-415.
329 (35) "Credit accident and health insurance" means insurance on a debtor to provide
330 indemnity for payments coming due on a specific loan or other credit transaction while the
331 debtor has a disability.
332 (36) (a) "Credit insurance" means insurance offered in connection with an extension of
333 credit that is limited to partially or wholly extinguishing that credit obligation.
334 (b) "Credit insurance" includes:
335 (i) credit accident and health insurance;
336 (ii) credit life insurance;
337 (iii) credit property insurance;
338 (iv) credit unemployment insurance;
339 (v) guaranteed automobile protection insurance;
340 (vi) involuntary unemployment insurance;

341 (vii) mortgage accident and health insurance;
342 (viii) mortgage guaranty insurance; and
343 (ix) mortgage life insurance.
344 (37) "Credit life insurance" means insurance on the life of a debtor in connection with
345 an extension of credit that pays a person if the debtor dies.
346 (38) "Creditor" means a person, including an insured, having a claim, whether:
347 (a) matured;
348 (b) unmatured;
349 (c) liquidated;
350 (d) unliquidated;
351 (e) secured;
352 (f) unsecured;
353 (g) absolute;
354 (h) fixed; or
355 (i) contingent.
356 (39) "Credit property insurance" means insurance:
357 (a) offered in connection with an extension of credit; and
358 (b) that protects the property until the debt is paid.
359 (40) "Credit unemployment insurance" means insurance:
360 (a) offered in connection with an extension of credit; and
361 (b) that provides indemnity if the debtor is unemployed for payments coming due on a:
362 (i) specific loan; or
363 (ii) credit transaction.
364 (41) (a) "Crop insurance" means insurance providing protection against damage to
365 crops from unfavorable weather conditions, fire or lightning, flood, hail, insect infestation,
366 disease, or other yield-reducing conditions or perils that is:
367 (i) provided by the private insurance market; or
368 (ii) subsidized by the Federal Crop Insurance Corporation.
369 (b) "Crop insurance" includes multiperil crop insurance.
370 (42) (a) "Customer service representative" means a person that provides an insurance
371 service and insurance product information:

372 (i) for the customer service representative's:
373 (A) producer;
374 (B) surplus lines producer; or
375 (C) consultant employer; and
376 (ii) to the customer service representative's employer's:
377 (A) customer;
378 (B) client; or
379 (C) organization.
380 (b) A customer service representative may only operate within the scope of authority of
381 the customer service representative's producer, surplus lines producer, or consultant employer.
382 (43) "Deadline" means a final date or time:
383 (a) imposed by:
384 (i) statute;
385 (ii) rule; or
386 (iii) order; and
387 (b) by which a required filing or payment must be received by the department.
388 (44) "Deemer clause" means a provision under this title under which upon the
389 occurrence of a condition precedent, the commissioner is considered to have taken a specific
390 action. If the statute so provides, a condition precedent may be the commissioner's failure to
391 take a specific action.
392 (45) "Degree of relationship" means the number of steps between two persons
393 determined by counting the generations separating one person from a common ancestor and
394 then counting the generations to the other person.
395 (46) "Department" means the Insurance Department.
396 (47) "Director" means a member of the board of directors of a corporation.
397 (48) "Disability" means a physiological or psychological condition that partially or
398 totally limits an individual's ability to:
399 (a) perform the duties of:
400 (i) that individual's occupation; or
401 (ii) an occupation for which the individual is reasonably suited by education, training,
402 or experience; or

403 (b) perform two or more of the following basic activities of daily living:
404 (i) eating;
405 (ii) toileting;
406 (iii) transferring;
407 (iv) bathing; or
408 (v) dressing.
409 (49) "Disability income insurance" is defined in Subsection (80).
410 (50) "Domestic insurer" means an insurer organized under the laws of this state.
411 (51) "Domiciliary state" means the state in which an insurer:
412 (a) is incorporated;
413 (b) is organized; or
414 (c) in the case of an alien insurer, enters into the United States.
415 (52) (a) "Eligible employee" means:
416 (i) an employee who:
417 (A) works on a full-time basis; and
418 (B) has a normal work week of 30 or more hours; or
419 (ii) a person described in Subsection (52)(b).
420 (b) "Eligible employee" includes:
421 (i) an owner who:
422 (A) works on a full-time basis; and
423 (B) has a normal work week of 30 or more hours; and
424 (ii) if the individual is included under a health benefit plan of a small employer:
425 (A) a sole proprietor;
426 (B) a partner in a partnership; or
427 (C) an independent contractor.
428 (c) "Eligible employee" does not include, unless eligible under Subsection (52)(b):
429 (i) an individual who works on a temporary or substitute basis for a small employer;
430 (ii) an employer's spouse who does not meet the requirements of Subsection (52)(a)(i);
431 or
432 (iii) a dependent of an employer who does not meet the requirements of Subsection
433 (52)(a)(i).

434 (53) "Employee" means:
435 (a) an individual employed by an employer; and
436 (b) an owner who meets the requirements of Subsection (52)(b)(i).
437 (54) "Employee benefits" means one or more benefits or services provided to:
438 (a) an employee; or
439 (b) a dependent of an employee.
440 (55) (a) "Employee welfare fund" means a fund:
441 (i) established or maintained, whether directly or through a trustee, by:
442 (A) one or more employers;
443 (B) one or more labor organizations; or
444 (C) a combination of employers and labor organizations; and
445 (ii) that provides employee benefits paid or contracted to be paid, other than income
446 from investments of the fund:
447 (A) by or on behalf of an employer doing business in this state; or
448 (B) for the benefit of a person employed in this state.
449 (b) "Employee welfare fund" includes a plan funded or subsidized by a user fee or tax
450 revenues.
451 (56) "Endorsement" means a written agreement attached to a policy or certificate to
452 modify the policy or certificate coverage.
453 (57) "Enrollment date," with respect to a health benefit plan, means:
454 (a) the first day of coverage; or
455 (b) if there is a waiting period, the first day of the waiting period.
456 (58) "Enterprise risk" means an activity, circumstance, event, or series of events
457 involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a
458 material adverse effect upon the financial condition or liquidity of the insurer or its insurance
459 holding company system as a whole, including anything that would cause:
460 (a) the insurer's risk-based capital to fall into an action or control level as set forth in
461 Sections 31A-17-601 through 31A-17-613; or
462 (b) the insurer to be in hazardous financial condition set forth in Section 31A-27a-101.
463 (59) (a) "Escrow" means:
464 (i) a transaction that effects the sale, transfer, encumbering, or leasing of real property,

465 when a person not a party to the transaction, and neither having nor acquiring an interest in the
466 title, performs, in accordance with the written instructions or terms of the written agreement
467 between the parties to the transaction, any of the following actions:
468 (A) the explanation, holding, or creation of a document; or
469 (B) the receipt, deposit, and disbursement of money;
470 (ii) a settlement or closing involving:
471 (A) a mobile home;
472 (B) a grazing right;
473 (C) a water right; or
474 (D) other personal property authorized by the commissioner.
475 (b) "Escrow" does not include:
476 (i) the following notarial acts performed by a notary within the state:
477 (A) an acknowledgment;
478 (B) a copy certification;
479 (C) jurat; and
480 (D) an oath or affirmation;
481 (ii) the receipt or delivery of a document; or
482 (iii) the receipt of money for delivery to the escrow agent.
483 (60) "Escrow agent" means an agency title insurance producer meeting the
484 requirements of Sections 31A-4-107, 31A-14-211, and 31A-23a-204, who is acting through an
485 individual title insurance producer licensed with an escrow subline of authority.
486 (61) (a) "Excludes" is not exhaustive and does not mean that another thing is not also
487 excluded.
488 (b) The items listed in a list using the term "excludes" are representative examples for
489 use in interpretation of this title.
490 (62) "Exclusion" means for the purposes of accident and health insurance that an
491 insurer does not provide insurance coverage, for whatever reason, for one of the following:
492 (a) a specific physical condition;
493 (b) a specific medical procedure;
494 (c) a specific disease or disorder; or
495 (d) a specific prescription drug or class of prescription drugs.

496 (63) "Expense reimbursement insurance" means insurance:
497 (a) written to provide a payment for an expense relating to hospital confinement
498 resulting from illness or injury; and
499 (b) written:
500 (i) as a daily limit for a specific number of days in a hospital; and
501 (ii) to have a one or two day waiting period following a hospitalization.
502 (64) "Fidelity insurance" means insurance guaranteeing the fidelity of a person holding
503 a position of public or private trust.
504 (65) (a) "Filed" means that a filing is:
505 (i) submitted to the department as required by and in accordance with applicable
506 statute, rule, or filing order;
507 (ii) received by the department within the time period provided in applicable statute,
508 rule, or filing order; and
509 (iii) accompanied by the appropriate fee in accordance with:
510 (A) Section 31A-3-103; or
511 (B) rule.
512 (b) "Filed" does not include a filing that is rejected by the department because it is not
513 submitted in accordance with Subsection (65)(a).
514 (66) "Filing," when used as a noun, means an item required to be filed with the
515 department including:
516 (a) a policy;
517 (b) a rate;
518 (c) a form;
519 (d) a document;
520 (e) a plan;
521 (f) a manual;
522 (g) an application;
523 (h) a report;
524 (i) a certificate;
525 (j) an endorsement;
526 (k) an actuarial certification;

527 (l) a licensee annual statement;
528 (m) a licensee renewal application;
529 (n) an advertisement;
530 (o) a binder; or
531 (p) an outline of coverage.
532 (67) "First party insurance" means an insurance policy or contract in which the insurer
533 agrees to pay a claim submitted to it by the insured for the insured's losses.
534 (68) "Foreign insurer" means an insurer domiciled outside of this state, including an
535 alien insurer.
536 (69) (a) "Form" means one of the following prepared for general use:
537 (i) a policy;
538 (ii) a certificate;
539 (iii) an application;
540 (iv) an outline of coverage; or
541 (v) an endorsement.
542 (b) "Form" does not include a document specially prepared for use in an individual
543 case.
544 (70) "Franchise insurance" means an individual insurance policy provided through a
545 mass marketing arrangement involving a defined class of persons related in some way other
546 than through the purchase of insurance.
547 (71) "General lines of authority" include:
548 (a) the general lines of insurance in Subsection (72);
549 (b) title insurance under one of the following sublines of authority:
550 (i) title examination, including authority to act as a title marketing representative;
551 (ii) escrow, including authority to act as a title marketing representative; and
552 (iii) title marketing representative only;
553 (c) surplus lines;
554 (d) workers' compensation; and
555 (e) another line of insurance that the commissioner considers necessary to recognize in
556 the public interest.
557 (72) "General lines of insurance" include:

558 (a) accident and health;
559 (b) casualty;
560 (c) life;
561 (d) personal lines;
562 (e) property; and
563 (f) variable contracts, including variable life and annuity.
564 (73) "Group health plan" means an employee welfare benefit plan to the extent that the
565 plan provides medical care:
566 (a) (i) to an employee; or
567 (ii) to a dependent of an employee; and
568 (b) (i) directly;
569 (ii) through insurance reimbursement; or
570 (iii) through another method.
571 (74) (a) "Group insurance policy" means a policy covering a group of persons that is
572 issued:
573 (i) to a policyholder on behalf of the group; and
574 (ii) for the benefit of a member of the group who is selected under a procedure defined
575 in:
576 (A) the policy; or
577 (B) an agreement that is collateral to the policy.
578 (b) A group insurance policy may include a member of the policyholder's family or a
579 dependent.
580 (75) "Guaranteed automobile protection insurance" means insurance offered in
581 connection with an extension of credit that pays the difference in amount between the
582 insurance settlement and the balance of the loan if the insured automobile is a total loss.
583 (76) (a) Except as provided in Subsection (76)(b), "health benefit plan" means a policy
584 or certificate that:
585 (i) provides health care insurance;
586 (ii) provides major medical expense insurance; or
587 (iii) is offered as a substitute for hospital or medical expense insurance, such as:
588 (A) a hospital confinement indemnity; or

589 (B) a limited benefit plan.
590 (b) "Health benefit plan" does not include a policy or certificate that:
591 (i) provides benefits solely for:
592 (A) accident;
593 (B) dental;
594 (C) income replacement;
595 (D) long-term care;
596 (E) a Medicare supplement;
597 (F) a specified disease;
598 (G) vision; or
599 (H) a short-term limited duration; or
600 (ii) is offered and marketed as supplemental health insurance.
601 (77) "Health care" means any of the following intended for use in the diagnosis,
602 treatment, mitigation, or prevention of a human ailment or impairment:
603 (a) a professional service;
604 (b) a personal service;
605 (c) a facility;
606 (d) equipment;
607 (e) a device;
608 (f) supplies; or
609 (g) medicine.
610 (78) (a) "Health care insurance" or "health insurance" means insurance providing:
611 (i) a health care benefit; or
612 (ii) payment of an incurred health care expense.
613 (b) "Health care insurance" or "health insurance" does not include accident and health
614 insurance providing a benefit for:
615 (i) replacement of income;
616 (ii) short-term accident;
617 (iii) fixed indemnity;
618 (iv) credit accident and health;
619 (v) supplements to liability;

620 (vi) workers' compensation;
621 (vii) automobile medical payment;
622 (viii) no-fault automobile;
623 (ix) equivalent self-insurance; or
624 (x) a type of accident and health insurance coverage that is a part of or attached to
625 another type of policy.
626 (79) "Health Insurance Portability and Accountability Act" means the Health Insurance
627 Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, as amended.
628 (80) "Income replacement insurance" or "disability income insurance" means insurance
629 written to provide payments to replace income lost from accident or sickness.
630 (81) "Indemnity" means the payment of an amount to offset all or part of an insured
631 loss.
632 (82) "Independent adjuster" means an insurance adjuster required to be licensed under
633 Section 31A-26-201 who engages in insurance adjusting as a representative of an insurer.
634 (83) "Independently procured insurance" means insurance procured under Section
635 31A-15-104.
636 (84) "Individual" means a natural person.
637 (85) "Inland marine insurance" includes insurance covering:
638 (a) property in transit on or over land;
639 (b) property in transit over water by means other than boat or ship;
640 (c) bailee liability;
641 (d) fixed transportation property such as bridges, electric transmission systems, radio
642 and television transmission towers and tunnels; and
643 (e) personal and commercial property floaters.
644 (86) "Insolvency" means that:
645 (a) an insurer is unable to pay its debts or meet its obligations as the debts and
646 obligations mature;
647 (b) an insurer's total adjusted capital is less than the insurer's mandatory control level
648 RBC under Subsection 31A-17-601(8)(c); or
649 (c) an insurer is determined to be hazardous under this title.
650 (87) (a) "Insurance" means:

651 (i) an arrangement, contract, or plan for the transfer of a risk or risks from one or more
652 persons to one or more other persons; or
653 (ii) an arrangement, contract, or plan for the distribution of a risk or risks among a
654 group of persons that includes the person seeking to distribute that person's risk.
655 (b) "Insurance" includes:
656 (i) a risk distributing arrangement providing for compensation or replacement for
657 damages or loss through the provision of a service or a benefit in kind;
658 (ii) a contract of guaranty or suretyship entered into by the guarantor or surety as a
659 business and not as merely incidental to a business transaction; and
660 (iii) a plan in which the risk does not rest upon the person who makes an arrangement,
661 but with a class of persons who have agreed to share the risk.
662 (88) "Insurance adjuster" means a person who directs or conducts the investigation,
663 negotiation, or settlement of a claim under an insurance policy other than life insurance or an
664 annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.
665 (89) "Insurance business" or "business of insurance" includes:
666 (a) providing health care insurance by an organization that is or is required to be
667 licensed under this title;
668 (b) providing a benefit to an employee in the event of a contingency not within the
669 control of the employee, in which the employee is entitled to the benefit as a right, which
670 benefit may be provided either:
671 (i) by a single employer or by multiple employer groups; or
672 (ii) through one or more trusts, associations, or other entities;
673 (c) providing an annuity:
674 (i) including an annuity issued in return for a gift; and
675 (ii) except an annuity provided by a person specified in Subsections 31A-22-1305(2)
676 and (3);
677 (d) providing the characteristic services of a motor club as outlined in Subsection
678 (117);
679 (e) providing another person with insurance;
680 (f) making as insurer, guarantor, or surety, or proposing to make as insurer, guarantor,
681 or surety, a contract or policy of title insurance;

682 (g) transacting or proposing to transact any phase of title insurance, including:
683 (i) solicitation;
684 (ii) negotiation preliminary to execution;
685 (iii) execution of a contract of title insurance;
686 (iv) insuring; and
687 (v) transacting matters subsequent to the execution of the contract and arising out of
688 the contract, including reinsurance;
689 (h) transacting or proposing a life settlement; and
690 (i) doing, or proposing to do, any business in substance equivalent to Subsections
691 (89)(a) through (h) in a manner designed to evade this title.
692 (90) "Insurance consultant" or "consultant" means a person who:
693 (a) advises another person about insurance needs and coverages;
694 (b) is compensated by the person advised on a basis not directly related to the insurance
695 placed; and
696 (c) except as provided in Section 31A-23a-501, is not compensated directly or
697 indirectly by an insurer or producer for advice given.
698 (91) "Insurance holding company system" means a group of two or more affiliated
699 persons, at least one of whom is an insurer.
700 (92) (a) "Insurance producer" or "producer" means a person licensed or required to be
701 licensed under the laws of this state to sell, solicit, or negotiate insurance.
702 (b) (i) "Producer for the insurer" means a producer who is compensated directly or
703 indirectly by an insurer for selling, soliciting, or negotiating an insurance product of that
704 insurer.
705 (ii) "Producer for the insurer" may be referred to as an "agent."
706 (c) (i) "Producer for the insured" means a producer who:
707 (A) is compensated directly and only by an insurance customer or an insured; and
708 (B) receives no compensation directly or indirectly from an insurer for selling,
709 soliciting, or negotiating an insurance product of that insurer to an insurance customer or
710 insured.
711 (ii) "Producer for the insured" may be referred to as a "broker."
712 (93) (a) "Insured" means a person to whom or for whose benefit an insurer makes a

713 promise in an insurance policy and includes:
714 (i) a policyholder;
715 (ii) a subscriber;
716 (iii) a member; and
717 (iv) a beneficiary.
718 (b) The definition in Subsection (93)(a):
719 (i) applies only to this title; and
720 (ii) does not define the meaning of this word as used in an insurance policy or
721 certificate.
722 (94) (a) "Insurer" means a person doing an insurance business as a principal including:
723 (i) a fraternal benefit society;
724 (ii) an issuer of a gift annuity other than an annuity specified in Subsections
725 31A-22-1305(2) and (3);
726 (iii) a motor club;
727 (iv) an employee welfare plan; and
728 (v) a person purporting or intending to do an insurance business as a principal on that
729 person's own account.
730 (b) "Insurer" does not include a governmental entity to the extent the governmental
731 entity is engaged in an activity described in Section 31A-12-107.
732 (95) "Interinsurance exchange" is defined in Subsection (148).
733 (96) "Involuntary unemployment insurance" means insurance:
734 (a) offered in connection with an extension of credit; and
735 (b) that provides indemnity if the debtor is involuntarily unemployed for payments
736 coming due on a:
737 (i) specific loan; or
738 (ii) credit transaction.
739 (97) (a) "Large employer," in connection with a health benefit plan, means an employer
740 who, with respect to a calendar year and to a plan year:
741 (i) employed an average of at least 51 employees on business days during the preceding
742 calendar year; and
743 (ii) employs at least one employee on the first day of the plan year.

744 (b) The number of employees shall be determined using the method set forth in 26
745 U.S.C. Sec. 4980H(c)(2).
746 (98) "Late enrollee," with respect to an employer health benefit plan, means an
747 individual whose enrollment is a late enrollment.
748 (99) "Late enrollment," with respect to an employer health benefit plan, means
749 enrollment of an individual other than:
750 (a) on the earliest date on which coverage can become effective for the individual
751 under the terms of the plan; or
752 (b) through special enrollment.
753 (100) (a) Except for a retainer contract or legal assistance described in Section
754 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for a
755 specified legal expense.
756 (b) "Legal expense insurance" includes an arrangement that creates a reasonable
757 expectation of an enforceable right.
758 (c) "Legal expense insurance" does not include the provision of, or reimbursement for,
759 legal services incidental to other insurance coverage.
760 (101) (a) "Liability insurance" means insurance against liability:
761 (i) for death, injury, or disability of a human being, or for damage to property,
762 exclusive of the coverages under:
763 (A) Subsection (111) for medical malpractice insurance;
764 (B) Subsection (139) for professional liability insurance; and
765 (C) Subsection [~~(175)~~] (176) for workers' compensation insurance;
766 (ii) for a medical, hospital, surgical, and funeral benefit to a person other than the
767 insured who is injured, irrespective of legal liability of the insured, when issued with or
768 supplemental to insurance against legal liability for the death, injury, or disability of a human
769 being, exclusive of the coverages under:
770 (A) Subsection (111) for medical malpractice insurance;
771 (B) Subsection (139) for professional liability insurance; and
772 (C) Subsection [~~(175)~~] (176) for workers' compensation insurance;
773 (iii) for loss or damage to property resulting from an accident to or explosion of a
774 boiler, pipe, pressure container, machinery, or apparatus;

775 (iv) for loss or damage to property caused by:
776 (A) the breakage or leakage of a sprinkler, water pipe, or water container; or
777 (B) water entering through a leak or opening in a building; or
778 (v) for other loss or damage properly the subject of insurance not within another kind
779 of insurance as defined in this chapter, if the insurance is not contrary to law or public policy.
780 (b) "Liability insurance" includes:
781 (i) vehicle liability insurance;
782 (ii) residential dwelling liability insurance; and
783 (iii) making inspection of, and issuing a certificate of inspection upon, an elevator,
784 boiler, machinery, or apparatus of any kind when done in connection with insurance on the
785 elevator, boiler, machinery, or apparatus.
786 (102) (a) "License" means authorization issued by the commissioner to engage in an
787 activity that is part of or related to the insurance business.
788 (b) "License" includes a certificate of authority issued to an insurer.
789 (103) (a) "Life insurance" means:
790 (i) insurance on a human life; and
791 (ii) insurance pertaining to or connected with human life.
792 (b) The business of life insurance includes:
793 (i) granting a death benefit;
794 (ii) granting an annuity benefit;
795 (iii) granting an endowment benefit;
796 (iv) granting an additional benefit in the event of death by accident;
797 (v) granting an additional benefit to safeguard the policy against lapse; and
798 (vi) providing an optional method of settlement of proceeds.
799 (104) "Limited license" means a license that:
800 (a) is issued for a specific product of insurance; and
801 (b) limits an individual or agency to transact only for that product or insurance.
802 (105) "Limited line credit insurance" includes the following forms of insurance:
803 (a) credit life;
804 (b) credit accident and health;
805 (c) credit property;

806 (d) credit unemployment;
807 (e) involuntary unemployment;
808 (f) mortgage life;
809 (g) mortgage guaranty;
810 (h) mortgage accident and health;
811 (i) guaranteed automobile protection; and
812 (j) another form of insurance offered in connection with an extension of credit that:
813 (i) is limited to partially or wholly extinguishing the credit obligation; and
814 (ii) the commissioner determines by rule, made in accordance with Title 63G, Chapter
815 3, Utah Administrative Rulemaking Act, should be designated as a form of limited line credit
816 insurance.
817 (106) "Limited line credit insurance producer" means a person who sells, solicits, or
818 negotiates one or more forms of limited line credit insurance coverage to an individual through
819 a master, corporate, group, or individual policy.
820 (107) "Limited line insurance" includes:
821 (a) bail bond;
822 (b) limited line credit insurance;
823 (c) legal expense insurance;
824 (d) motor club insurance;
825 (e) car rental related insurance;
826 (f) travel insurance;
827 (g) crop insurance;
828 (h) self-service storage insurance;
829 (i) guaranteed asset protection waiver;
830 (j) portable electronics insurance; and
831 (k) another form of limited insurance that the commissioner determines by rule, made
832 in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, should be
833 designated a form of limited line insurance.
834 (108) "Limited lines authority" includes the lines of insurance listed in Subsection
835 (107).
836 (109) "Limited lines producer" means a person who sells, solicits, or negotiates limited

837 lines insurance.

838 (110) (a) "Long-term care insurance" means an insurance policy or rider advertised,

839 marketed, offered, or designated to provide coverage:

840 (i) in a setting other than an acute care unit of a hospital;

841 (ii) for not less than 12 consecutive months for a covered person on the basis of:

842 (A) expenses incurred;

843 (B) indemnity;

844 (C) prepayment; or

845 (D) another method;

846 (iii) for one or more necessary or medically necessary services that are:

847 (A) diagnostic;

848 (B) preventative;

849 (C) therapeutic;

850 (D) rehabilitative;

851 (E) maintenance; or

852 (F) personal care; and

853 (iv) that may be issued by:

854 (A) an insurer;

855 (B) a fraternal benefit society;

856 (C) (I) a nonprofit health hospital; and

857 (II) a medical service corporation;

858 (D) a prepaid health plan;

859 (E) a health maintenance organization; or

860 (F) an entity similar to the entities described in Subsections (110)(a)(iv)(A) through (E)

861 to the extent that the entity is otherwise authorized to issue life or health care insurance.

862 (b) "Long-term care insurance" includes:

863 (i) any of the following that provide directly or supplement long-term care insurance:

864 (A) a group or individual annuity or rider; or

865 (B) a life insurance policy or rider;

866 (ii) a policy or rider that provides for payment of benefits on the basis of:

867 (A) cognitive impairment; or

868 (B) functional capacity; or
869 (iii) a qualified long-term care insurance contract.
870 (c) "Long-term care insurance" does not include:
871 (i) a policy that is offered primarily to provide basic Medicare supplement coverage;
872 (ii) basic hospital expense coverage;
873 (iii) basic medical/surgical expense coverage;
874 (iv) hospital confinement indemnity coverage;
875 (v) major medical expense coverage;
876 (vi) income replacement or related asset-protection coverage;
877 (vii) accident only coverage;
878 (viii) coverage for a specified:
879 (A) disease; or
880 (B) accident;
881 (ix) limited benefit health coverage; or
882 (x) a life insurance policy that accelerates the death benefit to provide the option of a
883 lump sum payment:
884 (A) if the following are not conditioned on the receipt of long-term care:
885 (I) benefits; or
886 (II) eligibility; and
887 (B) the coverage is for one or more the following qualifying events:
888 (I) terminal illness;
889 (II) medical conditions requiring extraordinary medical intervention; or
890 (III) permanent institutional confinement.
891 (111) "Medical malpractice insurance" means insurance against legal liability incident
892 to the practice and provision of a medical service other than the practice and provision of a
893 dental service.
894 (112) "Member" means a person having membership rights in an insurance
895 corporation.
896 (113) "Minimum capital" or "minimum required capital" means the capital that must be
897 constantly maintained by a stock insurance corporation as required by statute.
898 (114) "Mortgage accident and health insurance" means insurance offered in connection

899 with an extension of credit that provides indemnity for payments coming due on a mortgage
900 while the debtor has a disability.
901 (115) "Mortgage guaranty insurance" means surety insurance under which a mortgagee
902 or other creditor is indemnified against losses caused by the default of a debtor.
903 (116) "Mortgage life insurance" means insurance on the life of a debtor in connection
904 with an extension of credit that pays if the debtor dies.
905 (117) "Motor club" means a person:
906 (a) licensed under:
907 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
908 (ii) Chapter 11, Motor Clubs; or
909 (iii) Chapter 14, Foreign Insurers; and
910 (b) that promises for an advance consideration to provide for a stated period of time
911 one or more:
912 (i) legal services under Subsection 31A-11-102(1)(b);
913 (ii) bail services under Subsection 31A-11-102(1)(c); or
914 (iii) (A) trip reimbursement;
915 (B) towing services;
916 (C) emergency road services;
917 (D) stolen automobile services;
918 (E) a combination of the services listed in Subsections (117)(b)(iii)(A) through (D); or
919 (F) other services given in Subsections 31A-11-102(1)(b) through (f).
920 (118) "Mutual" means a mutual insurance corporation.
921 (119) "Network plan" means health care insurance:
922 (a) that is issued by an insurer; and
923 (b) under which the financing and delivery of medical care is provided, in whole or in
924 part, through a defined set of providers under contract with the insurer, including the financing
925 and delivery of an item paid for as medical care.
926 (120) "Nonparticipating" means a plan of insurance under which the insured is not
927 entitled to receive a dividend representing a share of the surplus of the insurer.
928 (121) "Ocean marine insurance" means insurance against loss of or damage to:
929 (a) ships or hulls of ships;

930 (b) goods, freight, cargoes, merchandise, effects, disbursements, profits, money,
931 securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia
932 interests, or other cargoes in or awaiting transit over the oceans or inland waterways;
933 (c) earnings such as freight, passage money, commissions, or profits derived from
934 transporting goods or people upon or across the oceans or inland waterways; or
935 (d) a vessel owner or operator as a result of liability to employees, passengers, bailors,
936 owners of other vessels, owners of fixed objects, customs or other authorities, or other persons
937 in connection with maritime activity.
938 (122) "Order" means an order of the commissioner.
939 (123) "Outline of coverage" means a summary that explains an accident and health
940 insurance policy.
941 (124) "Participating" means a plan of insurance under which the insured is entitled to
942 receive a dividend representing a share of the surplus of the insurer.
943 (125) "Participation," as used in a health benefit plan, means a requirement relating to
944 the minimum percentage of eligible employees that must be enrolled in relation to the total
945 number of eligible employees of an employer reduced by each eligible employee who
946 voluntarily declines coverage under the plan because the employee:
947 (a) has other group health care insurance coverage; or
948 (b) receives:
949 (i) Medicare, under the Health Insurance for the Aged Act, Title XVIII of the Social
950 Security Amendments of 1965; or
951 (ii) another government health benefit.
952 (126) "Person" includes:
953 (a) an individual;
954 (b) a partnership;
955 (c) a corporation;
956 (d) an incorporated or unincorporated association;
957 (e) a joint stock company;
958 (f) a trust;
959 (g) a limited liability company;
960 (h) a reciprocal;

961 (i) a syndicate; or
962 (j) another similar entity or combination of entities acting in concert.
963 (127) "Personal lines insurance" means property and casualty insurance coverage sold
964 for primarily noncommercial purposes to:
965 (a) an individual; or
966 (b) a family.
967 (128) "Plan sponsor" is as defined in 29 U.S.C. Sec. 1002(16)(B).
968 (129) "Plan year" means:
969 (a) the year that is designated as the plan year in:
970 (i) the plan document of a group health plan; or
971 (ii) a summary plan description of a group health plan;
972 (b) if the plan document or summary plan description does not designate a plan year or
973 there is no plan document or summary plan description:
974 (i) the year used to determine deductibles or limits;
975 (ii) the policy year, if the plan does not impose deductibles or limits on a yearly basis;
976 or
977 (iii) the employer's taxable year if:
978 (A) the plan does not impose deductibles or limits on a yearly basis; and
979 (B) (I) the plan is not insured; or
980 (II) the insurance policy is not renewed on an annual basis; or
981 (c) in a case not described in Subsection (129)(a) or (b), the calendar year.
982 (130) (a) "Policy" means a document, including an attached endorsement or application
983 that:
984 (i) purports to be an enforceable contract; and
985 (ii) memorializes in writing some or all of the terms of an insurance contract.
986 (b) "Policy" includes a service contract issued by:
987 (i) a motor club under Chapter 11, Motor Clubs;
988 (ii) a service contract provided under Chapter 6a, Service Contracts; and
989 (iii) a corporation licensed under:
990 (A) Chapter 7, Nonprofit Health Service Insurance Corporations; or
991 (B) Chapter 8, Health Maintenance Organizations and Limited Health Plans.

992 (c) "Policy" does not include:
993 (i) a certificate under a group insurance contract; or
994 (ii) a document that does not purport to have legal effect.
995 (131) "Policyholder" means a person who controls a policy, binder, or oral contract by
996 ownership, premium payment, or otherwise.
997 (132) "Policy illustration" means a presentation or depiction that includes
998 nonguaranteed elements of a policy of life insurance over a period of years.
999 (133) "Policy summary" means a synopsis describing the elements of a life insurance
1000 policy.
1001 (134) "PPACA" means the Patient Protection and Affordable Care Act, Pub. L. No.
1002 111-148 and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, and
1003 related federal regulations and guidance.
1004 (135) "Preexisting condition," with respect to a health benefit plan:
1005 (a) means a condition that was present before the effective date of coverage, whether or
1006 not medical advice, diagnosis, care, or treatment was recommended or received before that day;
1007 and
1008 (b) does not include a condition indicated by genetic information unless an actual
1009 diagnosis of the condition by a physician has been made.
1010 (136) (a) "Premium" means the monetary consideration for an insurance policy.
1011 (b) "Premium" includes, however designated:
1012 (i) an assessment;
1013 (ii) a membership fee;
1014 (iii) a required contribution; or
1015 (iv) monetary consideration.
1016 (c) (i) "Premium" does not include consideration paid to a third party administrator for
1017 the third party administrator's services.
1018 (ii) "Premium" includes an amount paid by a third party administrator to an insurer for
1019 insurance on the risks administered by the third party administrator.
1020 (137) "Principal officers" for a corporation means the officers designated under
1021 Subsection 31A-5-203(3).
1022 (138) "Proceeding" includes an action or special statutory proceeding.

1023 (139) "Professional liability insurance" means insurance against legal liability incident
1024 to the practice of a profession and provision of a professional service.
1025 (140) (a) Except as provided in Subsection (140)(b), "property insurance" means
1026 insurance against loss or damage to real or personal property of every kind and any interest in
1027 that property:
1028 (i) from all hazards or causes; and
1029 (ii) against loss consequential upon the loss or damage including vehicle
1030 comprehensive and vehicle physical damage coverages.
1031 (b) "Property insurance" does not include:
1032 (i) inland marine insurance; and
1033 (ii) ocean marine insurance.
1034 (141) "Qualified long-term care insurance contract" or "federally tax qualified
1035 long-term care insurance contract" means:
1036 (a) an individual or group insurance contract that meets the requirements of Section
1037 7702B(b), Internal Revenue Code; or
1038 (b) the portion of a life insurance contract that provides long-term care insurance:
1039 (i) (A) by rider; or
1040 (B) as a part of the contract; and
1041 (ii) that satisfies the requirements of Sections 7702B(b) and (e), Internal Revenue
1042 Code.
1043 (142) "Qualified United States financial institution" means an institution that:
1044 (a) is:
1045 (i) organized under the laws of the United States or any state; or
1046 (ii) in the case of a United States office of a foreign banking organization, licensed
1047 under the laws of the United States or any state;
1048 (b) is regulated, supervised, and examined by a United States federal or state authority
1049 having regulatory authority over a bank or trust company; and
1050 (c) meets the standards of financial condition and standing that are considered
1051 necessary and appropriate to regulate the quality of a financial institution whose letters of credit
1052 will be acceptable to the commissioner as determined by:
1053 (i) the commissioner by rule made in accordance with Title 63G, Chapter 3, Utah

1054 Administrative Rulemaking Act; or

1055 (ii) the Securities Valuation Office of the National Association of Insurance

1056 Commissioners.

1057 (143) (a) "Rate" means:

1058 (i) the cost of a given unit of insurance; or

1059 (ii) for property or casualty insurance, that cost of insurance per exposure unit either

1060 expressed as:

1061 (A) a single number; or

1062 (B) a pure premium rate, adjusted before the application of individual risk variations

1063 based on loss or expense considerations to account for the treatment of:

1064 (I) expenses;

1065 (II) profit; and

1066 (III) individual insurer variation in loss experience.

1067 (b) "Rate" does not include a minimum premium.

1068 (144) (a) Except as provided in Subsection (144)(b), "rate service organization" means

1069 a person who assists an insurer in rate making or filing by:

1070 (i) collecting, compiling, and furnishing loss or expense statistics;

1071 (ii) recommending, making, or filing rates or supplementary rate information; or

1072 (iii) advising about rate questions, except as an attorney giving legal advice.

1073 (b) "Rate service organization" does not mean:

1074 (i) an employee of an insurer;

1075 (ii) a single insurer or group of insurers under common control;

1076 (iii) a joint underwriting group; or

1077 (iv) an individual serving as an actuarial or legal consultant.

1078 (145) "Rating manual" means any of the following used to determine initial and

1079 renewal policy premiums:

1080 (a) a manual of rates;

1081 (b) a classification;

1082 (c) a rate-related underwriting rule; and

1083 (d) a rating formula that describes steps, policies, and procedures for determining

1084 initial and renewal policy premiums.

1085 (146) (a) "Rebate" means a licensee paying, allowing, giving, or offering to pay, allow,
1086 or give, directly or indirectly:
1087 (i) a refund of premium or portion of premium;
1088 (ii) a refund of commission or portion of commission;
1089 (iii) a refund of all or a portion of a consultant fee; or
1090 (iv) providing services or other benefits not specified in an insurance or annuity
1091 contract.
1092 (b) "Rebate" does not include:
1093 (i) a refund due to termination or changes in coverage;
1094 (ii) a refund due to overcharges made in error by the licensee; or
1095 (iii) savings or wellness benefits as provided in the contract by the licensee.
1096 (147) "Received by the department" means:
1097 (a) the date delivered to and stamped received by the department, if delivered in
1098 person;
1099 (b) the post mark date, if delivered by mail;
1100 (c) the delivery service's post mark or pickup date, if delivered by a delivery service;
1101 (d) the received date recorded on an item delivered, if delivered by:
1102 (i) facsimile;
1103 (ii) email; or
1104 (iii) another electronic method; or
1105 (e) a date specified in:
1106 (i) a statute;
1107 (ii) a rule; or
1108 (iii) an order.
1109 (148) "Reciprocal" or "interinsurance exchange" means an unincorporated association
1110 of persons:
1111 (a) operating through an attorney-in-fact common to all of the persons; and
1112 (b) exchanging insurance contracts with one another that provide insurance coverage
1113 on each other.
1114 (149) "Reinsurance" means an insurance transaction where an insurer, for
1115 consideration, transfers any portion of the risk it has assumed to another insurer. In referring to

1116 reinsurance transactions, this title sometimes refers to:
1117 (a) the insurer transferring the risk as the "ceding insurer"; and
1118 (b) the insurer assuming the risk as the:
1119 (i) "assuming insurer"; or
1120 (ii) "assuming reinsurer."
1121 (150) "Reinsurer" means a person licensed in this state as an insurer with the authority
1122 to assume reinsurance.
1123 (151) "Residential dwelling liability insurance" means insurance against liability
1124 resulting from or incident to the ownership, maintenance, or use of a residential dwelling that is
1125 a detached single family residence or multifamily residence up to four units.
1126 (152) (a) "Retrocession" means reinsurance with another insurer of a liability assumed
1127 under a reinsurance contract.
1128 (b) A reinsurer "retrocedes" when the reinsurer reinsures with another insurer part of a
1129 liability assumed under a reinsurance contract.
1130 (153) "Rider" means an endorsement to:
1131 (a) an insurance policy; or
1132 (b) an insurance certificate.
1133 (154) "Secondary medical condition" means a complication related to an exclusion
1134 from coverage in accident and health insurance.
1135 (155) (a) "Security" means a:
1136 (i) note;
1137 (ii) stock;
1138 (iii) bond;
1139 (iv) debenture;
1140 (v) evidence of indebtedness;
1141 (vi) certificate of interest or participation in a profit-sharing agreement;
1142 (vii) collateral-trust certificate;
1143 (viii) preorganization certificate or subscription;
1144 (ix) transferable share;
1145 (x) investment contract;
1146 (xi) voting trust certificate;

1147 (xii) certificate of deposit for a security;
1148 (xiii) certificate of interest of participation in an oil, gas, or mining title or lease or in
1149 payments out of production under such a title or lease;
1150 (xiv) commodity contract or commodity option;
1151 (xv) certificate of interest or participation in, temporary or interim certificate for,
1152 receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed
1153 in Subsections (155)(a)(i) through (xiv); or
1154 (xvi) another interest or instrument commonly known as a security.
1155 (b) "Security" does not include:
1156 (i) any of the following under which an insurance company promises to pay money in a
1157 specific lump sum or periodically for life or some other specified period:
1158 (A) insurance;
1159 (B) an endowment policy; or
1160 (C) an annuity contract; or
1161 (ii) a burial certificate or burial contract.
1162 (156) "Securityholder" means a specified person who owns a security of a person,
1163 including:
1164 (a) common stock;
1165 (b) preferred stock;
1166 (c) debt obligations; and
1167 (d) any other security convertible into or evidencing the right of any of the items listed
1168 in this Subsection (156).
1169 (157) (a) "Self-insurance" means an arrangement under which a person provides for
1170 spreading its own risks by a systematic plan.
1171 (b) Except as provided in this Subsection (157), "self-insurance" does not include an
1172 arrangement under which a number of persons spread their risks among themselves.
1173 (c) "Self-insurance" includes:
1174 (i) an arrangement by which a governmental entity undertakes to indemnify an
1175 employee for liability arising out of the employee's employment; and
1176 (ii) an arrangement by which a person with a managed program of self-insurance and
1177 risk management undertakes to indemnify its affiliates, subsidiaries, directors, officers, or

1178 employees for liability or risk that is related to the relationship or employment.
1179 (d) "Self-insurance" does not include an arrangement with an independent contractor.
1180 (158) "Sell" means to exchange a contract of insurance:
1181 (a) by any means;
1182 (b) for money or its equivalent; and
1183 (c) on behalf of an insurance company.
1184 (159) "Short-term care insurance" means an insurance policy or rider advertised,
1185 marketed, offered, or designed to provide coverage that is similar to long-term care insurance,
1186 but that provides coverage for less than 12 consecutive months for each covered person.
1187 (160) "Short-term limited duration health insurance" means health benefit coverage
1188 that:
1189 (a) is not renewable; and
1190 (b) expires on the date specified in the contract that is less than three months after the
1191 original effective date of the contract.
1192 [~~(160)~~] (161) "Significant break in coverage" means a period of 63 consecutive days
1193 during each of which an individual does not have creditable coverage.
1194 [~~(161)~~] (162) (a) "Small employer" means, in connection with a health benefit plan and
1195 with respect to a calendar year and to a plan year, an employer who:
1196 (i) employed at least one employee but not more than 50 employees on business days
1197 during the preceding calendar year; and
1198 (ii) employs at least one employee on the first day of the plan year.
1199 (b) The number of employees shall:
1200 (i) be determined using the method set forth in 26 U.S.C. Sec. 4980H(c)(2); and
1201 (ii) include an owner described in Subsection (52)(b)(i).
1202 (c) "Small employer" does not include a sole proprietor that does not employ at least
1203 one employee.
1204 [~~(162)~~] (163) "Special enrollment period," in connection with a health benefit plan, has
1205 the same meaning as provided in federal regulations adopted pursuant to the Health Insurance
1206 Portability and Accountability Act.
1207 [~~(163)~~] (164) (a) "Subsidiary" of a person means an affiliate controlled by that person
1208 either directly or indirectly through one or more affiliates or intermediaries.

1209 (b) "Wholly owned subsidiary" of a person is a subsidiary of which all of the voting
1210 shares are owned by that person either alone or with its affiliates, except for the minimum
1211 number of shares the law of the subsidiary's domicile requires to be owned by directors or
1212 others.

1213 [~~(164)~~] (165) Subject to Subsection (87)(b), "surety insurance" includes:

1214 (a) a guarantee against loss or damage resulting from the failure of a principal to pay or
1215 perform the principal's obligations to a creditor or other obligee;

1216 (b) bail bond insurance; and

1217 (c) fidelity insurance.

1218 [~~(165)~~] (166) (a) "Surplus" means the excess of assets over the sum of paid-in capital
1219 and liabilities.

1220 (b) (i) "Permanent surplus" means the surplus of an insurer or organization that is
1221 designated by the insurer or organization as permanent.

1222 (ii) Sections 31A-5-211, 31A-7-201, 31A-8-209, 31A-9-209, and 31A-14-205 require
1223 that insurers or organizations doing business in this state maintain specified minimum levels of
1224 permanent surplus.

1225 (iii) Except for assessable mutuals, the minimum permanent surplus requirement is the
1226 same as the minimum required capital requirement that applies to stock insurers.

1227 (c) "Excess surplus" means:

1228 (i) for a life insurer, accident and health insurer, health organization, or property and
1229 casualty insurer as defined in Section 31A-17-601, the lesser of:

1230 (A) that amount of an insurer's or health organization's total adjusted capital that
1231 exceeds the product of:

1232 (I) 2.5; and

1233 (II) the sum of the insurer's or health organization's minimum capital or permanent
1234 surplus required under Section 31A-5-211, 31A-9-209, or 31A-14-205; or

1235 (B) that amount of an insurer's or health organization's total adjusted capital that
1236 exceeds the product of:

1237 (I) 3.0; and

1238 (II) the authorized control level RBC as defined in Subsection 31A-17-601(8)(a); and

1239 (ii) for a monoline mortgage guaranty insurer, financial guaranty insurer, or title insurer

1240 that amount of an insurer's paid-in-capital and surplus that exceeds the product of:
1241 (A) 1.5; and
1242 (B) the insurer's total adjusted capital required by Subsection 31A-17-609(1).
1243 [~~(166)~~] (167) "Third party administrator" or "administrator" means a person who
1244 collects charges or premiums from, or who, for consideration, adjusts or settles claims of
1245 residents of the state in connection with insurance coverage, annuities, or service insurance
1246 coverage, except:
1247 (a) a union on behalf of its members;
1248 (b) a person administering a:
1249 (i) pension plan subject to the federal Employee Retirement Income Security Act of
1250 1974;
1251 (ii) governmental plan as defined in Section 414(d), Internal Revenue Code; or
1252 (iii) nonelecting church plan as described in Section 410(d), Internal Revenue Code;
1253 (c) an employer on behalf of the employer's employees or the employees of one or
1254 more of the subsidiary or affiliated corporations of the employer;
1255 (d) an insurer licensed under the following, but only for a line of insurance for which
1256 the insurer holds a license in this state:
1257 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
1258 (ii) Chapter 7, Nonprofit Health Service Insurance Corporations;
1259 (iii) Chapter 8, Health Maintenance Organizations and Limited Health Plans;
1260 (iv) Chapter 9, Insurance Fraternals; or
1261 (v) Chapter 14, Foreign Insurers;
1262 (e) a person:
1263 (i) licensed or exempt from licensing under:
1264 (A) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and
1265 Reinsurance Intermediaries; or
1266 (B) Chapter 26, Insurance Adjusters; and
1267 (ii) whose activities are limited to those authorized under the license the person holds
1268 or for which the person is exempt; or
1269 (f) an institution, bank, or financial institution:
1270 (i) that is:

1271 (A) an institution whose deposits and accounts are to any extent insured by a federal
1272 deposit insurance agency, including the Federal Deposit Insurance Corporation or National
1273 Credit Union Administration; or
1274 (B) a bank or other financial institution that is subject to supervision or examination by
1275 a federal or state banking authority; and
1276 (ii) that does not adjust claims without a third party administrator license.
1277 [~~(167)~~] (168) "Title insurance" means the insuring, guaranteeing, or indemnifying of an
1278 owner of real or personal property or the holder of liens or encumbrances on that property, or
1279 others interested in the property against loss or damage suffered by reason of liens or
1280 encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity
1281 or unenforceability of any liens or encumbrances on the property.
1282 [~~(168)~~] (169) "Total adjusted capital" means the sum of an insurer's or health
1283 organization's statutory capital and surplus as determined in accordance with:
1284 (a) the statutory accounting applicable to the annual financial statements required to be
1285 filed under Section 31A-4-113; and
1286 (b) another item provided by the RBC instructions, as RBC instructions is defined in
1287 Section 31A-17-601.
1288 [~~(169)~~] (170) (a) "Trustee" means "director" when referring to the board of directors of
1289 a corporation.
1290 (b) "Trustee," when used in reference to an employee welfare fund, means an
1291 individual, firm, association, organization, joint stock company, or corporation, whether acting
1292 individually or jointly and whether designated by that name or any other, that is charged with
1293 or has the overall management of an employee welfare fund.
1294 [~~(170)~~] (171) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted
1295 insurer" means an insurer:
1296 (i) not holding a valid certificate of authority to do an insurance business in this state;
1297 or
1298 (ii) transacting business not authorized by a valid certificate.
1299 (b) "Admitted insurer" or "authorized insurer" means an insurer:
1300 (i) holding a valid certificate of authority to do an insurance business in this state; and
1301 (ii) transacting business as authorized by a valid certificate.

1302 [~~(171)~~] (172) "Underwrite" means the authority to accept or reject risk on behalf of the
1303 insurer.
1304 [~~(172)~~] (173) "Vehicle liability insurance" means insurance against liability resulting
1305 from or incident to ownership, maintenance, or use of a land vehicle or aircraft, exclusive of a
1306 vehicle comprehensive or vehicle physical damage coverage under Subsection (140).
1307 [~~(173)~~] (174) "Voting security" means a security with voting rights, and includes a
1308 security convertible into a security with a voting right associated with the security.
1309 [~~(174)~~] (175) "Waiting period" for a health benefit plan means the period that must
1310 pass before coverage for an individual, who is otherwise eligible to enroll under the terms of
1311 the health benefit plan, can become effective.
1312 [~~(175)~~] (176) "Workers' compensation insurance" means:
1313 (a) insurance for indemnification of an employer against liability for compensation
1314 based on:
1315 (i) a compensable accidental injury; and
1316 (ii) occupational disease disability;
1317 (b) employer's liability insurance incidental to workers' compensation insurance and
1318 written in connection with workers' compensation insurance; and
1319 (c) insurance assuring to a person entitled to workers' compensation benefits the
1320 compensation provided by law.
1321 Section 2. Section **31A-2-308** is amended to read:
1322 **31A-2-308. Enforcement penalties and procedures.**
1323 (1) (a) A person who violates any insurance statute or rule or any order issued under
1324 Subsection 31A-2-201(4) shall forfeit to the state twice the amount of any profit gained from
1325 the violation, in addition to any other forfeiture or penalty imposed.
1326 (b) (i) The commissioner may order an individual producer, surplus line producer,
1327 limited line producer, managing general agent, reinsurance intermediary, adjuster, third party
1328 administrator, navigator, or insurance consultant who violates an insurance statute or rule to
1329 forfeit to the state not more than $2,500 for each violation.
1330 (ii) The commissioner may order any other person who violates an insurance statute or
1331 rule to forfeit to the state not more than $5,000 for each violation.
1332 (c) (i) The commissioner may order an individual producer, surplus line producer,

1333 limited line producer, managing general agent, reinsurance intermediary, adjuster, third party
1334 administrator, navigator, or insurance consultant who violates an order issued under Subsection
1335 31A-2-201(4) to forfeit to the state not more than $2,500 for each violation. Each day the
1336 violation continues is a separate violation.
1337 (ii) The commissioner may order any other person who violates an order issued under
1338 Subsection 31A-2-201(4) to forfeit to the state not more than $5,000 for each violation. Each
1339 day the violation continues is a separate violation.
1340 (d) The commissioner may accept or compromise any forfeiture under this Subsection
1341 (1) until after a complaint is filed under Subsection (2). After the filing of the complaint, only
1342 the attorney general may compromise the forfeiture.
1343 (2) When a person fails to comply with an order issued under Subsection
1344 31A-2-201(4), including a forfeiture order, the commissioner may file an action in any court of
1345 competent jurisdiction or obtain a court order or judgment:
1346 (a) enforcing the commissioner's order;
1347 (b) (i) directing compliance with the commissioner's order and restraining further
1348 violation of the order; and
1349 (ii) subjecting the person ordered to the procedures and sanctions available to the court
1350 for punishing contempt if the failure to comply continues; or
1351 (c) imposing a forfeiture in an amount the court considers just, up to $10,000 for each
1352 day the failure to comply continues after the filing of the complaint until judgment is rendered.
1353 (3) (a) The Utah Rules of Civil Procedure govern actions brought under Subsection (2),
1354 except that the commissioner may file a complaint seeking a court-ordered forfeiture under
1355 Subsection (2)(c) no sooner than two weeks after giving written notice of the commissioner's
1356 intention to proceed under Subsection (2)(c).
1357 (b) The commissioner's order issued under Subsection 31A-2-201(4) may contain a
1358 notice of intention to seek a court-ordered forfeiture if the commissioner's order is disobeyed.
1359 (4) If, after a court order is issued under Subsection (2), the person fails to comply with
1360 the commissioner's order or judgment:
1361 (a) the commissioner may certify the fact of the failure to the court by affidavit; and
1362 (b) the court may, after a hearing following at least five days written notice to the
1363 parties subject to the order or judgment, amend the order or judgment to add the forfeiture or

1364 forfeitures, as prescribed in Subsection (2)(c), until the person complies.
1365 (5) (a) The proceeds of the forfeitures under this section, including collection expenses,
1366 shall be paid into the General Fund.
1367 (b) The expenses of collection shall be credited to the department's budget.
1368 (c) The attorney general's budget shall be credited to the extent the department
1369 reimburses the attorney general's office for its collection expenses under this section.
1370 (6) (a) Forfeitures and judgments under this section bear interest at the rate charged by
1371 the United States Internal Revenue Service for past due taxes on the:
1372 (i) date of entry of the commissioner's order under Subsection (1); or
1373 (ii) date of judgment under Subsection (2).
1374 (b) Interest accrues from the later of the dates described in Subsection (6)(a) until the
1375 forfeiture and accrued interest are fully paid.
1376 (7) A forfeiture may not be imposed under Subsection (2)(c) if:
1377 (a) at the time the forfeiture action is commenced, the person was in compliance with
1378 the commissioner's order; or
1379 (b) the violation of the order occurred during the order's suspension.
1380 (8) The commissioner may seek an injunction as an alternative to issuing an order
1381 under Subsection 31A-2-201(4).
1382 (9) (a) A person is guilty of a class B misdemeanor if that person:
1383 (i) intentionally violates:
1384 (A) an insurance statute of this state; or
1385 (B) an order issued under Subsection 31A-2-201(4);
1386 (ii) intentionally permits a person over whom that person has authority to violate:
1387 (A) an insurance statute of this state; or
1388 (B) an order issued under Subsection 31A-2-201(4); or
1389 (iii) intentionally aids any person in violating:
1390 (A) an insurance statute of this state; or
1391 (B) an order issued under Subsection 31A-2-201(4).
1392 (b) Unless a specific criminal penalty is provided elsewhere in this title, the person may
1393 be fined not more than:
1394 (i) $10,000 if a corporation; or

1395 (ii) $5,000 if a person other than a corporation.
1396 (c) If the person is an individual, the person may, in addition, be imprisoned for up to
1397 one year.
1398 (d) As used in this Subsection (9), "intentionally" has the same meaning as under
1399 Subsection 76-2-103(1).
1400 (10) (a) A person who knowingly and intentionally violates Section 31A-4-102,
1401 31A-8a-208, 31A-15-105, 31A-23a-116, or 31A-31-111 is guilty of a felony as provided in this
1402 Subsection (10).
1403 (b) When the value of the property, money, or other things obtained or sought to be
1404 obtained in violation of Subsection (10)(a):
1405 (i) is less than $5,000, a person is guilty of a third degree felony; or
1406 (ii) is or exceeds $5,000, a person is guilty of a second degree felony.
1407 (11) (a) After a hearing, the commissioner may, in whole or in part, revoke, suspend,
1408 place on probation, limit, or refuse to renew the licensee's license or certificate of authority:
1409 (i) when a licensee of the department, other than a domestic insurer:
1410 (A) persistently or substantially violates the insurance law; or
1411 (B) violates an order of the commissioner under Subsection 31A-2-201(4);
1412 (ii) if there are grounds for delinquency proceedings against the licensee under Section
1413 31A-27a-207; or
1414 (iii) if the licensee's methods and practices in the conduct of the licensee's business
1415 endanger, or the licensee's financial resources are inadequate to safeguard, the legitimate
1416 interests of the licensee's customers and the public.
1417 (b) Additional license termination or probation provisions for licensees other than
1418 insurers are set forth in Sections 31A-19a-303, 31A-19a-304, 31A-23a-111, 31A-23a-112,
1419 31A-25-208, 31A-25-209, 31A-26-213, 31A-26-214, 31A-35-501, and 31A-35-503.
1420 (12) The enforcement penalties and procedures set forth in this section are not
1421 exclusive, but are cumulative of other rights and remedies the commissioner has pursuant to
1422 applicable law.
1423 Section 3. Section **31A-8-402.3** is amended to read:
1424 **31A-8-402.3. Discontinuance, nonrenewal, or changes to group health benefit**
1425 **plans.**

1426 (1) Except as otherwise provided in this section, a group health benefit plan for a plan
1427 sponsor is renewable and continues in force:
1428 (a) with respect to all eligible employees and dependents; and
1429 (b) at the option of the plan sponsor.
1430 (2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed for a
1431 network plan, if:
1432 (a) there is no longer any enrollee under the group health plan who lives, resides, or
1433 works in:
1434 (i) the service area of the insurer; or
1435 (ii) the area for which the insurer is authorized to do business; or
1436 (b) for coverage made available in the small or large employer market only through an
1437 association, if:
1438 (i) the employer's membership in the association ceases; and
1439 (ii) the coverage is terminated uniformly without regard to any health status-related
1440 factor relating to any covered individual.
1441 (3) A health benefit plan for a plan sponsor may be discontinued if:
1442 (a) a condition described in Subsection (2) exists;
1443 (b) the plan sponsor fails to pay premiums or contributions in accordance with the
1444 terms of the contract;
1445 (c) the plan sponsor:
1446 (i) performs an act or practice that constitutes fraud; or
1447 (ii) makes an intentional misrepresentation of material fact under the terms of the
1448 coverage;
1449 (d) the insurer:
1450 (i) elects to discontinue offering a particular health benefit [~~product~~] plan delivered or
1451 issued for delivery in this state; and
1452 (ii) (A) provides notice of the discontinuation in writing:
1453 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
1454 (II) at least 90 days before the date the coverage will be discontinued;
1455 (B) provides notice of the discontinuation in writing:
1456 (I) to the commissioner; and

1457 (II) at least three working days prior to the date the notice is sent to the affected plan
1458 sponsors, employees, and dependents of the plan sponsors or employees;
1459 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase:
1460 (I) all other health benefit [~~products~~] plans currently being offered by the insurer in the
1461 market; or
1462 (II) in the case of a large employer, any other health benefit [~~product~~] plan currently
1463 being offered in that market; and
1464 (D) in exercising the option to discontinue that product and in offering the option of
1465 coverage in this section, acts uniformly without regard to:
1466 (I) the claims experience of a plan sponsor;
1467 (II) any health status-related factor relating to any covered participant or beneficiary; or
1468 (III) any health status-related factor relating to any new participant or beneficiary who
1469 may become eligible for the coverage; or
1470 (e) the insurer:
1471 (i) elects to discontinue all of the insurer's health benefit plans in:
1472 (A) the small employer market;
1473 (B) the large employer market; or
1474 (C) both the small employer and large employer markets; and
1475 (ii) (A) provides notice of the discontinuation in writing:
1476 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
1477 (II) at least 180 days before the date the coverage will be discontinued;
1478 (B) provides notice of the discontinuation in writing:
1479 (I) to the commissioner in each state in which an affected insured individual is known
1480 to reside; and
1481 (II) at least 30 working days prior to the date the notice is sent to the affected plan
1482 sponsors, employees, and the dependents of the plan sponsors or employees;
1483 (C) discontinues and nonrenews all plans issued or delivered for issuance in the
1484 market; and
1485 (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.
1486 (4) A large employer health benefit plan may be discontinued or nonrenewed:
1487 (a) if a condition described in Subsection (2) exists; or

1488 (b) for noncompliance with the insurer's:
1489 (i) minimum participation requirements; or
1490 (ii) employer contribution requirements.
1491 (5) A small employer health benefit plan may be discontinued or nonrenewed:
1492 (a) if a condition described in Subsection (2) exists; or
1493 (b) for noncompliance with the insurer's employer contribution requirements.
1494 (6) A small employer health benefit plan may be nonrenewed:
1495 (a) if a condition described in Subsection (2) exists; or
1496 (b) for noncompliance with the insurer's minimum participation requirements.
1497 (7) (a) Except as provided in Subsection (7)(d), an eligible employee may be
1498 discontinued if after issuance of coverage the eligible employee:
1499 (i) engages in an act or practice in connection with the coverage that constitutes fraud;
1500 or
1501 (ii) makes an intentional misrepresentation of material fact in connection with the
1502 coverage.
1503 (b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:
1504 (i) 12 months after the date of discontinuance; and
1505 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
1506 to reenroll.
1507 (c) At the time the eligible employee's coverage is discontinued under Subsection
1508 (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is
1509 discontinued.
1510 (d) An eligible employee may not be discontinued under this Subsection (7) because of
1511 a fraud or misrepresentation that relates to health status.
1512 (8) For purposes of this section, a reference to "plan sponsor" includes a reference to
1513 the employer:
1514 (a) with respect to coverage provided to an employer member of the association; and
1515 (b) if the health benefit plan is made available by an insurer in the employer market
1516 only through:
1517 (i) an association;
1518 (ii) a trust; or

1519 (iii) a discretionary group.

1520 (9) An insurer may modify a health benefit plan for a plan sponsor only:

1521 (a) at the time of coverage renewal; and

1522 (b) if the modification is effective uniformly among all plans with that product.

1523 Section 4. Section **31A-8-402.5** is amended to read:

1524 **31A-8-402.5. Individual discontinuance and nonrenewal.**

1525 (1) (a) Except as otherwise provided in this section, a health benefit plan offered on an

1526 individual basis is renewable and continues in force:

1527 (i) with respect to all individuals or dependents; and

1528 (ii) at the option of the individual.

1529 (b) Subsection (1)(a) applies regardless of:

1530 (i) whether the contract is issued through:

1531 (A) a trust;

1532 (B) an association;

1533 (C) a discretionary group; or

1534 (D) other similar grouping; or

1535 (ii) the situs of delivery of the policy or contract.

1536 (2) A health benefit plan may be discontinued or nonrenewed:

1537 (a) for a network plan, if:

1538 (i) the individual no longer lives, resides, or works in:

1539 (A) the service area of the insurer; or

1540 (B) the area for which the insurer is authorized to do business; and

1541 (ii) coverage is terminated uniformly without regard to any health status-related factor

1542 relating to any covered individual; or

1543 (b) for coverage made available through an association, if:

1544 (i) the individual's membership in the association ceases; and

1545 (ii) the coverage is terminated uniformly without regard to any health status-related

1546 factor relating to any covered individual.

1547 (3) A health benefit plan may be discontinued if:

1548 (a) a condition described in Subsection (2) exists;

1549 (b) the individual fails to pay premiums or contributions in accordance with the terms

1550 of the health benefit plan, including any timeliness requirements;
1551 (c) the individual:
1552 (i) performs an act or practice in connection with the coverage that constitutes fraud; or
1553 (ii) makes an intentional misrepresentation of material fact under the terms of the
1554 coverage;
1555 (d) the insurer:
1556 (i) elects to discontinue offering a particular health benefit [~~product~~] plan delivered or
1557 issued for delivery in this state; and
1558 (ii) (A) provides notice of the discontinuation in writing:
1559 (I) to each individual provided coverage; and
1560 (II) at least 90 days before the date the coverage will be discontinued;
1561 (B) provides notice of the discontinuation in writing:
1562 (I) to the commissioner; and
1563 (II) at least three working days prior to the date the notice is sent to the affected
1564 individuals;
1565 (C) offers to each covered individual on a guaranteed issue basis, the option to
1566 purchase all other individual health benefit [~~products~~] plans currently being offered by the
1567 insurer for individuals in that market; and
1568 (D) acts uniformly without regard to any health status-related factor of covered
1569 individuals or dependents of covered individuals who may become eligible for coverage; or
1570 (e) the insurer:
1571 (i) elects to discontinue all of the insurer's health benefit plans in the individual market;
1572 and
1573 (ii) (A) provides notice of the discontinuation in writing:
1574 (I) to each individual provided coverage; and
1575 (II) at least 180 days before the date the coverage will be discontinued;
1576 (B) provides notice of the discontinuation in writing:
1577 (I) to the commissioner in each state in which an affected insured individual is known
1578 to reside; and
1579 (II) at least 30 working days prior to the date the notice is sent to the affected
1580 individuals;

1581 (C) discontinues and nonrenews all health benefit plans the insurer issues or delivers
1582 for issuance in the individual market; and
1583 (D) acts uniformly without regard to any health status-related factor of covered
1584 individuals or dependents of covered individuals who may become eligible for coverage.
1585 Section 5. Section **31A-14-205.5** is enacted to read:
1586 **31A-14-205.5. Place of business address information -- Record retention.**
1587 (1) (a) A licensee under this chapter shall register and maintain with the commissioner:
1588 (i) the address and the one or more telephone numbers of the licensee's principal place
1589 of business; and
1590 (ii) a valid business email address at which the commissioner may contact the licensee.
1591 (b) A licensee shall notify the commissioner within 30 days of a change of any of the
1592 following required to be registered with the commissioner under this section:
1593 (i) an address;
1594 (ii) a telephone number; or
1595 (iii) a business email address.
1596 (2) (a) Except as provided under Subsection (3), a licensee under this chapter shall
1597 keep at the address of the principal place of business registered under Subsection (1), separate
1598 and distinct books and records of the transactions consummated under the Utah license.
1599 (b) The books and records described in Subsection (2)(a) shall:
1600 (i) be in an organized form; and
1601 (ii) be available to the commissioner for inspection upon reasonable notice.
1602 (c) The books and records described in Subsection (2)(a) shall include the following:
1603 (i) if the licensee is a foreign insurer, alien insurer, commercially domiciled insurer,
1604 foreign title insurer, or foreign fraternal:
1605 (A) a record of each insurance contract procured by or issued through the licensee, with
1606 the names of the one or more insureds, the amount of premium and commissions or other
1607 compensation, and the subject of the insurance;
1608 (B) the name of any other producer, surplus lines producer, limited line producer,
1609 consultant, managing general agent, or reinsurance intermediary from whom business is
1610 accepted, and of a person to whom commissions or allowances of any kind are promised or
1611 paid; and

1612 (C) a record of the consumer complaints forwarded to the licensee by an insurance
1613 regulator; and
1614 (ii) any additional information that:
1615 (A) is customary for a similar business; or
1616 (B) may reasonably be required by the commissioner by rule made in accordance with
1617 Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
1618 (3) Subsection (2) is satisfied if the books and records specified in Subsection (2) can
1619 be obtained immediately from a central storage place or elsewhere by online computer
1620 terminals located at the registered address.
1621 (4) A licensee who represents only a single insurer satisfies Subsection (2) if the
1622 insurer maintains the books and records pursuant to Subsection (2) at a place satisfying
1623 Subsections (1) and (5).
1624 (5) (a) The books and records maintained under Subsection (2) shall be available for
1625 the inspection of the commissioner during the business hours for a period of time after the date
1626 of the transaction as specified by the commissioner by rule, made in accordance with Title
1627 63G, Chapter 3, Utah Administrative Rulemaking Act, but in no case for less than three
1628 calendar years in addition to the current calendar year.
1629 (b) Discarding a book or record after the applicable record retention period has expired
1630 does not place the licensee in violation of a later-adopted longer record retention period.
1631 Section 6. Section **31A-16-105** is amended to read:
1632 **31A-16-105. Registration of insurers.**
1633 (1) (a) An insurer that is authorized to do business in this state and that is a member of
1634 an insurance holding company system shall register with the commissioner, except a foreign
1635 insurer subject to registration requirements and standards adopted by statute or regulation in the
1636 jurisdiction of its domicile, if the requirements and standards are substantially similar to those
1637 contained in this section, Subsections 31A-16-106(1)(a) and (2) and either Subsection
1638 31A-16-106(1)(b) or a statutory provision similar to the following: "Each registered insurer
1639 shall keep current the information required to be disclosed in its registration statement by
1640 reporting all material changes or additions within 15 days after the end of the month in which it
1641 learns of each change or addition."
1642 (b) An insurer that is subject to registration under this section shall register within 15

1643 days after it becomes subject to registration, and annually thereafter by [~~May 1~~] June 30 of each
1644 year for the previous calendar year, unless the commissioner for good cause extends the time
1645 for registration and then at the end of the extended time period. The commissioner may require
1646 any insurer authorized to do business in the state, which is a member of a holding company
1647 system, and which is not subject to registration under this section, to furnish a copy of the
1648 registration statement, the summary specified in Subsection (3), or any other information filed
1649 by the insurer with the insurance regulatory authority of domiciliary jurisdiction.
1650 (2) An insurer subject to registration shall file the registration statement with the
1651 commissioner on a form and in a format prescribed by the National Association of Insurance
1652 Commissioners, which shall contain the following current information:
1653 (a) the capital structure, general financial condition, and ownership and management of
1654 the insurer and any person controlling the insurer;
1655 (b) the identity and relationship of every member of the insurance holding company
1656 system;
1657 (c) any of the following agreements in force, and transactions currently outstanding or
1658 which have occurred during the last calendar year between the insurer and its affiliates:
1659 (i) loans, other investments, or purchases, sales or exchanges of securities of the
1660 affiliates by the insurer or of securities of the insurer by its affiliates;
1661 (ii) purchases, sales, or exchanges of assets;
1662 (iii) transactions not in the ordinary course of business;
1663 (iv) guarantees or undertakings for the benefit of an affiliate which result in an actual
1664 contingent exposure of the insurer's assets to liability, other than insurance contracts entered
1665 into in the ordinary course of the insurer's business;
1666 (v) all management agreements, service contracts, and all cost-sharing arrangements;
1667 (vi) reinsurance agreements;
1668 (vii) dividends and other distributions to shareholders; and
1669 (viii) consolidated tax allocation agreements;
1670 (d) any pledge of the insurer's stock, including stock of any subsidiary or controlling
1671 affiliate, for a loan made to any member of the insurance holding company system;
1672 (e) if requested by the commissioner, financial statements of or within an insurance
1673 holding company system, including all affiliates:

1674 (i) which may include annual audited financial statements filed with the United States
1675 Securities and Exchange Commission pursuant to the Securities Act of 1933, as amended, or
1676 the Securities Exchange Act of 1934, as amended; and
1677 (ii) which request is satisfied by providing the commissioner with the most recently
1678 filed parent corporation financial statements that have been filed with the United States
1679 Securities and Exchange Commission;
1680 (f) any other matters concerning transactions between registered insurers and any
1681 affiliates as may be included in any subsequent registration forms adopted or approved by the
1682 commissioner;
1683 (g) statements that the insurer's board of directors oversees corporate governance and
1684 internal controls and that the insurer's officers or senior management have approved,
1685 implemented, and continue to maintain and monitor corporate governance and internal control
1686 procedures; and
1687 (h) any other information required by rule made by the commissioner in accordance
1688 with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
1689 (3) All registration statements shall contain a summary outlining all items in the
1690 current registration statement representing changes from the prior registration statement.
1691 (4) No information need be disclosed on the registration statement filed pursuant to
1692 Subsection (2) if the information is not material for the purposes of this section. Unless the
1693 commissioner by rule or order provides otherwise, sales, purchases, exchanges, loans or
1694 extensions of credit, investments, or guarantees involving one-half of 1%, or less, of an
1695 insurer's admitted assets as of the next preceding December 31 may not be considered material
1696 for purposes of this section.
1697 (5) Subject to Section 31A-16-106, each registered insurer shall report to the
1698 commissioner a dividend or other distribution to shareholders within 15 business days
1699 following the declaration of the dividend or distribution.
1700 (6) Any person within an insurance holding company system subject to registration
1701 shall provide complete and accurate information to an insurer if the information is reasonably
1702 necessary to enable the insurer to comply with the provisions of this chapter.
1703 (7) The commissioner shall terminate the registration of any insurer which
1704 demonstrates that it no longer is a member of an insurance holding company system.

1705 (8) The commissioner may require or allow two or more affiliated insurers subject to
1706 registration under this section to file a consolidated registration statement.
1707 (9) The commissioner may allow an insurer which is authorized to do business in this
1708 state, and which is part of an insurance holding company system, to register on behalf of any
1709 affiliated insurer which is required to register under Subsection (1) and to file all information
1710 and material required to be filed under this section.
1711 (10) This section does not apply to any insurer, information, or transaction if, and to
1712 the extent that, the commissioner by rule or order exempts the insurer from this section.
1713 (11) Any person may file with the commissioner a disclaimer of affiliation with any
1714 authorized insurer, or a disclaimer of affiliation may be filed by any insurer or any member of
1715 an insurance holding company system. The disclaimer shall fully disclose all material
1716 relationships and bases for affiliation between the person and the insurer as well as the basis for
1717 disclaiming the affiliation. A disclaimer of affiliation is considered to have been granted
1718 unless the commissioner, within 30 days following receipt of a complete disclaimer, notifies
1719 the filing party the disclaimer is disallowed. If disallowed, the disclaiming party may request
1720 an administrative hearing, which shall be granted. The disclaiming party shall be relieved of its
1721 duty to register under this section if approval of the disclaimer is granted by the commissioner,
1722 or if the disclaimer is considered to have been approved.
1723 (12) The ultimate controlling person of an insurer subject to registration shall also file
1724 an annual enterprise risk report. The annual enterprise risk report shall, to the best of the
1725 ultimate controlling person's knowledge and belief, identify the material risks within the
1726 insurance holding company that could pose enterprise risk to the insurer. The annual enterprise
1727 risk report shall be filed with the lead state commissioner of the insurance holding company
1728 system as determined by the procedures within the Financial Analysis Handbook adopted by
1729 the National Association of Insurance Commissioners.
1730 (13) The failure to file a registration statement or any summary of the registration
1731 statement or enterprise risk filing required by this section within the time specified for the
1732 filing is a violation of this section.
1733 Section 7. Section **31A-16a-101** is enacted to read:
1734 **CHAPTER 16a. RISK MANAGEMENT AND OWN RISK AND**
1735 **SOLVENCY ASSESSMENT ACT**

1736 **31A-16a-101. Title -- Scope.**

1737 (1) This chapter is known as the "Risk Management and Own Risk and Solvency
1738 Assessment Act."

1739 (2) This chapter applies to an insurer domiciled in this state unless exempt pursuant to
1740 Section 31A-16a-106.

1741 Section 8. Section **31A-16a-102** is enacted to read:

1742 **31A-16a-102. Definitions.**

1743 As used in this chapter:

1744 (1) "Insurance group," for the purpose of conducting an own risk and solvency
1745 assessment, means those insurers and affiliates included within an insurance holding company
1746 system as defined in Section 31A-1-301.

1747 (2) "Insurer" means the same as that term is defined in Section 31A-1-301, except that
1748 it does not include agency, authority, or instrumentality of the United States, its possessions
1749 and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or
1750 political subdivision of a state.

1751 (3) "ORSA guidance manual" means the version of the Own Risk and Solvency
1752 Assessment Guidance Manual developed and adopted by the National Association of Insurance
1753 Commissioners and as amended from time to time.

1754 (4) "ORSA summary report" means a confidential high-level summary of an insurer or
1755 insurance group's own risk and solvency assessment.

1756 (5) "Own risk and solvency assessment" means a confidential internal assessment,
1757 appropriate to the nature, scale, and complexity of an insurer or insurance group, conducted by
1758 that insurer or insurance group, of the material and relevant risks associated with the insurer or
1759 insurance group's current business plan and the sufficiency of capital resources to support those
1760 risks.

1761 Section 9. Section **31A-16a-103** is enacted to read:

1762 **31A-16a-103. Risk management framework.**

1763 An insurer shall maintain a risk management framework to assist the insurer with
1764 identifying, assessing, monitoring, managing, and reporting on its material and relevant risks.
1765 This requirement may be satisfied if the insurance group of which the insurer is a member
1766 maintains a risk management framework applicable to the operations of the insurer.

1767 Section 10. Section **31A-16a-104** is enacted to read:

1768 **31A-16a-104. Own risk and solvency assessment requirement.**

1769 Subject to Section 31A-16a-106, an insurer, or the insurance group of which the insurer
1770 is a member, shall regularly conduct an own risk and solvency assessment consistent with a
1771 process comparable to the ORSA guidance manual. The insurer or insurance group shall
1772 conduct the own risk and solvency assessment no less than annually but also at any time when
1773 there are significant changes to the risk profile of the insurer or the insurance group of which
1774 the insurer is a member.

1775 Section 11. Section **31A-16a-105** is enacted to read:

1776 **31A-16a-105. ORSA summary report.**

1777 (1) (a) Upon the commissioner's request, and no more than once each year, an insurer
1778 shall submit to the commissioner an ORSA summary report or any combination of reports that
1779 together contain the information described in the ORSA guidance manual, applicable to the
1780 insurer, the insurance group of which it is a member, or both.

1781 (b) Notwithstanding a request from the commissioner, if the insurer is a member of an
1782 insurance group, the insurer shall submit the one or more reports required by this Subsection
1783 (1) if the commissioner is the lead state commissioner of the insurance group as determined by
1784 the procedures within the Financial Analysis Handbook adopted by the National Association of
1785 Insurance Commissioners.

1786 (2) The one or more reports required under Subsection (1) shall include a signature of
1787 the insurer's or insurance group's chief risk officer or other executive having responsibility for
1788 the oversight of the insurer's enterprise risk management process attesting to the best of the
1789 executive's belief and knowledge that:

1790 (a) the insurer applies the enterprise risk management process described in the ORSA
1791 summary report; and

1792 (b) a copy of the report has been provided to the insurer's board of directors or the
1793 appropriate committee of the board of directors.

1794 (3) An insurer may comply with Subsection (1) by providing the most recent and
1795 substantially similar one or more reports provided by the insurer or another member of an
1796 insurance group of which the insurer is a member to the commissioner of another state or to a
1797 supervisor or regulator of a foreign jurisdiction, if that report provides information that is

1798 comparable to the information described in the ORSA guidance manual. A report that is in a
1799 language other than English must be accompanied by a translation of that report into the
1800 English language.
1801 Section 12. Section **31A-16a-106** is enacted to read:
1802 **31A-16a-106. Exemption.**
1803 (1) An insurer shall be exempt from the requirements of this chapter, if:
1804 (a) the insurer has annual direct written and unaffiliated assumed premium, including
1805 international direct and assumed premium, but excluding premiums reinsured with the Federal
1806 Crop Insurance Corporation and Federal Flood Program, less than $500,000,000; and
1807 (b) the insurance group of which the insurer is a member has annual direct written and
1808 unaffiliated assumed premium, including international direct and assumed premium, but
1809 excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood
1810 Program, less than $1,000,000,000.
1811 (2) If an insurer qualifies for exemption pursuant to Subsection (1)(a), but the
1812 insurance group of which the insurer is a member does not qualify for exemption pursuant to
1813 Subsection (1)(b), the ORSA summary report that is required pursuant to Section 31A-16a-105
1814 shall include every insurer within the insurance group. This requirement may be satisfied by the
1815 submission of more than one ORSA summary report for any combination of insurers provided
1816 any combination of reports includes every insurer within the insurance group.
1817 (3) If an insurer does not qualify for exemption pursuant to Subsection (1)(a), but the
1818 insurance group of which it is a member qualifies for exemption pursuant to Subsection (1)(b),
1819 the only ORSA summary report that may be required pursuant Section 31A-16a-105 shall be
1820 the report applicable to that insurer.
1821 (4) An insurer that does not qualify for exemption pursuant to Subsection (1) may
1822 apply to the commissioner for a waiver from the requirements of this chapter based upon
1823 unique circumstances. In deciding whether to grant the insurer's request for waiver, the
1824 commissioner may consider the type and volume of business written, ownership and
1825 organizational structure, and any other factor the commissioner considers relevant to the
1826 insurer or insurance group of which the insurer is a member. If the insurer is part of an
1827 insurance group with insurers domiciled in more than one state, the commissioner shall
1828 coordinate with the lead state commissioner and with the other domiciliary commissioners in

1829 considering whether to grant the insurer's request for a waiver.

1830 (5) Notwithstanding the exemptions stated in this section:

1831 (a) the commissioner may require that an insurer maintain a risk management

1832 framework, conduct an own risk and solvency assessment and file an ORSA summary report

1833 based on unique circumstances, including the type and volume of business written, ownership

1834 and organizational structure, federal agency requests, and international supervisor requests; or

1835 (b) the commissioner may require that an insurer maintain a risk management

1836 framework, conduct an own risk and solvency assessment and file an ORSA summary report if

1837 the insurer has risk-based capital for company action level event as set forth in Sections

1838 31A-17-601 through 31A-17-613, meets one or more of the standards of an insurer considered

1839 to be in hazardous financial condition as defined in Section 31A-27a-101, or otherwise exhibits

1840 qualities of a troubled insurer as determined by the commissioner.

1841 (6) If an insurer that qualifies for an exemption pursuant to Subsection (1)

1842 subsequently no longer qualifies for that exemption due to changes in premium as reflected in

1843 the insurer's most recent annual statement or in the most recent annual statements of the

1844 insurers within the insurance group of which the insurer is a member, the insurer has one

1845 calendar year following the calendar year the threshold is exceeded to comply with the

1846 requirements of this chapter.

1847 Section 13. Section **31A-16a-107** is enacted to read:

1848 **31A-16a-107. Contents of ORSA summary report.**

1849 (1) The ORSA summary report shall be prepared consistent with the ORSA guidance

1850 manual, subject to the requirements of Subsection (2). Documentation supporting information

1851 shall be maintained and made available upon examination or upon request of the

1852 commissioner.

1853 (2) The review of the ORSA summary report, and any additional requests for

1854 information, shall be made using similar procedures as used in the analysis and examination of

1855 multi-state or global insurers and insurance groups.

1856 Section 14. Section **31A-16a-108** is enacted to read:

1857 **31A-16a-108. Confidentiality.**

1858 (1) (a) A document, material, or other information, including the ORSA summary

1859 report, in the possession of or control of the department that is obtained by, created by, or

1860 disclosed to the commissioner or any other person under this chapter, is recognized by this state
1861 as being proprietary and to contain trade secrets. The document, material, or other information
1862 is confidential by law and may not be subject to Title 63G, Chapter 2, Government Records
1863 Access and Management Act, may not be subject to subpoena, and may not be subject to
1864 discovery or admissible in evidence in any private civil action.
1865 (b) Notwithstanding Subsection (1)(a), the commissioner may use a document,
1866 material, or other information in furtherance of any regulatory or legal action brought as a part
1867 of the official duties. The commissioner may not otherwise make the document, material, or
1868 other information public without the prior written consent of the insurer.
1869 (2) Neither the commissioner nor any person who received a document, material, or
1870 other information related to an own risk and solvency assessment, through examination or
1871 otherwise, while acting under the authority of the commissioner or with whom the document,
1872 material, or other information is shared pursuant to this chapter is permitted or required to
1873 testify in any private civil action concerning any confidential document, material, or
1874 information subject to Subsection (1).
1875 (3) To assist in the performance of the commissioner's regulatory duties, the
1876 commissioner:
1877 (a) may, upon request, share a document, material, or other information related to an
1878 own risk solvency assessment, including a confidential and privileged document, material, or
1879 information subject to Subsection (1), including proprietary and trade secret documents and
1880 materials with other state, federal, and international financial regulatory agencies, including
1881 members of any supervisory college as described in the Section 31A-16-108.5, with the
1882 National Association of Insurance Commissioners and with any third-party consultants
1883 designated by the commissioner, provided that the recipient agrees in writing to maintain the
1884 confidentiality and privileged status of documents, materials, or other information related to an
1885 own risk and solvency assessment and has verified in writing the legal authority to maintain
1886 confidentiality;
1887 (b) may receive a document, material, or other information related to an own risk and
1888 solvency assessment, including an otherwise confidential and privileged document, material, or
1889 information, including proprietary and trade secret information or documents, from regulatory
1890 officials of other foreign or domestic jurisdictions, including members of any supervisory

1891 college as described in Section 31A-16-108.5 and from the National Association of Insurance
1892 Commissioners, and shall maintain as confidential or privileged a document, material, or
1893 information received with notice or the understanding that it is confidential or privileged under
1894 the laws of the jurisdiction that is the source of the document, material, or information; and
1895 (c) shall enter into a written agreement with the National Association of Insurance
1896 Commissioners or a third-party consultant governing sharing and use of information provided
1897 pursuant to this chapter, consistent with this Subsection (3) that shall:
1898 (i) specify procedures and protocols regarding the confidentiality and security of
1899 information shared with the National Association of Insurance Commissioners or a third-party
1900 consultant pursuant to this chapter, including procedures and protocols for sharing by the
1901 National Association of Insurance Commissioners with other state regulators from states in
1902 which the insurance group has domiciled insurers with the agreement providing that the
1903 recipient agrees in writing to maintain the confidentiality and privileged status of a document,
1904 material, or other information related to an own risk and solvency assessment and verifies in
1905 writing the legal authority to maintain confidentiality;
1906 (ii) specify that ownership of information shared with the National Association of
1907 Insurance Commissioners or a third-party consultant pursuant to this chapter remains with the
1908 commissioner, and that the National Association of Insurance Commissioners' or a third-party
1909 consultant's use of the information is subject to the direction of the commissioner;
1910 (iii) prohibit the National Association of Insurance Commissioners or third-party
1911 consultant from storing the information shared pursuant to this chapter in a permanent database
1912 after the underlying analysis is completed;
1913 (iv) require prompt notice to be given to an insurer whose confidential information in
1914 the possession of the National Association of Insurance Commissioners or a third-party
1915 consultant pursuant to this chapter is subject to a request or subpoena to the National
1916 Association of Insurance Commissioners or a third-party consultant for disclosure or
1917 production;
1918 (v) require the National Association of Insurance Commissioners or a third-party
1919 consultant to consent to intervention by an insurer in any judicial or administrative action in
1920 which the National Association of Insurance Commissioners or a third-party consultant may be
1921 required to disclose confidential information about the insurer shared with the National

1922 Association of Insurance Commissioners or a third-party consultant pursuant to this chapter;
1923 and
1924 (vi) in the case of an agreement involving a third-party consultant, provide for the
1925 insurer's written consent.
1926 (4) The sharing of information or a document by the commissioner pursuant to this
1927 chapter does not constitute a delegation of regulatory authority or rulemaking, and the
1928 commissioner is solely responsible for the administration, execution, and enforcement of this
1929 chapter.
1930 (5) A waiver of an applicable privilege or claim of confidentiality in a document,
1931 proprietary and trade-secret material, or other information related to an own risk and solvency
1932 assessment may not occur as a result of disclosure of the own risk and solvency assessment
1933 related information or a document to the commissioner under this section or as a result of
1934 sharing as authorized in this chapter.
1935 (6) A document, material, or other information in the possession or control of the
1936 National Association of Insurance Commissioners or a third-party consultant pursuant to this
1937 chapter shall be confidential by law and privileged, may not be subject to Title 63G, Chapter 2,
1938 Government Records Access and Management Act, is not subject to subpoena, and shall not be
1939 subject to discovery or admissible in evidence in any private civil action.
1940 Section 15. Section **31A-16a-109** is enacted to read:
1941 **31A-16a-109. Sanctions.**
1942 An insurer failing, without just cause, to timely file the ORSA summary report as
1943 required in this chapter is required, after notice and hearing, is subject to a penalty under
1944 Section 31A-2-308 for each day's delay, to be recovered by the commissioner and the penalty
1945 so recovered shall be paid into the General Fund. The maximum penalty under this section is a
1946 penalty permitted under Section 31A-2-308. The commissioner may reduce the penalty if the
1947 insurer demonstrates to the commissioner that the imposition of the penalty would constitute a
1948 financial hardship to the insurer.
1949 Section 16. Section **31A-16a-110** is enacted to read:
1950 **31A-16a-110. Severability Clause.**
1951 If a provision of this chapter, or the application of this chapter to any person or
1952 circumstance, is held invalid, the invalidation does not affect the provisions or applications of

1953 this chapter that can be given effect without the invalid provision or application, and to that end
1954 the provisions of this chapter are severable.

1955 Section 17. Section **31A-17-404** is amended to read:
1956 **31A-17-404. Credit allowed a domestic ceding insurer against reserves for**
1957 **reinsurance.**
1958 (1) A domestic ceding insurer is allowed credit for reinsurance as either an asset or a
1959 reduction from liability for reinsurance ceded only if the reinsurer meets the requirements of
1960 Subsection (3), (4), (5), (6), (7), or (8), subject to the following:
1961 (a) Credit is allowed under Subsection (3), (4), or (5) only with respect to a cession of a
1962 kind or class of business that the assuming insurer is licensed or otherwise permitted to write or
1963 assume:
1964 (i) in its state of domicile; or
1965 (ii) in the case of a United States branch of an alien assuming insurer, in the state
1966 through which it is entered and licensed to transact insurance or reinsurance.
1967 (b) Credit is allowed under Subsection (5) or (6) only if the applicable requirements of
1968 Subsection (9) are met.
1969 (2) A domestic ceding insurer is allowed credit for reinsurance ceded:
1970 (a) only if the reinsurance is payable in a manner consistent with Section 31A-22-1201;
1971 (b) only to the extent that the accounting:
1972 (i) is consistent with the terms of the reinsurance contract; and
1973 (ii) clearly reflects:
1974 (A) the amount and nature of risk transferred; and
1975 (B) liability, including contingent liability, of the ceding insurer;
1976 (c) only to the extent the reinsurance contract shifts insurance policy risk from the
1977 ceding insurer to the assuming reinsurer in fact and not merely in form; and
1978 (d) only if the reinsurance contract contains a provision placing on the reinsurer the
1979 credit risk of all dealings with intermediaries regarding the reinsurance contract.
1980 (3) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an
1981 assuming insurer that is licensed to transact insurance or reinsurance in this state.
1982 (4) (a) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an

1983 assuming insurer that is accredited by the commissioner as a reinsurer in this state.
1984 (b) An insurer is accredited as a reinsurer if the insurer:
1985 (i) files with the commissioner evidence of the insurer's submission to this state's
1986 jurisdiction;
1987 (ii) submits to the commissioner's authority to examine the insurer's books and records;
1988 (iii) (A) is licensed to transact insurance or reinsurance in at least one state; or
1989 (B) in the case of a United States branch of an alien assuming insurer, is entered
1990 through and licensed to transact insurance or reinsurance in at least one state;
1991 (iv) files annually with the commissioner a copy of the insurer's:
1992 (A) annual statement filed with the insurance department of its state of domicile; and
1993 (B) most recent audited financial statement; and
1994 (v) (A) (I) has not had its accreditation denied by the commissioner within 90 days of
1995 the day on which the insurer submits the information required by this Subsection (4); and
1996 (II) maintains a surplus with regard to policyholders in an amount not less than
1997 $20,000,000; or
1998 (B) (I) has its accreditation approved by the commissioner; and
1999 (II) maintains a surplus with regard to policyholders in an amount less than
2000 $20,000,000.
2001 (c) Credit may not be allowed a domestic ceding insurer if the assuming insurer's
2002 accreditation is revoked by the commissioner after a notice and hearing.
2003 (5) (a) A domestic ceding insurer is allowed a credit if:
2004 (i) the reinsurance is ceded to an assuming insurer that is:
2005 (A) domiciled in a state meeting the requirements of Subsection (5)(a)(ii); or
2006 (B) in the case of a United States branch of an alien assuming insurer, is entered
2007 through a state meeting the requirements of Subsection (5)(a)(ii);
2008 (ii) the state described in Subsection (5)(a)(i) employs standards regarding credit for
2009 reinsurance substantially similar to those applicable under this section; and
2010 (iii) the assuming insurer or United States branch of an alien assuming insurer:
2011 (A) maintains a surplus with regard to policyholders in an amount not less than
2012 $20,000,000; and
2013 (B) submits to the authority of the commissioner to examine its books and records.

2014 (b) The requirements of Subsections (5)(a)(i) and (ii) do not apply to reinsurance ceded
2015 and assumed pursuant to a pooling arrangement among insurers in the same holding company
2016 system.
2017 (6) (a) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an
2018 assuming insurer that maintains a trust fund:
2019 (i) created in accordance with rules made by the commissioner pursuant to Title 63G,
2020 Chapter 3, Utah Administrative Rulemaking Act; and
2021 (ii) in a qualified United States financial institution for the payment of a valid claim of:
2022 (A) a United States ceding insurer of the assuming insurer;
2023 (B) an assign of the United States ceding insurer; and
2024 (C) a successor in interest to the United States ceding insurer.
2025 (b) To enable the commissioner to determine the sufficiency of the trust fund described
2026 in Subsection (6)(a), the assuming insurer shall:
2027 (i) report annually to the commissioner information substantially the same as that
2028 required to be reported on the National Association of Insurance Commissioners Annual
2029 Statement form by a licensed insurer; and
2030 (ii) (A) submit to examination of its books and records by the commissioner; and
2031 (B) pay the cost of an examination.
2032 (c) (i) Credit for reinsurance may not be granted under this Subsection (6) unless the
2033 form of the trust and any amendment to the trust is approved by:
2034 (A) the commissioner of the state where the trust is domiciled; or
2035 (B) the commissioner of another state who, pursuant to the terms of the trust
2036 instrument, accepts principal regulatory oversight of the trust.
2037 (ii) The form of the trust and an amendment to the trust shall be filed with the
2038 commissioner of every state in which a ceding insurer beneficiary of the trust is domiciled.
2039 (iii) The trust instrument shall provide that a contested claim is valid and enforceable
2040 upon the final order of a court of competent jurisdiction in the United States.
2041 (iv) The trust shall vest legal title to its assets in its one or more trustees for the benefit
2042 of:
2043 (A) a United States ceding insurer of the assuming insurer;
2044 (B) an assign of the United States ceding insurer; or

2045 (C) a successor in interest to the United States ceding insurer.
2046 (v) The trust and the assuming insurer are subject to examination as determined by the
2047 commissioner.
2048 (vi) The trust shall remain in effect for as long as the assuming insurer has an
2049 outstanding obligation due under a reinsurance agreement subject to the trust.
2050 (vii) No later than February 28 of each year, the trustee of the trust shall:
2051 (A) report to the commissioner in writing the balance of the trust;
2052 (B) list the trust's investments at the end of the preceding calendar year; and
2053 (C) (I) certify the date of termination of the trust, if so planned; or
2054 (II) certify that the trust will not expire prior to the following December 31.
2055 (d) The following requirements apply to the following categories of assuming insurer:
2056 (i) For a single assuming insurer:
2057 (A) the trust fund shall consist of funds in trust in an amount not less than the assuming
2058 insurer's liabilities attributable to reinsurance ceded by United States ceding insurers; and
2059 (B) the assuming insurer shall maintain a trusteed surplus of not less than $20,000,000,
2060 except as provided in Subsection (6)(d)(ii).
2061 (ii) (A) At any time after the assuming insurer has permanently discontinued
2062 underwriting new business secured by the trust for at least three full years, the commissioner
2063 with principal regulatory oversight of the trust may authorize a reduction in the required
2064 trusteed surplus, but only after a finding, based on an assessment of the risk, that the new
2065 required surplus level is adequate for the protection of United States ceding insurers,
2066 policyholders, and claimants in light of reasonably foreseeable adverse loss development.
2067 (B) The risk assessment may involve an actuarial review, including an independent
2068 analysis of reserves and cash flows, and shall consider all material risk factors, including, when
2069 applicable, the lines of business involved, the stability of the incurred loss estimates, and the
2070 effect of the surplus requirements on the assuming insurer's liquidity or solvency.
2071 (C) The minimum required trusteed surplus may not be reduced to an amount less than
2072 30% of the assuming insurer's liabilities attributable to reinsurance ceded by United States
2073 ceding insurers covered by the trust.
2074 (iii) For a group acting as assuming insurer, including incorporated and individual
2075 unincorporated underwriters:

2076 (A) for reinsurance ceded under a reinsurance agreement with an inception,
2077 amendment, or renewal date on or after August 1, 1995, the trust shall consist of a trusteed
2078 account in an amount not less than the respective underwriters' several liabilities attributable to
2079 business ceded by the one or more United States domiciled ceding insurers to an underwriter of
2080 the group;
2081 (B) for reinsurance ceded under a reinsurance agreement with an inception date on or
2082 before July 31, 1995, and not amended or renewed after July 31, 1995, notwithstanding the
2083 other provisions of this chapter, the trust shall consist of a trusteed account in an amount not
2084 less than the respective underwriters' several insurance and reinsurance liabilities attributable to
2085 business written in the United States;
2086 (C) in addition to a trust described in Subsection (6)(d)(iii)(A) or (B), the group shall
2087 maintain in trust a trusteed surplus of which $100,000,000 is held jointly for the benefit of the
2088 one or more United States domiciled ceding insurers of a member of the group for all years of
2089 account;
2090 (D) the incorporated members of the group:
2091 (I) may not be engaged in a business other than underwriting as a member of the group;
2092 and
2093 (II) are subject to the same level of regulation and solvency control by the group's
2094 domiciliary regulator as are the unincorporated members; and
2095 (E) within 90 days after the day on which the group's financial statements are due to be
2096 filed with the group's domiciliary regulator, the group shall provide to the commissioner:
2097 (I) an annual certification by the group's domiciliary regulator of the solvency of each
2098 underwriter member; or
2099 (II) if a certification is unavailable, a financial statement, prepared by an independent
2100 public accountant, of each underwriter member of the group.
2101 (iv) For a group of incorporated underwriters under common administration, the group
2102 shall:
2103 (A) have continuously transacted an insurance business outside the United States for at
2104 least three years immediately preceding the day on which the group makes application for
2105 accreditation;
2106 (B) maintain aggregate policyholders' surplus of at least $10,000,000,000;

2107 (C) maintain a trust fund in an amount not less than the group's several liabilities
2108 attributable to business ceded by the one or more United States domiciled ceding insurers to a
2109 member of the group pursuant to a reinsurance contract issued in the name of the group;
2110 (D) in addition to complying with the other provisions of this Subsection (6)(d)(iv),
2111 maintain a joint trusteed surplus of which $100,000,000 is held jointly for the benefit of the one
2112 or more United States domiciled ceding insurers of a member of the group as additional
2113 security for these liabilities; and
2114 (E) within 90 days after the day on which the group's financial statements are due to be
2115 filed with the group's domiciliary regulator, make available to the commissioner:
2116 (I) an annual certification of each underwriter member's solvency by the member's
2117 domiciliary regulator; and
2118 (II) a financial statement of each underwriter member of the group prepared by an
2119 independent public accountant.
2120 (7) If reinsurance is ceded to an assuming insurer not meeting the requirements of
2121 Subsection (3), (4), (5), or (6), a domestic ceding insurer is allowed credit only as to the
2122 insurance of a risk located in a jurisdiction where the reinsurance is required by applicable law
2123 or regulation of that jurisdiction.
2124 (8) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an
2125 assuming insurer that secures its obligations in accordance with this Subsection (8):
2126 (a) The insurer shall be certified by the commissioner as a reinsurer in this state.
2127 (b) To be eligible for certification, the assuming insurer shall:
2128 (i) be domiciled and licensed to transact insurance or reinsurance in a qualified
2129 jurisdiction, as determined by the commissioner pursuant to Subsection (8)(d);
2130 (ii) maintain minimum capital and surplus, or its equivalent, in an amount to be
2131 determined by the commissioner pursuant to rules made in accordance with Title 63G, Chapter
2132 3, Utah Administrative Rulemaking Act;
2133 (iii) maintain financial strength ratings from two or more rating agencies considered
2134 acceptable by the commissioner pursuant to rules made in accordance with Title 63G, Chapter
2135 3, Utah Administrative Rulemaking Act; and
2136 (iv) agree to:
2137 (A) submit to the jurisdiction of this state;

2138 (B) appoint the commissioner as its agent for service of process in this state;
2139 (C) provide security for 100% of the assuming insurer's liabilities attributable to
2140 reinsurance ceded by United States ceding insurers if it resists enforcement of a final United
2141 States judgment;
2142 (D) agree to meet applicable information filing requirements as determined by the
2143 commissioner including an application for certification, a renewal and on an ongoing basis; and
2144 (E) any other requirements for certification considered relevant by the commissioner.
2145 (c) An association, including incorporated and individual unincorporated underwriters,
2146 may be a certified reinsurer. To be eligible for certification, in addition to satisfying
2147 requirements of Subsections (8)(a) and (b), the association:
2148 (i) shall satisfy its minimum capital and surplus requirements through the capital and
2149 surplus equivalents, net of liabilities, of the association and its members, which shall include a
2150 joint central fund that may be applied to any unsatisfied obligation of the association or any of
2151 its members in an amount determined by the commissioner to provide adequate protection;
2152 (ii) may not have incorporated members of the association engaged in any business
2153 other than underwriting as a member of the association;
2154 (iii) shall be subject to the same level of regulation and solvency control of the
2155 incorporated members of the association by the association's domiciliary regulator as are the
2156 unincorporated members; and
2157 (iv) within 90 days after its financial statements are due to be filed with the
2158 association's domiciliary regulator provide:
2159 (A) to the commissioner an annual certification by the association's domiciliary
2160 regulator of the solvency of each underwriter member; or
2161 (B) if a certification is unavailable, financial statements prepared by independent
2162 public accountants, of each underwriter member of the association.
2163 (d) The commissioner shall create and publish a list of qualified jurisdictions under
2164 which an assuming insurer licensed and domiciled in the jurisdiction is eligible to be
2165 considered for certification by the commissioner as a certified reinsurer.
2166 (i) To determine whether the domiciliary jurisdiction of a non-United States assuming
2167 insurer is eligible to be recognized as a qualified jurisdiction, the commissioner:
2168 (A) shall evaluate the appropriateness and effectiveness of the reinsurance supervisory

2169 system of the jurisdiction, both initially and on an ongoing basis;
2170 (B) shall consider the rights, the benefits, and the extent of reciprocal recognition
2171 afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the
2172 United States;
2173 (C) shall require the qualified jurisdiction to share information and cooperate with the
2174 commissioner with respect to all certified reinsurers domiciled within that jurisdiction; and
2175 (D) may not recognize a jurisdiction as a qualified jurisdiction if the commissioner has
2176 determined that the jurisdiction does not adequately and promptly enforce final United States
2177 judgments and arbitration awards.
2178 (ii) The commissioner may consider additional factors in determining a qualified
2179 jurisdiction.
2180 (iii) A list of qualified jurisdictions shall be published through the National
2181 Association of Insurance Commissioners' Committee Process and the commissioner shall:
2182 (A) consider this list in determining qualified jurisdictions; and
2183 (B) if the commissioner approves a jurisdiction as qualified that does not appear on the
2184 National Association of Insurance Commissioner's list of qualified jurisdictions, provide
2185 thoroughly documented justification in accordance with criteria to be developed by rule made
2186 in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
2187 (iv) United States jurisdictions that meet the requirement for accreditation under the
2188 National Association of Insurance Commissioners' financial standards and accreditation
2189 program shall be recognized as qualified jurisdictions.
2190 (v) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction,
2191 the commissioner may suspend the reinsurer's certification indefinitely, in lieu of revocation.
2192 (e) The commissioner shall:
2193 (i) assign a rating to each certified reinsurer, giving due consideration to the financial
2194 strength ratings that have been assigned by rating agencies considered acceptable to the
2195 commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative
2196 Rulemaking Act; and
2197 (ii) publish a list of all certified reinsurers and their ratings.
2198 (f) A certified reinsurer shall secure obligations assumed from United States ceding
2199 insurers under this Subsection (8) at a level consistent with its rating, as specified in rules made

2200 by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative
2201 Rulemaking Act.
2202 (i) For a domestic ceding insurer to qualify for full financial statement credit for
2203 reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a
2204 form acceptable to the commissioner and consistent with Section 31A-17-404.1, or in a
2205 multibeneficiary trust in accordance with Subsections (5), (6), and (7), except as otherwise
2206 provided in this Subsection (8).
2207 (ii) If a certified reinsurer maintains a trust to fully secure its obligations subject to
2208 Subsections (5), (6), and (7), and chooses to secure its obligations incurred as a certified
2209 reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate
2210 trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a
2211 certified reinsurer with reduced security as permitted by this Subsection (8) or comparable laws
2212 of other United States jurisdictions and for its obligations subject to Subsections (5), (6), and
2213 (7).
2214 (iii) It shall be a condition to the grant of certification under this Subsection (8) that the
2215 certified reinsurer shall have bound itself[~~,~~]:
2216 (A) by the language of the trust and agreement with the commissioner with principal
2217 regulatory oversight of the trust account[~~,~~]; and
2218 (B) upon termination of the trust account, to fund, [~~upon termination of the trust~~
2219 ~~account,~~] out of the remaining surplus of the trust, any deficiency of any other [~~the~~] trust
2220 account.
2221 (iv) The minimum trusteed surplus requirements provided in Subsections (5), (6), and
2222 (7) are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer
2223 for the purpose of securing obligations incurred under this Subsection (8), except that the trust
2224 shall maintain a minimum trusteed surplus of $10,000,000.
2225 (v) With respect to obligations incurred by a certified reinsurer under this Subsection
2226 (8), if the security is insufficient, the commissioner:
2227 (A) shall reduce the allowable credit by an amount proportionate to the deficiency; and
2228 (B) may impose further reductions in allowable credit upon finding that there is a
2229 material risk that the certified reinsurer's obligations will not be paid in full when due.
2230 (vi) For purposes of this Subsection (8), a certified reinsurer whose certification has

2231 been terminated for any reason shall be treated as a certified reinsurer required to secure 100%
2232 of its obligations.
2233 (A) As used in this Subsection (8), the term "terminated" refers to revocation,
2234 suspension, voluntary surrender, and inactive status.
2235 (B) If the commissioner continues to assign a higher rating as permitted by other
2236 provisions of this section, the requirement under this Subsection (8)(f)(vi) does not apply to a
2237 certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.
2238 (g) If an applicant for certification has been certified as a reinsurer in a National
2239 Association of Insurance Commissioners' accredited jurisdiction, the commissioner may:
2240 (i) defer to that jurisdiction's certification;
2241 (ii) defer to the rating assigned by that jurisdiction; and
2242 (iii) consider such reinsurer to be a certified reinsurer in this state.
2243 (h) (i) A certified reinsurer that ceases to assume new business in this state may request
2244 to maintain its certification in inactive status in order to continue to qualify for a reduction in
2245 security for its in-force business.
2246 (ii) An inactive certified reinsurer shall continue to comply with all applicable
2247 requirements of this Subsection (8).
2248 (iii) The commissioner shall assign a rating to a reinsurer that qualifies under this
2249 Subsection (8)(h), that takes into account, if relevant, the reasons why the reinsurer is not
2250 assuming new business.
2251 (9) Reinsurance credit may not be allowed a domestic ceding insurer unless the
2252 assuming insurer under the reinsurance contract submits to the jurisdiction of Utah courts by:
2253 (a) (i) being an admitted insurer; and
2254 (ii) submitting to jurisdiction under Section 31A-2-309;
2255 (b) having irrevocably appointed the commissioner as the domestic ceding insurer's
2256 agent for service of process in an action arising out of or in connection with the reinsurance,
2257 which appointment is made under Section 31A-2-309; or
2258 (c) agreeing in the reinsurance contract:
2259 (i) that if the assuming insurer fails to perform its obligations under the terms of the
2260 reinsurance contract, the assuming insurer, at the request of the ceding insurer, shall:
2261 (A) submit to the jurisdiction of a court of competent jurisdiction in a state of the

2262 United States;

2263 (B) comply with all requirements necessary to give the court jurisdiction; and

2264 (C) abide by the final decision of the court or of an appellate court in the event of an

2265 appeal; and

2266 (ii) to designate the commissioner or a specific attorney licensed to practice law in this

2267 state as its attorney upon whom may be served lawful process in an action, suit, or proceeding

2268 instituted by or on behalf of the ceding company.

2269 (10) Submitting to the jurisdiction of Utah courts under Subsection (9) does not

2270 override a duty or right of a party under the reinsurance contract, including a requirement that

2271 the parties arbitrate their disputes.

2272 (11) If an assuming insurer does not meet the requirements of Subsection (3), (4), or

2273 (5), the credit permitted by Subsection (6) or (8) may not be allowed unless the assuming

2274 insurer agrees in the trust instrument to the following conditions:

2275 (a) (i) Notwithstanding any other provision in the trust instrument, if an event

2276 described in Subsection (11)(a)(ii) occurs the trustee shall comply with:

2277 (A) an order of the commissioner with regulatory oversight over the trust; or

2278 (B) an order of a court of competent jurisdiction directing the trustee to transfer to the

2279 commissioner with regulatory oversight all of the assets of the trust fund.

2280 (ii) This Subsection (11)(a) applies if:

2281 (A) the trust fund is inadequate because the trust contains an amount less than the

2282 amount required by Subsection (6)(d); or

2283 (B) the grantor of the trust is:

2284 (I) declared insolvent; or

2285 (II) placed into receivership, rehabilitation, liquidation, or similar proceeding under the

2286 laws of its state or country of domicile.

2287 (b) The assets of a trust fund described in Subsection (11)(a) shall be distributed by and

2288 a claim shall be filed with and valued by the commissioner with regulatory oversight in

2289 accordance with the laws of the state in which the trust is domiciled that are applicable to the

2290 liquidation of a domestic insurance company.

2291 (c) If the commissioner with regulatory oversight determines that the assets of the trust

2292 fund, or any part of the assets, are not necessary to satisfy the claims of the one or more United

2293 States ceding insurers of the grantor of the trust, the assets, or a part of the assets, shall be
2294 returned by the commissioner with regulatory oversight to the trustee for distribution in
2295 accordance with the trust instrument.
2296 (d) A grantor shall waive any right otherwise available to it under United States law
2297 that is inconsistent with this Subsection (11).
2298 (12) If an accredited or certified reinsurer ceases to meet the requirements for
2299 accreditation or certification, the commissioner may suspend or revoke the reinsurer's
2300 accreditation or certification.
2301 (a) The commissioner shall give the reinsurer notice and opportunity for hearing.
2302 (b) The suspension or revocation may not take effect until after the commissioner's
2303 order after a hearing, unless:
2304 (i) the reinsurer waives its right to hearing;
2305 (ii) the commissioner's order is based on:
2306 (A) regulatory action by the reinsurer's domiciliary jurisdiction; or
2307 (B) the voluntary surrender or termination of the reinsurer's eligibility to transact
2308 insurance or reinsurance business in its domiciliary jurisdiction or primary certifying state
2309 under Subsection (8)(g); or
2310 (iii) the commissioner's finding that an emergency requires immediate action and a
2311 court of competent jurisdiction has not stayed the commissioner's action.
2312 (c) While a reinsurer's accreditation or certification is suspended, no reinsurance
2313 contract issued or renewed after the effective date of the suspension qualifies for credit except
2314 to the extent that the reinsurer's obligations under the contract are secured in accordance with
2315 Section 31A-17-404.1.
2316 (d) If a reinsurer's accreditation or certification is revoked, no credit for reinsurance
2317 may be granted after the effective date of the revocation except to the extent that the reinsurer's
2318 obligations under the contract are secured in accordance with Subsection (8)(f) or Section
2319 31A-17-404.1.
2320 (13) (a) A ceding insurer shall take steps to manage its reinsurance recoverables
2321 proportionate to its own book of business.
2322 (b) (i) A domestic ceding insurer shall notify the commissioner within 30 days after
2323 reinsurance recoverables from any single assuming insurer, or group of affiliated assuming

2324 insurers:
2325 (A) exceeds 50% of the domestic ceding insurer's last reported surplus to
2326 policyholders; or
2327 (B) after it is determined that reinsurance recoverables from any single assuming
2328 insurer, or group of affiliated assuming insurers, is likely to exceed 50% of the domestic ceding
2329 insurer's last reported surplus to policyholders.
2330 (ii) The notification required by Subsection (13)(b)(i) shall demonstrate that the
2331 exposure is safely managed by the domestic ceding insurer.
2332 (c) A ceding insurer shall take steps to diversify its reinsurance program.
2333 (d) (i) A domestic ceding insurer shall notify the commissioner within 30 days after
2334 ceding or being likely to cede more than 20% of the ceding insurer's gross written premium in
2335 the prior calendar year to any:
2336 (A) single assuming insurer; or
2337 (B) group of affiliated assuming insurers.
2338 (ii) The notification shall demonstrate that the exposure is safely managed by the
2339 domestic ceding insurer.
2340 Section 18. Section **31A-17-603** is amended to read:
2341 **31A-17-603. Company action level event.**
2342 (1) "Company action level event" means any of the following events:
2343 (a) the filing of an RBC report by an insurer or health organization that indicates that:
2344 (i) the insurer's or health organization's total adjusted capital is greater than or equal to
2345 its regulatory action level RBC but less than its company action level RBC;
2346 (ii) if a life [~~or~~], accident and health insurer, or health organization, the insurer [~~has~~] or
2347 health organization:
2348 (A) has total adjusted capital that is greater than or equal to its company action level
2349 RBC but less than the product of its authorized control level RBC and 3.0; and
2350 (B) triggers the trend test determined in accordance with the trend test calculation
2351 included in the life [~~or~~], fraternal, or health RBC instructions; or
2352 (iii) if a property and casualty insurer, the insurer has:
2353 (A) total adjusted capital that is greater than or equal to its company action level RBC,
2354 but less than the product of its authorized control level RBC and 3.0; and

2355 (B) triggers the trend test determined in accordance with the trend test calculation
2356 included in the property and casualty RBC instructions;
2357 (b) the notification by the commissioner to the insurer or health organization of an
2358 adjusted RBC report that indicates an event in Subsection (1)(a), provided the insurer or health
2359 organization does not challenge the adjusted RBC report under Section 31A-17-607; or
2360 (c) if, pursuant to Section 31A-17-607, an insurer or health organization challenges an
2361 adjusted RBC report that indicates the event in Subsection (1)(a), the notification by the
2362 commissioner to the insurer or health organization that after a hearing the commissioner rejects
2363 the insurer's or health organization's challenge.
2364 (2) (a) In the event of a company action level event, the insurer or health organization
2365 shall prepare and submit to the commissioner an RBC plan that shall:
2366 (i) identify the conditions that contribute to the company action level event;
2367 (ii) contain proposals of corrective actions that the insurer or health organization
2368 intends to take and that are expected to result in the elimination of the company action level
2369 event;
2370 (iii) provide projections of the insurer's or health organization's financial results in the
2371 current year and at least the four succeeding years, both in the absence of proposed corrective
2372 actions and giving effect to the proposed corrective actions, including projections of:
2373 (A) statutory operating income;
2374 (B) net income;
2375 (C) capital;
2376 (D) surplus; and
2377 (E) RBC levels;
2378 (iv) identify the key assumptions impacting the insurer's or health organization's
2379 projections and the sensitivity of the projections to the assumptions; and
2380 (v) identify the quality of, and problems associated with, the insurer's or health
2381 organization's business, including its assets, anticipated business growth and associated surplus
2382 strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each
2383 case.
2384 (b) For purposes of Subsection (2)(a)(iii), the projections for both new and renewal
2385 business may include separate projections for each major line of business and separately

2386 identify each significant income, expense, and benefit component.
2387 (3) The RBC plan shall be submitted:
2388 (a) within 45 days of the company action level event; or
2389 (b) if the insurer or health organization challenges an adjusted RBC report pursuant to
2390 Section 31A-17-607, within 45 days after notification to the insurer or health organization that
2391 after a hearing the commissioner rejects the insurer's or health organization's challenge.
2392 (4) (a) Within 60 days after the submission by an insurer or health organization of an
2393 RBC plan to the commissioner, the commissioner shall notify the insurer or health organization
2394 whether the RBC plan:
2395 (i) shall be implemented; or
2396 (ii) is unsatisfactory.
2397 (b) If the commissioner determines the RBC plan is unsatisfactory, the notification to
2398 the insurer or health organization shall set forth the reasons for the determination, and may
2399 propose revisions that will render the RBC plan satisfactory. Upon notification from the
2400 commissioner, the insurer or health organization shall:
2401 (i) prepare a revised RBC plan that incorporates any revision proposed by the
2402 commissioner; and
2403 (ii) submit the revised RBC plan to the commissioner:
2404 (A) within 45 days after the notification from the commissioner; or
2405 (B) if the insurer challenges the notification from the commissioner under Section
2406 31A-17-607, within 45 days after a notification to the insurer or health organization that after a
2407 hearing the commissioner rejects the insurer's or health organization's challenge.
2408 (5) In the event of a notification by the commissioner to an insurer or health
2409 organization that the insurer's or health organization's RBC plan or revised RBC plan is
2410 unsatisfactory, the commissioner may specify in the notification that the notification constitutes
2411 a regulatory action level event subject to the insurer's or health organization's right to a hearing
2412 under Section 31A-17-607.
2413 (6) Every domestic insurer or health organization that files an RBC plan or revised
2414 RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with
2415 the insurance commissioner in any state in which the insurer or health organization is
2416 authorized to do business if:

2417 (a) the state has an RBC provision substantially similar to Subsection 31A-17-608(1);
2418 and
2419 (b) the insurance commissioner of that state notifies the insurer or health organization
2420 of its request for the filing in writing, in which case the insurer or health organization shall file
2421 a copy of the RBC plan or revised RBC plan in that state no later than the later of:
2422 (i) 15 days after the receipt of notice to file a copy of its RBC plan or revised RBC plan
2423 with that state; or
2424 (ii) the date on which the RBC plan or revised RBC plan is filed under Subsections (3)
2425 and (4).
2426 Section 19. Section **31A-22-505** is amended to read:
2427 **31A-22-505. Association groups.**
2428 (1) A policy is subject to the requirements of this section if the policy is issued as
2429 policyholder to an association or to the trustees of a fund established, created, or maintained for
2430 the benefit of members of one or more associations:
2431 (a) with a minimum membership of 100 persons[,];
2432 (b) with a constitution and bylaws[, and which];
2433 (c) having a shared or common purpose that is not primarily a business or customer
2434 relationship; and
2435 (d) that has been in active existence for at least two years[, is subject to the following
2436 requirements:].
2437 [(1)] (2) The policy may insure members and employees of the association, employees
2438 of the members, one or more of the preceding entities, or all of any classes of these named
2439 entities for the benefit of persons other than the employees' employer, or any officials,
2440 representatives, trustees, or agents of the employer or association.
2441 [(2)] (3) The premiums shall be paid by the policyholder from funds contributed by the
2442 associations, by employer members, from funds contributed by the covered persons, or from
2443 any combination of these. Except as provided under Section 31A-22-512, a policy on which no
2444 part of the premium is contributed by the covered persons, specifically for their insurance, is
2445 required to insure all eligible persons.
2446 Section 20. Section **31A-22-605** is amended to read:
2447 **31A-22-605. Accident and health insurance standards.**

2448 (1) The purposes of this section include:
2449 (a) reasonable standardization and simplification of terms and coverages of individual
2450 and franchise accident and health insurance policies, including accident and health insurance
2451 contracts of insurers licensed under Chapter 7, Nonprofit Health Service Insurance
2452 Corporations, and Chapter 8, Health Maintenance Organizations and Limited Health Plans, to
2453 facilitate public understanding and comparison in purchasing;
2454 (b) elimination of provisions contained in individual and franchise accident and health
2455 insurance contracts that may be misleading or confusing in connection with either the purchase
2456 of those types of coverages or the settlement of claims; and
2457 (c) full disclosure in the sale of individual and franchise accident and health insurance
2458 contracts.
2459 (2) As used in this section:
2460 (a) "Direct response insurance policy" means an individual insurance policy solicited
2461 and sold without the policyholder having direct contact with a natural person intermediary.
2462 (b) "Medicare" <u>means the same as that term</u> is defined in Subsection 31A-22-620(1)(e).
2463 (c) "Medicare supplement policy" <u>means the same as that term</u> is defined in Subsection
2464 31A-22-620(1)(f).
2465 (3) [~~This~~] <u>Except as provided in Subsection (10), this</u> section applies to all individual
2466 and franchise accident and health policies.
2467 (4) The commissioner shall adopt rules<u>, made in accordance with Title 63G, Chapter 3,</u>
2468 <u>Utah Administrative Rulemaking Act,</u> relating to the following matters:
2469 (a) standards for the manner and content of policy provisions, and disclosures to be
2470 made in connection with the sale of policies covered by this section, dealing with at least the
2471 following matters:
2472 (i) terms of renewability;
2473 (ii) initial and subsequent conditions of eligibility;
2474 (iii) nonduplication of coverage provisions;
2475 (iv) coverage of dependents;
2476 (v) preexisting conditions;
2477 (vi) termination of insurance;
2478 (vii) probationary periods;

2479 (viii) limitations;
2480 (ix) exceptions;
2481 (x) reductions;
2482 (xi) elimination periods;
2483 (xii) requirements for replacement;
2484 (xiii) recurrent conditions;
2485 (xiv) coverage of persons eligible for Medicare; and
2486 (xv) definition of terms;
2487 (b) minimum standards for benefits under each of the following categories of coverage
2488 in policies covered in this section:
2489 (i) basic hospital expense coverage;
2490 (ii) basic medical-surgical expense coverage;
2491 (iii) hospital confinement indemnity coverage;
2492 (iv) major medical expense coverage;
2493 (v) income replacement coverage;
2494 (vi) accident only coverage;
2495 (vii) specified disease or specified accident coverage;
2496 (viii) limited benefit health coverage; and
2497 (ix) nursing home and long-term care coverage;
2498 (c) the content and format of the outline of coverage, in addition to that required under
2499 Subsection (6);
2500 (d) the method of identification of policies and contracts based upon coverages
2501 provided; and
2502 (e) rating practices.
2503 (5) Nothing in Subsection (4)(b) precludes the issuance of policies that combine
2504 categories of coverage in [~~that subsection~~] Subsection (4)(b) provided that any combination of
2505 categories meets the standards of a component category of coverage.
2506 (6) The commissioner may adopt rules, made in accordance with Title 63G, Chapter 3,
2507 Utah Administrative Rulemaking Act, relating to the following matters:
2508 (a) establishing disclosure requirements for insurance policies covered in this section,
2509 designed to adequately inform the prospective insured of the need for and extent of the

2510 coverage offered, and requiring that this disclosure be furnished to the prospective insured with
2511 the application form, unless it is a direct response insurance policy;
2512 (b) (i) prescribing caption or notice requirements designed to inform prospective
2513 insureds that particular insurance coverages are not Medicare Supplement coverages;
2514 (ii) the requirements of Subsection (6)(b)(i) apply to all insurance policies and
2515 certificates sold to persons eligible for Medicare; and
2516 (c) requiring the disclosures or information brochures to be furnished to the
2517 prospective insured on direct response insurance policies, upon his request or, in any event, no
2518 later than the time of the policy delivery.
2519 (7) A policy covered by this section may be issued only if it meets the minimum
2520 standards established by the commissioner under Subsection (4), an outline of coverage
2521 accompanies the policy or is delivered to the applicant at the time of the application, and,
2522 except with respect to direct response insurance policies, an acknowledged receipt is provided
2523 to the insurer. The outline of coverage shall include:
2524 (a) a statement identifying the applicable categories of coverage provided by the policy
2525 as prescribed under Subsection (4);
2526 (b) a description of the principal benefits and coverage;
2527 (c) a statement of the exceptions, reductions, and limitations contained in the policy;
2528 (d) a statement of the renewal provisions, including any reservation by the insurer of a
2529 right to change premiums;
2530 (e) a statement that the outline is a summary of the policy issued or applied for and that
2531 the policy should be consulted to determine governing contractual provisions; and
2532 (f) any other contents the commissioner prescribes.
2533 (8) If a policy is issued on a basis other than that applied for, the outline of coverage
2534 shall accompany the policy when it is delivered and it shall clearly state that it is not the policy
2535 for which application was made.
2536 (9) (a) Notwithstanding Subsection 31A-22-606(1), limited accident and health
2537 policies or certificates issued to persons eligible for Medicare shall contain a notice
2538 prominently printed on or attached to the cover or front page which states that the policyholder
2539 or certificate holder has the right to return the policy for any reason within 30 days after its
2540 delivery and to have the premium refunded.

2541 (b) This Subsection (9) does not apply to a policy issued to an employer group.
2542 (10) The commissioner shall adopt rules for policy provisions, disclosures, and
2543 minimum standards for individual and group short-term limited duration health insurance.
2544 Section 21. Section **31A-22-610.5** is amended to read:
2545 **31A-22-610.5. Dependent coverage.**
2546 (1) As used in this section, "child" has the same meaning as defined in Section
2547 78B-12-102.
2548 (2) (a) Any individual or group accident and health insurance policy or health
2549 maintenance organization contract that provides coverage for a policyholder's or certificate
2550 holder's dependent may not terminate coverage of an unmarried dependent by reason of the
2551 dependent's age before the dependent's 26th birthday and shall, upon application, provide
2552 coverage for all unmarried dependents up to age 26.
2553 (b) The cost of coverage for unmarried dependents 19 to 26 years of age shall be
2554 included in the premium on the same basis as other dependent coverage.
2555 (c) This section does not prohibit the employer from requiring the employee to pay all
2556 or part of the cost of coverage for unmarried dependents.
2557 (d) An individual health insurance policy, group health insurance policy, or health
2558 maintenance organization shall continue in force coverage for a dependent through the last day
2559 of the month in which the dependent ceases to be a dependent:
2560 (i) if premiums are paid; and
2561 (ii) notwithstanding Section 31A-8-402.3, 31A-8-402.5, 31A-22-721, 31A-30-107.1,
2562 or 31A-30-107.3.
2563 (3) An individual or group accident and health insurance policy or health maintenance
2564 organization contract shall reinstate dependent coverage, and for purposes of all exclusions and
2565 limitations, shall treat the dependent as if the coverage had been in force since it was
2566 terminated; if:
2567 (a) the dependent has not reached the age of 26 by July 1, 1995;
2568 (b) the dependent had coverage prior to July 1, 1994;
2569 (c) prior to July 1, 1994, the dependent's coverage was terminated solely due to the age
2570 of the dependent; and
2571 (d) the policy has not been terminated since the dependent's coverage was terminated.

2572 (4) (a) When a parent is required by a court or administrative order to provide health
2573 insurance coverage for a child, an accident and health insurer may not deny enrollment of a
2574 child under the accident and health insurance plan of the child's parent on the grounds the
2575 child:
2576 (i) was born out of wedlock and is entitled to coverage under Subsection (5);
2577 (ii) was born out of wedlock and the custodial parent seeks enrollment for the child
2578 under the custodial parent's policy;
2579 (iii) is not claimed as a dependent on the parent's federal tax return; or
2580 (iv) does not reside with the parent or in the insurer's service area.
2581 (b) A child enrolled as required under Subsection (4)(a)(iv) is subject to the terms of
2582 the accident and health insurance plan contract pertaining to services received outside of an
2583 insurer's service area. A health maintenance organization shall comply with Section
2584 31A-8-502.
2585 (5) When a child has accident and health coverage through an insurer of a noncustodial
2586 parent, and when requested by the noncustodial or custodial parent, the insurer shall:
2587 (a) provide information to the custodial parent as necessary for the child to obtain
2588 benefits through that coverage, but the insurer or employer, or the agents or employees of either
2589 of them, are not civilly or criminally liable for providing information in compliance with this
2590 Subsection (5)(a), whether the information is provided pursuant to a verbal or written request;
2591 (b) permit the custodial parent or the service provider, with the custodial parent's
2592 approval, to submit claims for covered services without the approval of the noncustodial
2593 parent; and
2594 (c) make payments on claims submitted in accordance with Subsection (5)(b) directly
2595 to the custodial parent, the child who obtained benefits, the provider, or the state Medicaid
2596 agency.
2597 (6) When a parent is required by a court or administrative order to provide health
2598 coverage for a child, and the parent is eligible for family health coverage, the insurer shall:
2599 (a) permit the parent to enroll, under the family coverage, a child who is otherwise
2600 eligible for the coverage without regard to an enrollment season restrictions;
2601 (b) if the parent is enrolled but fails to make application to obtain coverage for the
2602 child, enroll the child under family coverage upon application of the child's other parent, the

2603 state agency administering the Medicaid program, or the state agency administering 42 U.S.C.
2604 Sec. 651 through 669, the child support enforcement program; and
2605 (c) (i) when the child is covered by an individual policy, not disenroll or eliminate
2606 coverage of the child unless the insurer is provided satisfactory written evidence that:
2607 (A) the court or administrative order is no longer in effect; or
2608 (B) the child is or will be enrolled in comparable accident and health coverage through
2609 another insurer which will take effect not later than the effective date of disenrollment; or
2610 (ii) when the child is covered by a group policy, not disenroll or eliminate coverage of
2611 the child unless the employer is provided with satisfactory written evidence, which evidence is
2612 also provided to the insurer, that Subsection (9)(c)(i), (ii) or (iii) has happened.
2613 (7) An insurer may not impose requirements on a state agency that has been assigned
2614 the rights of an individual eligible for medical assistance under Medicaid and covered for
2615 accident and health benefits from the insurer that are different from requirements applicable to
2616 an agent or assignee of any other individual so covered.
2617 (8) Insurers may not reduce their coverage of pediatric vaccines below the benefit level
2618 in effect on May 1, 1993.
2619 (9) When a parent is required by a court or administrative order to provide health
2620 coverage, which is available through an employer doing business in this state, the employer
2621 shall:
2622 (a) permit the parent to enroll under family coverage any child who is otherwise
2623 eligible for coverage without regard to any enrollment season restrictions;
2624 (b) if the parent is enrolled but fails to make application to obtain coverage of the child,
2625 enroll the child under family coverage upon application by the child's other parent, by the state
2626 agency administering the Medicaid program, or the state agency administering 42 U.S.C. Sec.
2627 651 through 669, the child support enforcement program;
2628 (c) not disenroll or eliminate coverage of the child unless the employer is provided
2629 satisfactory written evidence that:
2630 (i) the court order is no longer in effect;
2631 (ii) the child is or will be enrolled in comparable coverage which will take effect no
2632 later than the effective date of disenrollment; or
2633 (iii) the employer has eliminated family health coverage for all of its employees; and

2634 (d) withhold from the employee's compensation the employee's share, if any, of
2635 premiums for health coverage and to pay this amount to the insurer.
2636 (10) An order issued under Section 62A-11-326.1 may be considered a "qualified
2637 medical support order" for the purpose of enrolling a dependent child in a group accident and
2638 health insurance plan as defined in Section 609(a), Federal Employee Retirement Income
2639 Security Act of 1974.
2640 (11) This section does not affect any insurer's ability to require as a precondition of any
2641 child being covered under any policy of insurance that:
2642 (a) the parent continues to be eligible for coverage;
2643 (b) the child shall be identified to the insurer with adequate information to comply with
2644 this section; and
2645 (c) the premium shall be paid when due.
2646 (12) [~~The provisions of this section apply~~] This section applies to employee welfare
2647 benefit plans as defined in Section 26-19-2.
2648 [~~(13) The commissioner shall adopt rules interpreting and implementing this section~~
2649 ~~with regard to out-of-area court ordered dependent coverage.~~]
2650 (13) (a) A policy that provides coverage to a child of a group member may not deny
2651 eligibility for coverage to a child solely because:
2652 (i) the child does not reside with the insured; or
2653 (ii) the child is solely dependent on a former spouse of the insured rather than on the
2654 insured.
2655 (b) A child who does not reside with the insured may be excluded on the same basis as
2656 a child who resides with the insured.
2657 Section 22. Section **31A-22-614.5** is amended to read:
2658 **31A-22-614.5. Uniform claims processing -- Electronic exchange of health**
2659 **information.**
2660 (1) (a) Except as provided in Subsection (1)(c), [~~all insurers~~] an insurer offering health
2661 insurance shall use a uniform claim form and uniform billing and claim codes.
2662 (b) Beginning January 1, 2011, all health benefit plans, and dental and vision plans,
2663 shall provide for the electronic exchange of uniform:
2664 (i) eligibility and coverage information; and

2665 (ii) coordination of benefits information.
2666 (c) For purposes of Subsection (1)(a), "health insurance" does not include a policy or
2667 certificate that provides benefits solely for:
2668 (i) income replacement; or
2669 (ii) long-term care.
2670 (2) (a) The uniform electronic standards and information required in Subsection (1)
2671 shall be adopted and approved by the commissioner in accordance with Title 63G, Chapter 3,
2672 Utah Administrative Rulemaking Act.
2673 (b) When adopting rules under this section the commissioner:
2674 (i) shall:
2675 (A) consult with national and state organizations involved with the standardized
2676 exchange of health data, and the electronic exchange of health data, to develop the standards
2677 for the use and electronic exchange of uniform:
2678 (I) claim forms;
2679 (II) billing and claim codes;
2680 (III) insurance eligibility and coverage information; and
2681 (IV) coordination of benefits information; and
2682 (B) meet federal mandatory minimum standards following the adoption of national
2683 requirements for transaction and data elements in the federal Health Insurance Portability and
2684 Accountability Act;
2685 (ii) may not require an insurer or administrator to use a specific software product or
2686 vendor; and
2687 (iii) may require an insurer who participates in the all payer database created under
2688 Section 26-33a-106.1 to allow data regarding demographic and insurance coverage information
2689 to be electronically shared with the state's designated secure health information master person
2690 index to be used:
2691 (A) in compliance with data security standards established by:
2692 (I) the federal Health Insurance Portability and Accountability Act; and
2693 (II) the electronic commerce agreements established in a business associate agreement;
2694 and
2695 (B) for the purpose of coordination of health benefit plans.

2696 (3) (a) The commissioner shall coordinate the administrative rules adopted under the
2697 provisions of this section with the administrative rules adopted by the Department of Health for
2698 the implementation of the standards for the electronic exchange of clinical health information
2699 under Section 26-1-37. The department shall establish procedures for developing the rules
2700 adopted under this section, which ensure that the Department of Health is given the opportunity
2701 to comment on proposed rules.
2702 (b) (i) The commissioner may provide information to health care providers regarding
2703 resources available to a health care provider to verify whether a health care provider's practice
2704 management software system meets the uniform electronic standards for data exchange
2705 required by this section.
2706 (ii) The commissioner may provide the information described in Subsection (3)(b)(i)
2707 by partnering with:
2708 (A) a not-for-profit, broad based coalition of state health care insurers and health care
2709 providers who are involved in the electronic exchange of the data required by this section; or
2710 (B) some other person that the commissioner determines is appropriate to provide the
2711 information described in Subsection (3)(b)(i).
2712 (c) The commissioner shall regulate any fees charged by insurers to the providers for:
2713 (i) uniform claim forms;
2714 (ii) electronic billing; or
2715 (iii) the electronic exchange of clinical health information permitted by Section
2716 26-1-37.
2717 (4) This section does not require a person to provide information concerning an
2718 employer self-insured employee welfare benefit plan as defined in 29 U.S.C. Sec. 1002(1).
2719 Section 23. Section **31A-22-645** is enacted to read:
2720 **31A-22-645. Alcohol and drug dependency treatment.**
2721 (1) An insurer offering a health benefit plan providing coverage for alcohol or drug
2722 dependency treatment may require an inpatient facility to be licensed by:
2723 (a) (i) the Department of Human Services, under Title 62A, Chapter 2, Licensure of
2724 Programs and Facilities; or
2725 (ii) the Department of Health; or
2726 (b) for an inpatient facility located outside the state, a state agency similar to one

2727 described in Subsection (1)(a).

2728 (2) For inpatient coverage provided pursuant to Subsection (1), an insurer may require
2729 an inpatient facility to be accredited by the following:

2730 (a) the Joint Commission; and

2731 (b) one other nationally recognized accrediting agency.

2732 Section 24. Section **31A-22-701** is amended to read:

2733 **31A-22-701. Groups eligible for group or blanket insurance.**

2734 (1) As used in this section, "association group" means a lawfully formed association of
2735 individuals or business entities that:

2736 (a) purchases insurance on a group basis on behalf of members; and

2737 (b) is formed and maintained in good faith for purposes other than obtaining insurance.

2738 (2) A group accident and health insurance policy may be issued to:

2739 (a) a group:

2740 (i) to which a group life insurance policy may be issued under Sections 31A-22-502,
2741 31A-22-503, 31A-22-504, 31A-22-506, 31A-22-507, and 31A-22-509; and

2742 (ii) that is formed and maintained in good faith for a purpose other than obtaining
2743 insurance;

2744 (b) an association group that:

2745 (i) has been actively in existence for at least five years;

2746 (ii) has a constitution and bylaws;

2747 (iii) has a shared or common purpose that is not primarily a business or customer
2748 relationship;

2749 [~~(iii)~~] (iv) is formed and maintained in good faith for purposes other than obtaining
2750 insurance;

2751 [~~(iv)~~] (v) does not condition membership in the association group on any health
2752 status-related factor relating to an individual, including an employee of an employer or a
2753 dependent of an employee;

2754 [~~(v)~~] (vi) makes accident and health insurance coverage offered through the association
2755 group available to all members regardless of any health status-related factor relating to the
2756 members or individuals eligible for coverage through a member;

2757 [~~(vi)~~] (vii) does not make accident and health insurance coverage offered through the

2758 association group available other than in connection with a member of the association group;
2759 and
2760 [(vii)] (viii) is actuarially sound; or
2761 (c) a group specifically authorized by the commissioner under Section 31A-22-509,
2762 upon a finding that:
2763 (i) authorization is not contrary to the public interest;
2764 (ii) the group is actuarially sound;
2765 (iii) formation of the proposed group may result in economies of scale in acquisition,
2766 administrative, marketing, and brokerage costs;
2767 (iv) the insurance policy, insurance certificate, or other indicia of coverage that will be
2768 offered to the proposed group is substantially equivalent to insurance policies that are
2769 otherwise available to similar groups;
2770 (v) the group would not present hazards of adverse selection;
2771 (vi) the premiums for the insurance policy and any contributions by or on behalf of the
2772 insured persons are reasonable in relation to the benefits provided; and
2773 (vii) the group is formed and maintained in good faith for a purpose other than
2774 obtaining insurance.
2775 (3) A blanket accident and health insurance policy:
2776 (a) covers a defined class of persons;
2777 (b) may not be offered or underwritten on an individual basis;
2778 (c) shall cover only a group that is:
2779 (i) actuarially sound; and
2780 (ii) formed and maintained in good faith for a purpose other than obtaining insurance;
2781 and
2782 (d) may be issued only to:
2783 (i) a common carrier or an operator, owner, or lessee of a means of transportation, as
2784 policyholder, covering persons who may become passengers as defined by reference to the
2785 person's travel status;
2786 (ii) an employer, as policyholder, covering any group of employees, dependents, or
2787 guests, as defined by reference to specified hazards incident to any activities of the
2788 policyholder;

2789 (iii) an institution of learning, including a school district, a school jurisdictional unit, or
2790 the head, principal, or governing board of a school jurisdictional unit, as policyholder, covering
2791 students, teachers, or employees;
2792 (iv) a religious, charitable, recreational, educational, or civic organization, or branch of
2793 one of those organizations, as policyholder, covering a group of members or participants as
2794 defined by reference to specified hazards incident to the activities sponsored or supervised by
2795 the policyholder;
2796 (v) a sports team, camp, or sponsor of a sports team or camp, as policyholder, covering
2797 members, campers, employees, officials, or supervisors;
2798 (vi) a volunteer fire department, first aid, civil defense, or other similar volunteer
2799 organization, as policyholder, covering a group of members or participants as defined by
2800 reference to specified hazards incident to activities sponsored, supervised, or participated in by
2801 the policyholder;
2802 (vii) a newspaper or other publisher, as policyholder, covering its carriers;
2803 (viii) an association, including a labor union, that has a constitution and bylaws and
2804 that is organized in good faith for purposes other than that of obtaining insurance, as
2805 policyholder, covering a group of members or participants as defined by reference to specified
2806 hazards incident to the activities or operations sponsored or supervised by the policyholder; and
2807 (ix) any other class of risks that, in the judgment of the commissioner, may be properly
2808 eligible for blanket accident and health insurance.
2809 (4) The judgment of the commissioner may be exercised on the basis of:
2810 (a) individual risks;
2811 (b) a class of risks; or
2812 (c) both Subsections (4)(a) and (b).
2813 Section 25. Section **31A-22-716** is amended to read:
2814 **31A-22-716. Required provision for notice of termination.**
2815 (1) [~~Every~~] A policy for group or blanket accident and health coverage issued or
2816 renewed after July 1, 1990, shall include a provision that obligates the policyholder to give 30
2817 days prior written notice of termination to each employee or group member and to notify each
2818 employee or group member of the employee's or group member's rights to continue coverage
2819 upon termination.

2820 (2) An insurer's monthly notice to the policyholder of premium payments due shall
2821 include a statement of the policyholder's obligations as set forth in Subsection (1). Insurers
2822 shall provide a sample notice to the policyholder at least once a year.
2823 [~~(3) For the purpose of compliance with federal law and the Health Insurance~~
2824 ~~Portability and Accountability Act, all health benefit plans, health insurers, and student health~~
2825 ~~plans shall provide a certificate of creditable coverage to each covered person upon the person's~~
2826 ~~termination from the plan as soon as reasonably possible.~~]
2827 Section 26. Section **31A-22-721** is amended to read:
2828 **31A-22-721. A health benefit plan for a plan sponsor -- Discontinuance and**
2829 **nonrenewal.**
2830 (1) Except as otherwise provided in this section, a health benefit plan for a plan
2831 sponsor is renewable and continues in force:
2832 (a) with respect to all eligible employees and dependents; and
2833 (b) at the option of the plan sponsor.
2834 (2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed for a
2835 network plan, if:
2836 (a) there is no longer any enrollee under the group health plan who lives, resides, or
2837 works in:
2838 (i) the service area of the insurer; or
2839 (ii) the area for which the insurer is authorized to do business; or
2840 (b) for coverage made available in the small or large employer market only through an
2841 association, if:
2842 (i) the employer's membership in the association ceases; and
2843 (ii) the coverage is terminated uniformly without regard to any health status-related
2844 factor relating to any covered individual.
2845 (3) A health benefit plan for a plan sponsor may be discontinued if:
2846 (a) a condition described in Subsection (2) exists;
2847 (b) the plan sponsor fails to pay premiums or contributions in accordance with the
2848 terms of the contract;
2849 (c) the plan sponsor:
2850 (i) performs an act or practice that constitutes fraud; or

2851 (ii) makes an intentional misrepresentation of material fact under the terms of the
2852 coverage;
2853 (d) the insurer:
2854 (i) elects to discontinue offering a particular health benefit [~~product~~] plan delivered or
2855 issued for delivery in this state;
2856 (ii) (A) provides notice of the discontinuation in writing:
2857 (I) to each plan sponsor, employee, and dependent of a plan sponsor or employee; and
2858 (II) at least 90 days before the date the coverage will be discontinued;
2859 (B) provides notice of the discontinuation in writing:
2860 (I) to the commissioner; and
2861 (II) at least three working days prior to the date the notice is sent to the affected plan
2862 sponsors, employees, and dependents of plan sponsors or employees;
2863 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase any
2864 other health benefit [~~products~~] plans currently being offered:
2865 (I) by the insurer in the market; or
2866 (II) in the case of a large employer, any other health benefit plan currently being
2867 offered in that market; and
2868 (D) in exercising the option to discontinue that [~~product~~] health benefit plan and in
2869 offering the option of coverage in this section, the insurer acts uniformly without regard to:
2870 (I) the claims experience of a plan sponsor;
2871 (II) any health status-related factor relating to any covered participant or beneficiary; or
2872 (III) any health status-related factor relating to a new participant or beneficiary who
2873 may become eligible for coverage; or
2874 (e) the insurer:
2875 (i) elects to discontinue all of the insurer's health benefit plans:
2876 (A) in the small employer market; or
2877 (B) the large employer market; or
2878 (C) both the small and large employer markets; and
2879 (ii) (A) provides notice of the discontinuance in writing:
2880 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
2881 (II) at least 180 days before the date the coverage will be discontinued;

2882 (B) provides notice of the discontinuation in writing:
2883 (I) to the commissioner in each state in which an affected insured individual is known
2884 to reside; and
2885 (II) at least 30 business days prior to the date the notice is sent to the affected plan
2886 sponsors, employees, and dependents of a plan sponsor or employee;
2887 (C) discontinues and nonrenews all plans issued or delivered for issuance in the
2888 market; and
2889 (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.
2890 (4) A large employer health benefit plan may be discontinued or nonrenewed:
2891 (a) if a condition described in Subsection (2) exists; or
2892 (b) for noncompliance with the insurer's:
2893 (i) minimum participation requirements; or
2894 (ii) employer contribution requirements.
2895 (5) A small employer health benefit plan may be discontinued or nonrenewed:
2896 (a) if a condition described in Subsection (2) exists; or
2897 (b) for noncompliance with the insurer's employer contribution requirements.
2898 (6) A small employer health benefit plan may be nonrenewed:
2899 (a) if a condition described in Subsection (2) exists; or
2900 (b) for noncompliance with the insurer's minimum participation requirements.
2901 (7) (a) Except as provided in Subsection (7)(d), an eligible employee may be
2902 discontinued if after issuance of coverage the eligible employee:
2903 (i) engages in an act or practice that constitutes fraud in connection with the coverage;
2904 or
2905 (ii) makes an intentional misrepresentation of material fact in connection with the
2906 coverage.
2907 (b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:
2908 (i) 12 months after the date of discontinuance; and
2909 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
2910 to reenroll.
2911 (c) At the time the eligible employee's coverage is discontinued under Subsection
2912 (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is

2913 discontinued.

2914 (d) An eligible employee may not be discontinued under this Subsection (7) because of
2915 a fraud or misrepresentation that relates to health status.

2916 (8) (a) Except as provided in Subsection (8)(b), an insurer that elects to discontinue
2917 offering a health benefit plan under Subsection (3)(e) shall be prohibited from writing new
2918 business in such market in this state for a period of five years beginning on the date of
2919 discontinuation of the last coverage that is discontinued.

2920 (b) The commissioner may waive the prohibition under Subsection (8)(a) when the
2921 commissioner finds that waiver is in the public interest:

2922 (i) to promote competition; or

2923 (ii) to resolve inequity in the marketplace.

2924 (9) If an insurer is doing business in one established geographic service area of the
2925 state, this section applies only to the insurer's operations in that geographic service area.

2926 (10) An insurer may modify a health benefit plan for a plan sponsor only:

2927 (a) at the time of coverage renewal; and

2928 (b) if the modification is effective uniformly among all plans with a particular product
2929 or service.

2930 (11) For purposes of this section, a reference to "plan sponsor" includes a reference to
2931 the employer:

2932 (a) with respect to coverage provided to an employer member of the association; and

2933 (b) if the health benefit plan is made available by an insurer in the employer market
2934 only through:

2935 (i) an association;

2936 (ii) a trust; or

2937 (iii) a discretionary group.

2938 (12) (a) A small employer that, after purchasing a health benefit plan in the small group
2939 market, employs on average more than 50 eligible employees on each business day in a
2940 calendar year may continue to renew the health benefit plan purchased in the small group
2941 market.

2942 (b) A large employer that, after purchasing a health benefit plan in the large group
2943 market, employs on average less than 51 eligible employees on each business day in a calendar

2944 year may continue to renew the health benefit plan purchased in the large group market.
2945 (13) An insurer offering employer sponsored health benefit plans shall comply with the
2946 Health Insurance Portability and Accountability Act, 42 U.S.C. Sec. 300gg and 300gg-1.
2947 Section 27. Section **31A-22-1902** is amended to read:
2948 **31A-22-1902. Definitions.**
2949 As used in this part:
2950 (1) "Administrator" means the same as that term is defined in Section 67-4a-102.
2951 (2) "Asymmetric conduct" means an insurer's use of the death master file or other
2952 similar database before July 1, 2015, in connection with searching for information regarding
2953 whether annuitants under the insurer's annuities might be deceased, but not in connection with
2954 whether the insureds under the insurer's policies might be deceased.
2955 (3) (a) "Contract" means an annuity contract.
2956 (b) "Contract" does not include an annuity used to fund an employment-based
2957 retirement plan or program when:
2958 (i) the insurer does not perform the record keeping services; or
2959 (ii) the insurer is not committed by terms of the annuity contract to pay death benefits
2960 to the beneficiaries of specific plan participants.
2961 (4) "Death master file" means the United States Social Security Administration's Death
2962 Master File or another database or service that is at least as comprehensive as the United States
2963 Social Security Administration's Death Master File for determining that a person has reportedly
2964 died.
2965 (5) "Death master file match" means a search of a death master file that results in a
2966 match of the Social Security number, or the name and date of birth of an insured, annuity
2967 owner, or retained asset account holder.
2968 [~~(6) "Knowledge of death" means:~~]
2969 [~~(a) receipt of an original or valid copy of a certified death certificate; or~~]
2970 [~~(b) a death master file match validated by the insurer in accordance with Subsection~~
2971 ~~31A-22-1903(1)(a).~~]
2972 [~~(7)~~] (6) (a) "Policy" means a policy or certificate of life insurance that provides a death
2973 benefit.
2974 (b) "Policy" does not include:

2975 (i) a policy or certificate of life insurance that provides a death benefit under an
2976 employee benefit plan:
2977 (A) subject to the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec.
2978 1002, as periodically amended; or
2979 (B) under [~~any~~] a federal employee benefit program;
2980 (ii) a policy or certificate of life insurance that is used to fund a preneed funeral
2981 contract or prearrangement;
2982 (iii) a policy or certificate of credit life or accidental death insurance; or
2983 (iv) a policy issued to a group master policyholder for which the insurer does not
2984 provide record keeping services.
2985 [~~(8)~~] (7) "Record keeping services" means those circumstances under which the insurer
2986 agrees with a group policy or contract customer to be responsible for obtaining, maintaining,
2987 and administering, in its own or its agents' systems, information about each individual insured
2988 under an insured's group insurance contract, or a line of coverage under the group insurance
2989 contract, at least the following information:
2990 (a) social security number, or name and date of birth;
2991 (b) beneficiary designation information;
2992 (c) coverage eligibility;
2993 (d) benefit amount; and
2994 (e) premium payment status.
2995 [~~(9)~~] (8) "Retained asset account" means [~~any~~] a mechanism whereby the settlement of
2996 proceeds payable under a policy or contract is accomplished by the insurer or an entity acting
2997 on behalf of the insurer by depositing the proceeds into an account with check or draft writing
2998 privileges, where those proceeds are retained by the insurer or its agent, pursuant to a
2999 supplementary contract not involving annuity benefits other than death benefits.
3000 Section 28. Section **31A-23a-111** is amended to read:
3001 **31A-23a-111. Revoking, suspending, surrendering, lapsing, limiting, or otherwise**
3002 **terminating a license -- Forfeiture -- Rulemaking for renewal or reinstatement.**
3003 (1) A license type issued under this chapter remains in force until:
3004 (a) revoked or suspended under Subsection (5);
3005 (b) surrendered to the commissioner and accepted by the commissioner in lieu of

3006 administrative action;
3007 (c) the licensee dies or is adjudicated incompetent as defined under:
3008 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
3009 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and
3010 Minors;
3011 (d) lapsed under Section 31A-23a-113; or
3012 (e) voluntarily surrendered.
3013 (2) The following may be reinstated within one year after the day on which the license
3014 is no longer in force:
3015 (a) a lapsed license; or
3016 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may
3017 not be reinstated after the license period in which the license is voluntarily surrendered.
3018 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a
3019 license, submission and acceptance of a voluntary surrender of a license does not prevent the
3020 department from pursuing additional disciplinary or other action authorized under:
3021 (a) this title; or
3022 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah
3023 Administrative Rulemaking Act.
3024 (4) A line of authority issued under this chapter remains in force until:
3025 (a) the qualifications pertaining to a line of authority are no longer met by the licensee;
3026 or
3027 (b) the supporting license type:
3028 (i) is revoked or suspended under Subsection (5);
3029 (ii) is surrendered to the commissioner and accepted by the commissioner in lieu of
3030 administrative action;
3031 (iii) lapses under Section 31A-23a-113; or
3032 (iv) is voluntarily surrendered; or
3033 (c) the licensee dies or is adjudicated incompetent as defined under:
3034 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
3035 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and
3036 Minors.

3037 (5) (a) If the commissioner makes a finding under Subsection (5)(b), as part of an
3038 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the
3039 commissioner may:
3040 (i) revoke:
3041 (A) a license; or
3042 (B) a line of authority;
3043 (ii) suspend for a specified period of 12 months or less:
3044 (A) a license; or
3045 (B) a line of authority;
3046 (iii) limit in whole or in part:
3047 (A) a license; or
3048 (B) a line of authority; [~~or~~]
3049 (iv) deny a license application[~~.~~];
3050 (v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or
3051 (iv) take a combination of actions under Subsections (5)(a)(i) through (iv) and
3052 Subsection (5)(a)(v).
3053 (b) The commissioner may take an action described in Subsection (5)(a) if the
3054 commissioner finds that the licensee:
3055 (i) is unqualified for a license or line of authority under Section 31A-23a-104,
3056 31A-23a-105, or 31A-23a-107;
3057 (ii) violates:
3058 (A) an insurance statute;
3059 (B) a rule that is valid under Subsection 31A-2-201(3); or
3060 (C) an order that is valid under Subsection 31A-2-201(4);
3061 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other
3062 delinquency proceedings in any state;
3063 (iv) fails to pay a final judgment rendered against the person in this state within 60
3064 days after the day on which the judgment became final;
3065 (v) fails to meet the same good faith obligations in claims settlement that is required of
3066 admitted insurers;
3067 (vi) is affiliated with and under the same general management or interlocking

3068 directorate or ownership as another insurance producer that transacts business in this state
3069 without a license;
3070 (vii) refuses:
3071 (A) to be examined; or
3072 (B) to produce its accounts, records, and files for examination;
3073 (viii) has an officer who refuses to:
3074 (A) give information with respect to the insurance producer's affairs; or
3075 (B) perform any other legal obligation as to an examination;
3076 (ix) provides information in the license application that is:
3077 (A) incorrect;
3078 (B) misleading;
3079 (C) incomplete; or
3080 (D) materially untrue;
3081 (x) violates an insurance law, valid rule, or valid order of another regulatory agency in
3082 any jurisdiction;
3083 (xi) obtains or attempts to obtain a license through misrepresentation or fraud;
3084 (xii) improperly withholds, misappropriates, or converts money or properties received
3085 in the course of doing insurance business;
3086 (xiii) intentionally misrepresents the terms of an actual or proposed:
3087 (A) insurance contract;
3088 (B) application for insurance; or
3089 (C) life settlement;
3090 (xiv) is convicted of a felony;
3091 (xv) admits or is found to have committed an insurance unfair trade practice or fraud;
3092 (xvi) in the conduct of business in this state or elsewhere:
3093 (A) uses fraudulent, coercive, or dishonest practices; or
3094 (B) demonstrates incompetence, untrustworthiness, or financial irresponsibility;
3095 (xvii) has an insurance license, or its equivalent, denied, suspended, or revoked in
3096 another state, province, district, or territory;
3097 (xviii) forges another's name to:
3098 (A) an application for insurance; or

3099 (B) a document related to an insurance transaction;
3100 (xix) improperly uses notes or another reference material to complete an examination
3101 for an insurance license;
3102 (xx) knowingly accepts insurance business from an individual who is not licensed;
3103 (xxi) fails to comply with an administrative or court order imposing a child support
3104 obligation;
3105 (xxii) fails to:
3106 (A) pay state income tax; or
3107 (B) comply with an administrative or court order directing payment of state income
3108 tax;
3109 (xxiii) violates or permits others to violate the federal Violent Crime Control and Law
3110 Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and therefore under 18 U.S.C. Sec. 1033 is
3111 prohibited from engaging in the business of insurance; or
3112 (xxiv) engages in a method or practice in the conduct of business that endangers the
3113 legitimate interests of customers and the public.
3114 (c) For purposes of this section, if a license is held by an agency, both the agency itself
3115 and any individual designated under the license are considered to be the holders of the license.
3116 (d) If an individual designated under the agency license commits an act or fails to
3117 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,
3118 the commissioner may suspend, revoke, or limit the license of:
3119 (i) the individual;
3120 (ii) the agency, if the agency:
3121 (A) is reckless or negligent in its supervision of the individual; or
3122 (B) knowingly participates in the act or failure to act that is the ground for suspending,
3123 revoking, or limiting the license; or
3124 (iii) (A) the individual; and
3125 (B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).
3126 (6) A licensee under this chapter is subject to the penalties for acting as a licensee
3127 without a license if:
3128 (a) the licensee's license is:
3129 (i) revoked;

3130 (ii) suspended;
3131 (iii) limited;
3132 (iv) surrendered in lieu of administrative action;
3133 (v) lapsed; or
3134 (vi) voluntarily surrendered; and
3135 (b) the licensee:
3136 (i) continues to act as a licensee; or
3137 (ii) violates the terms of the license limitation.
3138 (7) A licensee under this chapter shall immediately report to the commissioner:
3139 (a) a revocation, suspension, or limitation of the person's license in another state, the
3140 District of Columbia, or a territory of the United States;
3141 (b) the imposition of a disciplinary sanction imposed on that person by another state,
3142 the District of Columbia, or a territory of the United States; or
3143 (c) a judgment or injunction entered against that person on the basis of conduct
3144 involving:
3145 (i) fraud;
3146 (ii) deceit;
3147 (iii) misrepresentation; or
3148 (iv) a violation of an insurance law or rule.
3149 (8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a
3150 license in lieu of administrative action may specify a time, not to exceed five years, within
3151 which the former licensee may not apply for a new license.
3152 (b) If no time is specified in an order or agreement described in Subsection (8)(a), the
3153 former licensee may not apply for a new license for five years from the day on which the order
3154 or agreement is made without the express approval by the commissioner.
3155 (9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of
3156 a license issued under this part if so ordered by a court.
3157 (10) The commissioner shall by rule prescribe the license renewal and reinstatement
3158 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
3159 Section 29. Section **31A-23a-115** is amended to read:
3160 **31A-23a-115. Appointment of individual and agency insurance producer, limited**

3161 **line producer, or managing general agent -- Reports and lists.**
3162 (1) (a) An insurer shall appoint an individual or agency with whom it has a contract as
3163 an insurance producer, limited line producer, or managing general agent to act on the insurer's
3164 behalf in order for the licensee to do business for the insurer in this state.
3165 (b) An insurer shall report to the commissioner, at intervals and in the form the
3166 commissioner establishes by rule made in accordance with Title 63G, Chapter 3, Utah
3167 Administrative Rulemaking Act:
3168 (i) a new appointment; and
3169 (ii) a termination of appointment.
3170 (2) An insurer shall notify a producer that the producer's appointment is terminated by
3171 the insurer and of the reason for termination at an interval and in the form the commissioner
3172 establishes by rule made in accordance with Title 63G, Chapter 3, Utah Administrative
3173 Rulemaking Act.
3174 [~~(2)~~] (3) (a) (i) An insurer shall report to the commissioner the cause of termination of
3175 an appointment if:
3176 (A) the reason for termination is a reason described in Subsection 31A-23a-111(5)(b);
3177 or
3178 (B) the insurer has knowledge that the individual or agency licensee is found to have
3179 engaged in an activity described in Subsection 31A-23a-111(5)(b) by:
3180 (I) a court;
3181 (II) a government body; or
3182 (III) a self-regulatory organization, which the commissioner may define by rule made
3183 in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
3184 (ii) The information provided to the commissioner under this Subsection [~~(2)~~] (3) is a
3185 private record under Title 63G, Chapter 2, Government Records Access and Management Act.
3186 (b) An insurer is immune from civil action, civil penalty, or damages if the insurer
3187 complies in good faith with this Subsection [~~(2)~~] (3) in reporting to the commissioner the cause
3188 of termination of an appointment.
3189 (c) Notwithstanding any other provision in this section, an insurer is not immune from
3190 any action or resulting penalty imposed on the reporting insurer as a result of proceedings
3191 brought by or on behalf of the department if the action is based on evidence other than the

3192 report submitted in compliance with this Subsection [~~(2)~~] (3).

3193 [~~(3)~~] (4) If an insurer appoints an agency, the insurer need not appoint, report, or pay
3194 appointment reporting fees for an individual designated on the agency's license under Section
3195 31A-23a-302.

3196 [~~(4)~~] (5) If an insurer contracts with or lists a licensee in a report submitted under
3197 Subsection [~~(2)~~] (3), there is a rebuttable presumption that in placing a risk with the insurer the
3198 contracted or appointed licensee or any of the licensee's licensed employees act on behalf of the
3199 insurer.

3200 Section 30. Section **31A-23a-203** is amended to read:

3201 **31A-23a-203. Training period requirements.**

3202 (1) A producer is eligible to become a surplus lines producer only if the producer:

3203 (a) has passed the applicable surplus lines producer examination;

3204 (b) has been a producer with property or casualty or both lines of authority for at least
3205 three years during the four years immediately preceding the date of application; and

3206 (c) has paid the applicable fee under Section 31A-3-103.

3207 (2) A person is eligible to become a consultant only if the person has acted in a
3208 capacity that would provide the person with preparation to act as an insurance consultant for a
3209 period aggregating not less than three years during the four years immediately preceding the
3210 date of application.

3211 (3) (a) A resident producer with an accident and health line of authority may only sell
3212 long-term care insurance if the producer:

3213 (i) initially completes a minimum of three hours of long-term care training before
3214 selling long-term care coverage; and

3215 (ii) after completing the training required by Subsection (3)(a)(i), completes a
3216 minimum of three hours of long-term care training during each subsequent two-year licensing
3217 period.

3218 (b) A course taken to satisfy a long-term care training requirement may be used toward
3219 satisfying a producer continuing education requirement.

3220 (c) Long-term care training is not a continuing education requirement to renew a
3221 producer license.

3222 (d) An insurer that issues long-term care insurance shall demonstrate to the

3223 commissioner, upon request, that a producer who is appointed by the insurer and who sells
3224 long-term care insurance coverage is in compliance with this Subsection (3).
3225 (4) (a) A resident producer with a property line of authority may only sell flood
3226 insurance coverage under the National Flood Insurance Program if the producer completes a
3227 minimum of three hours of flood insurance training related to the National Flood Insurance
3228 Program before selling flood insurance coverage.
3229 (b) A course taken to satisfy a flood insurance training requirement may be used
3230 toward satisfying a producer continuing education requirement.
3231 (c) Flood insurance training is not a continuing education requirement to renew a
3232 producer license.
3233 (d) An insurer that issues flood insurance shall demonstrate to the commissioner, upon
3234 request, that a producer who is appointed by the insurer and who sells flood insurance coverage
3235 is in compliance with this Subsection (4).
3236 [~~(4)~~] (5) The training periods required under this section apply only to an individual
3237 applying for a license under this chapter.
3238 Section 31. Section **31A-23a-302** is amended to read:
3239 **31A-23a-302. Agency designations.**
3240 (1) An agency shall designate an individual that has an individual producer, surplus
3241 lines producer, limited line producer, consultant, managing general agent, or reinsurance
3242 intermediary license to act on the agency's behalf in order for the licensee to do business for the
3243 agency in this state.
3244 (2) An agency shall report to the commissioner, at intervals and in the form the
3245 commissioner establishes by rule made in accordance with Title 63G, Chapter 3, Utah
3246 Administrative Rulemaking Act:
3247 (a) a new designation; and
3248 (b) a terminated designation.
3249 (3) An agency shall notify an individual designee that the individual's designation is
3250 terminated by the agency and of the reason for termination at an interval and in the form the
3251 commissioner establishes by rule made in accordance with Title 63G, Chapter 3, Utah
3252 Administrative Rulemaking Act.
3253 [~~(3)~~] (4) (a) An agency licensed under this chapter shall report to the commissioner the

3254 cause of termination of a designation if:

3255 (i) the reason for termination is a reason described in Subsection 31A-23a-111(5)(b);

3256 or

3257 (ii) the agency has knowledge that the individual licensee is found to have engaged in

3258 an activity described in Subsection 31A-23a-111(5)(b) by:

3259 (A) a court;

3260 (B) a government body; or

3261 (C) a self-regulatory organization, which the commissioner may define by rule made in

3262 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

3263 (b) The information provided the commissioner under Subsection [~~(3)~~] (4)(a) is a

3264 private record under Title 63G, Chapter 2, Government Records Access and Management Act.

3265 (c) An agency is immune from civil action, civil penalty, or damages if the agency

3266 complies in good faith with this Subsection [~~(3)~~] (4) in reporting to the commissioner the cause

3267 of termination of a designation.

3268 (d) Notwithstanding any other provision in this section, an agency is not immune from

3269 an action or resulting penalty imposed on the reporting agency as a result of proceedings

3270 brought by or on behalf of the department if the action is based on evidence other than the

3271 report submitted in compliance with this Subsection [~~(3)~~] (4).

3272 [~~(4)~~] (5) An agency licensed under this chapter may act in a capacity for which it is

3273 licensed only through an individual who is licensed under this chapter to act in the same

3274 capacity.

3275 [~~(5)~~] (6) An agency licensed under this chapter shall designate and report to the

3276 commissioner in accordance with any rule made by the commissioner in accordance with Title

3277 63G, Chapter 3, Utah Administrative Rulemaking Act, the name of the designated responsible

3278 licensed individual who has authority to act on behalf of the agency in the matters pertaining to

3279 compliance with this title and orders of the commissioner.

3280 [~~(6)~~] (7) If an agency contracts with or designates a licensee in reports submitted under

3281 Subsection (2) or [~~(5)~~] (6), there is a rebuttable presumption that the contracted or designated

3282 licensee acts on behalf of the agency.

3283 [~~(7)~~] (8) (a) When a license is held by an agency, both the agency itself and any

3284 individual contracted or designated under the agency license shall be considered to be the

3285 holder of the agency license for purposes of this section.
3286 (b) If an individual contracted or designated under the agency license commits an act or
3287 fails to perform a duty that is a ground for suspending, revoking, or limiting the agency license,
3288 or assessing a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i), the commissioner
3289 may assess a forfeiture, suspend, revoke, or limit the license of, or take a combination of these
3290 actions against:
3291 (i) the individual;
3292 (ii) the agency, if the agency:
3293 (A) is reckless or negligent in its supervision of the individual; or
3294 (B) knowingly participates in the act or failure to act that is the ground for assessing a
3295 forfeiture, or suspending, revoking, or limiting the license; or
3296 (iii) (A) the individual; and
3297 (B) the agency if the agency meets the requirements of Subsection [(7)] (8)(b)(ii).
3298 Section 32. Section **31A-23a-407** is amended to read:
3299 **31A-23a-407. Liability for acts of title insurance producers.**
3300 (1) Subject to the other provisions in this section, a title insurer that contracts with or
3301 appoints an individual title insurance producer or an agency title insurance producer is liable to
3302 a buyer, seller, borrower, lender, or third party that deposits money with the individual title
3303 insurance producer or agency title insurance producer for the receipt and disbursement of
3304 money deposited with the individual title insurance producer or agency title insurance producer
3305 for a transaction when a commitment for a policy of title insurance of that title insurer is
3306 ordered, issued, or distributed or a title insurance policy of that title insurer is issued, except
3307 that once a title insurer is named in an issued commitment only that title insurer is liable as a
3308 title insurer under this section.
3309 (2) The liability of a title insurer under Subsection (1) and the liability of an individual
3310 title insurance producer or agency title insurance producer for the receipt and disbursement of
3311 money deposited with the individual title insurance producer or agency title insurance producer
3312 is limited to the amount of money received and disbursed, not to exceed the amount of
3313 proposed insurance set forth in the commitment or title insurance policy described in
3314 Subsection (1) plus 10% of the amount of the proposed insurance.
3315 (3) The liability described in Subsection (1) does not modify, mitigate, impair, or affect

3316 the contractual obligations between an individual title insurance producer or agency title
3317 insurance producer and the title insurer.
3318 (4) The liability of a title insurer with respect to the condition of title to the real
3319 property that is the subject of a title insurance policy or a title insurance commitment for a title
3320 insurance policy is limited to the terms, conditions, and stipulations contained in the title
3321 insurance policy or title commitment.
3322 Section 33. Section **31A-23a-412** is amended to read:
3323 **31A-23a-412. Place of business and residence address -- Records.**
3324 (1) (a) A licensee under this chapter shall register and maintain with the commissioner:
3325 (i) the address and the one or more telephone numbers of the licensee's principal place
3326 of business; and
3327 (ii) a valid business email address at which the commissioner may contact the licensee.
3328 (b) If a licensee is an individual, in addition to complying with Subsection (1)(a) the
3329 individual shall register and maintain with the commissioner the individual's residence address
3330 and telephone number.
3331 (c) A licensee shall notify the commissioner within 30 days of a change of any of the
3332 following required to be registered with the commissioner under this section:
3333 (i) an address;
3334 (ii) a telephone number; or
3335 (iii) a business email address.
3336 (2) (a) Except as provided under Subsection (3), a licensee under this chapter or an
3337 insurer under Chapter 14, Foreign Insurers, shall keep at the principal place of business address
3338 registered under Subsection (1), separate and distinct books and records of the transactions
3339 consummated under the Utah license.
3340 (b) The books and records described in Subsection (2)(a) shall:
3341 (i) be in an organized form;
3342 (ii) be available to the commissioner for inspection upon reasonable notice; and
3343 (iii) include all of the following:
3344 (A) if the licensee is a producer, surplus lines producer, limited line producer,
3345 consultant, managing general agent, or reinsurance intermediary:
3346 (I) a record of each insurance contract procured by or issued through the licensee, with

3347 the names of insurers and insureds, the amount of premium and commissions or other
3348 compensation, and the subject of the insurance;
3349 (II) the names of any other producers, surplus lines producers, limited line producers,
3350 consultants, managing general agents, or reinsurance intermediaries from whom business is
3351 accepted, and of persons to whom commissions or allowances of any kind are promised or
3352 paid; and
3353 (III) a record of the consumer complaints forwarded to the licensee by an insurance
3354 regulator;
3355 (B) if the licensee is a consultant, a record of each agreement outlining the work
3356 performed and the fee for the work; and
3357 (C) any additional information which:
3358 (I) is customary for a similar business; or
3359 (II) may reasonably be required by the commissioner by rule made in accordance with
3360 Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
3361 (3) Subsection (2) is satisfied if the books and records specified in Subsection (2) can
3362 be obtained immediately from a central storage place or elsewhere by on-line computer
3363 terminals located at the registered address.
3364 (4) A licensee who represents only a single insurer satisfies Subsection (2) if the
3365 insurer maintains the books and records pursuant to Subsection (2) at a place satisfying
3366 Subsections (1) and (5).
3367 (5) (a) The books and records maintained under Subsection (2) or Section
3368 31A-23a-413 shall be available for the inspection of the commissioner during the business
3369 hours for a period of time after the date of the transaction as specified by the commissioner by
3370 rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, but
3371 in no case for less than three calendar years in addition to the current calendar year [~~plus three~~
3372 ~~years~~].
3373 (b) Discarding [~~books and records~~] a book or record after the applicable record
3374 retention period has expired does not place the licensee in violation of a later-adopted longer
3375 record retention period.
3376 Section 34. Section **31A-23a-501** is amended to read:
3377 **31A-23a-501. Licensee compensation.**

3378 (1) As used in this section:
3379 (a) "Commission compensation" includes funds paid to or credited for the benefit of a
3380 licensee from:
3381 (i) commission amounts deducted from insurance premiums on insurance sold by or
3382 placed through the licensee;
3383 (ii) commission amounts received from an insurer or another licensee as a result of the
3384 sale or placement of insurance; or
3385 (iii) overrides, bonuses, contingent bonuses, or contingent commissions received from
3386 an insurer or another licensee as a result of the sale or placement of insurance.
3387 (b) (i) "Compensation from an insurer or third party administrator" means
3388 commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options,
3389 gifts, prizes, or any other form of valuable consideration:
3390 (A) whether or not payable pursuant to a written agreement; and
3391 (B) received from:
3392 (I) an insurer; or
3393 (II) a third party to the transaction for the sale or placement of insurance.
3394 (ii) "Compensation from an insurer or third party administrator" does not mean
3395 compensation from a customer that is:
3396 (A) a fee or pass-through costs as provided in Subsection (1)(e); or
3397 (B) a fee or amount collected by or paid to the producer that does not exceed an
3398 amount established by the commissioner by administrative rule.
3399 (c) (i) "Customer" means:
3400 (A) the person signing the application or submission for insurance; or
3401 (B) the authorized representative of the insured actually negotiating the placement of
3402 insurance with the producer.
3403 (ii) "Customer" does not mean a person who is a participant or beneficiary of:
3404 (A) an employee benefit plan; or
3405 (B) a group or blanket insurance policy or group annuity contract sold, solicited, or
3406 negotiated by the producer or affiliate.
3407 (d) (i) "Noncommission compensation" includes all funds paid to or credited for the
3408 benefit of a licensee other than commission compensation.

3409 (ii) "Noncommission compensation" does not include charges for pass-through costs
3410 incurred by the licensee in connection with obtaining, placing, or servicing an insurance policy.
3411 (e) "Pass-through costs" include:
3412 (i) costs for copying documents to be submitted to the insurer; and
3413 (ii) bank costs for processing cash or credit card payments.
3414 (2) A licensee may receive from an insured or from a person purchasing an insurance
3415 policy, noncommission compensation if the noncommission compensation is stated on a
3416 separate, written disclosure.
3417 (a) The disclosure required by this Subsection (2) shall:
3418 (i) include the signature of the insured or prospective insured acknowledging the
3419 noncommission compensation;
3420 (ii) clearly specify:
3421 (A) the amount of any known noncommission compensation; and
3422 (B) the type and amount, if known, of any potential and contingent noncommission
3423 compensation; and
3424 (iii) be provided to the insured or prospective insured before the performance of the
3425 service.
3426 (b) Noncommission compensation shall be:
3427 (i) limited to actual or reasonable expenses incurred for services; and
3428 (ii) uniformly applied to all insureds or prospective insureds in a class or classes of
3429 business or for a specific service or services.
3430 (c) A copy of the signed disclosure required by this Subsection (2) shall be maintained
3431 by any licensee who collects or receives the noncommission compensation or any portion of
3432 the noncommission compensation.
3433 (d) All accounting records relating to noncommission compensation shall be
3434 maintained by the person described in Subsection (2)(c) in a manner that facilitates an audit.
3435 (3) (a) A licensee may receive noncommission compensation when acting as a
3436 producer for the insured in connection with the actual sale or placement of insurance if:
3437 (i) the producer and the insured have agreed on the producer's noncommission
3438 compensation; and
3439 (ii) the producer has disclosed to the insured the existence and source of any other

3440 compensation that accrues to the producer as a result of the transaction.

3441 (b) The disclosure required by this Subsection (3) shall:

3442 (i) include the signature of the insured or prospective insured acknowledging the

3443 noncommission compensation;

3444 (ii) clearly specify:

3445 (A) the amount of any known noncommission compensation;

3446 (B) the type and amount, if known, of any potential and contingent noncommission

3447 compensation; and

3448 (C) the existence and source of any other compensation; and

3449 (iii) be provided to the insured or prospective insured before the performance of the

3450 service.

3451 (c) The following additional noncommission compensation is authorized:

3452 (i) compensation received by a producer of a compensated corporate surety who under

3453 procedures approved by a rule or order of the commissioner is paid by surety bond principal

3454 debtors for extra services;

3455 (ii) compensation received by an insurance producer who is also licensed as a public

3456 adjuster under Section 31A-26-203, for services performed for an insured in connection with a

3457 claim adjustment, so long as the producer does not receive or is not promised compensation for

3458 aiding in the claim adjustment prior to the occurrence of the claim;

3459 (iii) compensation received by a consultant as a consulting fee, provided the consultant

3460 complies with the requirements of Section 31A-23a-401; or

3461 (iv) other compensation arrangements approved by the commissioner after a finding

3462 that they do not violate Section 31A-23a-401 and are not harmful to the public.

3463 (d) Subject to Section 31A-23a-402.5, a producer for the insured may receive

3464 compensation from an insured through an insurer, for the negotiation and sale of a health

3465 benefit plan, if there is a separate written agreement between the insured and the licensee for

3466 the compensation. An insurer who passes through the compensation from the insured to the

3467 licensee under this Subsection (3)(d) is not providing direct or indirect compensation or

3468 commission compensation to the licensee.

3469 (4) (a) For purposes of this Subsection (4):

3470 (i) "Large customer" means an employer who, with respect to a calendar year and to a

3471 plan year:
3472 (A) employed an average of at least 100 eligible employees on each business day
3473 during the preceding calendar year; and
3474 (B) employs at least two employees on the first day of the plan year.
3475 (ii) "Producer" includes:
3476 (A) a producer;
3477 (B) an affiliate of a producer; or
3478 (C) a consultant.
3479 (b) A producer may not accept or receive any compensation from an insurer or third
3480 party administrator for the initial placement of a health benefit plan, other than a hospital
3481 confinement indemnity policy, unless prior to a large customer's initial purchase of the health
3482 benefit plan the producer discloses in writing to the large customer that the producer will
3483 receive compensation from the insurer or third party administrator for the placement of
3484 insurance, including the amount or type of compensation known to the producer at the time of
3485 the disclosure.
3486 (c) A producer shall:
3487 (i) obtain the large customer's signed acknowledgment that the disclosure under
3488 Subsection (4)(b) was made to the large customer; or
3489 (ii) (A) sign a statement that the disclosure required by Subsection (4)(b) was made to
3490 the large customer; and
3491 (B) keep the signed statement on file in the producer's office while the health benefit
3492 plan placed with the large customer is in force.
3493 (d) A licensee who collects or receives any part of the compensation from an insurer or
3494 third party administrator in a manner that facilitates an audit shall, while the health benefit plan
3495 placed with the large customer is in force, maintain a copy of:
3496 (i) the signed acknowledgment described in Subsection (4)(c)(i); or
3497 (ii) the signed statement described in Subsection (4)(c)(ii).
3498 (e) Subsection (4)(c) does not apply to:
3499 (i) a person licensed as a producer who acts only as an intermediary between an insurer
3500 and the customer's producer, including a managing general agent; or
3501 (ii) the placement of insurance in a secondary or residual market.

3502 (f) (i) A producer shall provide to a large customer listed in this Subsection (4)(f) an
3503 annual accounting, as defined by rule made by the department in accordance with Title 63G,
3504 Chapter 3, Utah Administrative Rulemaking Act, of all amounts the producer receives in
3505 commission compensation from an insurer or third party administrator as a result of the sale or
3506 placement of a health benefit plan to a large customer that is:
3507 (A) the state;
3508 (B) a political subdivision or instrumentality of the state or a combination thereof
3509 primarily engaged in educational activities or the administration or servicing of educational
3510 activities, including the State Board of Education and its instrumentalities, an institution of
3511 higher education and its branches, a school district and its instrumentalities, a vocational and
3512 technical school, and an entity arising out of a consolidation agreement between entities
3513 described under this Subsection (4)(f)(i)(B);
3514 (C) a county, city, town, local district under Title 17B, Limited Purpose Local
3515 Government Entities - Local Districts, special service district under Title 17D, Chapter 1,
3516 Special Service District Act, an entity created by an interlocal cooperation agreement under
3517 Title 11, Chapter 13, Interlocal Cooperation Act, or any other governmental entity designated
3518 in statute as a political subdivision of the state; or
3519 (D) a quasi-public corporation, that has the same meaning as defined in Section
3520 63E-1-102.
3521 (ii) The department shall pattern the annual accounting required by this Subsection
3522 (4)(f) on the insurance related information on Internal Revenue Service Form 5500 and its
3523 relevant attachments.
3524 (g) At the request of the department, a producer shall provide the department a copy of:
3525 (i) a disclosure required by this Subsection (4); or
3526 (ii) an Internal Revenue Service Form 5500 and its relevant attachments.
3527 (5) This section does not alter the right of any licensee to recover from an insured the
3528 amount of any premium due for insurance effected by or through that licensee or to charge a
3529 reasonable rate of interest upon past-due accounts.
3530 (6) This section does not apply to bail bond producers or bail enforcement agents as
3531 defined in Section 31A-35-102.
3532 (7) A licensee may not receive noncommission compensation from an insurer, insured,

3533 or enrollee for providing a service or engaging in an act that is required to be provided or
3534 performed in order to receive commission compensation, except for the surplus lines
3535 transactions that do not receive commissions.
3536 Section 35. Section **31A-23b-102** is amended to read:
3537 **31A-23b-102. Definitions.**
3538 As used in this chapter:
3539 [~~(1) "Compensation" is as defined in:~~]
3540 [~~(a) Subsections 31A-23a-501(1)(a), (b), and (d); and~~]
3541 [~~(b) PPACA.~~]
3542 [~~(2)~~] (1) "Enroll" and "enrollment" mean to:
3543 (a) (i) obtain personally identifiable information about an individual; and
3544 (ii) inform an individual about accident and health insurance plans or public programs
3545 offered on an exchange;
3546 (b) solicit insurance; or
3547 (c) submit to the exchange:
3548 (i) personally identifiable information about an individual; and
3549 (ii) an individual's selection of a particular accident and health insurance plan or public
3550 program offered on the exchange.
3551 [~~(3)~~] (2) (a) "Exchange" means an online marketplace that is certified by the United
3552 States Department of Health and Human Services as either a state-based small employer
3553 exchange or a federally facilitated individual exchange under PPACA.
3554 (b) "Exchange" does not include an online marketplace for the purchase of health
3555 insurance if the online marketplace is not a certified exchange in accordance with Subsection
3556 [~~(3)~~] (2)(a).
3557 [~~(4)~~] (3) "Navigator":
3558 (a) means a person who facilitates enrollment in an exchange by offering to assist, or
3559 who advertises any services to assist, with:
3560 (i) the selection of and enrollment in a qualified health plan or a public program
3561 offered on an exchange; or
3562 (ii) applying for premium subsidies through an exchange; and
3563 (b) includes a person who is an in-person assister or a certified application counselor as

3564 described in federal regulations or guidance issued under PPACA.

3565 [(5)] (4) "Personally identifiable information" is as defined in 45 C.F.R. Sec. 155.260.

3566 [(6)] (5) "Public programs" means the state Medicaid program in Title 26, Chapter 18,
3567 Medical Assistance Act, and Chapter 40, Utah Children's Health Insurance Act.

3568 [(7)] (6) "Resident" is as defined by rule made by the commissioner in accordance with
3569 Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

3570 [(8)] (7) "Solicit" is as defined in Section 31A-23a-102.

3571 Section 36. Section **31A-23b-202.5** is amended to read:

3572 **31A-23b-202.5. License types.**

3573 (1) A license issued under this chapter shall be issued under the license types described
3574 in Subsection (2).

3575 (2) A license type under this chapter shall be a navigator line of authority or a certified
3576 application counselor line of authority. A license type is intended to describe the matters to be
3577 considered under any education, examination, and training required of an applicant under this
3578 chapter.

3579 (3) (a) A navigator line of authority includes the enrollment process as described in
3580 Subsection 31A-23b-102[(4)](3)(a).

3581 (b) (i) A certified application counselor line of authority is limited to providing
3582 information and assistance to individuals and employees about public programs and premium
3583 subsidies available through the exchange.

3584 (ii) A certified application counselor line of authority does not allow the certified
3585 application counselor to assist a person with the selection of or enrollment in a qualified health
3586 plan offered on an exchange.

3587 Section 37. Section **31A-23b-209** is amended to read:

3588 **31A-23b-209. Agency designations.**

3589 (1) An organization shall be licensed as a navigator agency if the organization acts as a
3590 navigator.

3591 (2) A navigator agency that does business in the state shall designate an individual who
3592 is licensed under this chapter to act on the agency's behalf.

3593 (3) A navigator agency shall report to the commissioner, at intervals and in the form
3594 the commissioner establishes by rule made in accordance with Title 63G, Chapter 3, Utah

3595 Administrative Rulemaking Act:

3596 (a) a new designation under Subsection (2); and

3597 (b) a terminated designation under Subsection (2).

3598 (4) A navigator agency shall notify an individual designee that the individual's

3599 designation is terminated by the agency and of the reason for termination at an interval and in

3600 the form the commissioner establishes by rule made in accordance with Title 63G, Chapter 3,

3601 Utah Administrative Rulemaking Act.

3602 [~~(4)~~] (5) (a) A navigator agency licensed under this chapter shall report to the

3603 commissioner the cause of termination of a designation if:

3604 (i) the reason for termination is a reason described in Subsection 31A-23b-401(4)(b);

3605 or

3606 (ii) the navigator agency has knowledge that the individual licensee engaged in an

3607 activity described in Subsection 31A-23b-401(4)(b) by:

3608 (A) a court;

3609 (B) a government body; or

3610 (C) a self-regulatory organization, which the commissioner may define by rule made in

3611 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

3612 (b) The information provided to the commissioner under Subsection [~~(4)~~] (5)(a) is a

3613 private record under Title 63G, Chapter 2, Government Records Access and Management Act.

3614 (c) A navigator agency is immune from civil action, civil penalty, or damages if the

3615 agency complies in good faith with this Subsection [~~(4)~~] (5) by reporting to the commissioner

3616 the cause of termination of a designation.

3617 (d) A navigator agency is not immune from an action or resulting penalty imposed on

3618 the reporting agency as a result of proceedings brought by or on behalf of the department if the

3619 action is based on evidence other than the report submitted in compliance with this Subsection

3620 [~~(4)~~] (5).

3621 [~~(5)~~] (6) A navigator agency licensed under this chapter may act in a capacity for which

3622 it is licensed only through an individual who is licensed under this chapter to act in the same

3623 capacity.

3624 [~~(6)~~] (7) A navigator agency licensed under this chapter shall designate and report to

3625 the commissioner, in accordance with any rule made by the commissioner pursuant to Title

3626 63G, Chapter 3, Utah Administrative Rulemaking Act, the name of the designated responsible
3627 licensed individual who has authority to act on behalf of the navigator agency in the matters
3628 pertaining to compliance with this title and orders of the commissioner.
3629 [(7)] (8) If a navigator agency contracts with or designates a licensee in reports
3630 submitted under Subsection (3) or [(6)] (7), there is a rebuttable presumption that the
3631 contracted or designated licensee acts on behalf of the navigator agency.
3632 [(8)] (9) (a) When a license is held by a navigator agency, both the navigator agency
3633 itself and any individual contracted or designated under the navigator agency license are
3634 considered the holders of the navigator agency license for purposes of this section.
3635 (b) If an individual contracted or designated under the navigator agency license
3636 commits an act or fails to perform a duty that is a ground for suspending, revoking, or limiting
3637 the navigator agency license, or assessing a forfeiture under Subsection 31A-2-308(1)(b)(i) or
3638 (1)(c)(i), the commissioner may assess a forfeiture, suspend, revoke, or limit the license of, or
3639 take a combination of these actions against:
3640 (i) the individual;
3641 (ii) the navigator agency, if the navigator agency:
3642 (A) is reckless or negligent in its supervision of the individual; or
3643 (B) knowingly participates in the act or failure to act that is the ground for suspending,
3644 revoking, or limiting the license, or assessing a forfeiture; or
3645 (iii) (A) the individual; and
3646 (B) the navigator agency, if the agency meets the requirements of Subsection [(8)]
3647 (9)(b)(ii).
3648 Section 38. Section **31A-23b-210** is amended to read:
3649 **31A-23b-210. Place of business and residence address -- Records.**
3650 (1) (a) A licensee under this chapter shall register and maintain with the commissioner:
3651 (i) the address and the one or more telephone numbers of the licensee's principal place
3652 of business; and
3653 (ii) a valid business email address at which the commissioner may contact the licensee.
3654 (b) If a licensee is an individual, in addition to complying with Subsection (1)(a), the
3655 individual shall register and maintain with the commissioner the individual's residence address
3656 and telephone number.

3657 (c) A licensee shall notify the commissioner within 30 days of a change of any of the
3658 following required to be registered with the commissioner under this section:
3659 (i) an address;
3660 (ii) a telephone number; or
3661 (iii) a business email address.
3662 (2) Except as provided under Subsection (3), a licensee under this chapter shall keep at
3663 the principal place of business address registered under Subsection (1), separate and distinct
3664 books and records of the transactions consummated under the Utah license.
3665 (3) Subsection (2) is satisfied if the books and records specified in Subsection (2) can
3666 be obtained immediately from a central storage place or elsewhere by online computer
3667 terminals located at the registered address.
3668 (4) (a) The books and records maintained under Subsection (2) shall be available for
3669 the inspection by the commissioner during the business hours for a period of time after the date
3670 of the transaction as specified by the commissioner by rule, but in no case for less than the
3671 current calendar year plus three years.
3672 (b) Discarding books and records after the applicable record retention period has
3673 expired does not place the licensee in violation of a later-adopted longer record retention
3674 period.
3675 Section 39. Section **31A-23b-401** is amended to read:
3676 **31A-23b-401. Revoking, suspending, surrendering, lapsing, limiting, or otherwise**
3677 **terminating a license -- Rulemaking for renewal or reinstatement.**
3678 (1) A license as a navigator under this chapter remains in force until:
3679 (a) revoked or suspended under Subsection (4);
3680 (b) surrendered to the commissioner and accepted by the commissioner in lieu of
3681 administrative action;
3682 (c) the licensee dies or is adjudicated incompetent as defined under:
3683 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
3684 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and
3685 Minors;
3686 (d) lapsed under this section; or
3687 (e) voluntarily surrendered.

3688 (2) The following may be reinstated within one year after the day on which the license
3689 is no longer in force:
3690 (a) a lapsed license; or
3691 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may
3692 not be reinstated after the license period in which the license is voluntarily surrendered.
3693 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a
3694 license, submission and acceptance of a voluntary surrender of a license does not prevent the
3695 department from pursuing additional disciplinary or other action authorized under:
3696 (a) this title; or
3697 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah
3698 Administrative Rulemaking Act.
3699 (4) (a) If the commissioner makes a finding under Subsection (4)(b), as part of an
3700 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the
3701 commissioner may:
3702 (i) revoke a license;
3703 (ii) suspend a license for a specified period of 12 months or less;
3704 (iii) limit a license in whole or in part; [or]
3705 (iv) deny a license application[.];
3706 (v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or
3707 (iv) take a combination of actions under Subsections (4)(a)(i) through (iv) and
3708 Subsection (4)(a)(v).
3709 (b) The commissioner may take an action described in Subsection (4)(a) if the
3710 commissioner finds that the licensee:
3711 (i) is unqualified for a license under Section 31A-23b-204, 31A-23b-205, or
3712 31A-23b-206;
3713 (ii) violated:
3714 (A) an insurance statute;
3715 (B) a rule that is valid under Subsection 31A-2-201(3); or
3716 (C) an order that is valid under Subsection 31A-2-201(4);
3717 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other
3718 delinquency proceedings in any state;

3719 (iv) failed to pay a final judgment rendered against the person in this state within 60
3720 days after the day on which the judgment became final;
3721 (v) refused:
3722 (A) to be examined; or
3723 (B) to produce its accounts, records, and files for examination;
3724 (vi) had an officer who refused to:
3725 (A) give information with respect to the navigator's affairs; or
3726 (B) perform any other legal obligation as to an examination;
3727 (vii) provided information in the license application that is:
3728 (A) incorrect;
3729 (B) misleading;
3730 (C) incomplete; or
3731 (D) materially untrue;
3732 (viii) violated an insurance law, valid rule, or valid order of another regulatory agency
3733 in any jurisdiction;
3734 (ix) obtained or attempted to obtain a license through misrepresentation or fraud;
3735 (x) improperly withheld, misappropriated, or converted money or properties received
3736 in the course of doing insurance business;
3737 (xi) intentionally misrepresented the terms of an actual or proposed:
3738 (A) insurance contract;
3739 (B) application for insurance; or
3740 (C) application for public program;
3741 (xii) is convicted of a felony;
3742 (xiii) admitted or is found to have committed an insurance unfair trade practice or
3743 fraud;
3744 (xiv) in the conduct of business in this state or elsewhere:
3745 (A) used fraudulent, coercive, or dishonest practices; or
3746 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;
3747 (xv) had an insurance license, navigator license, or its equivalent, denied, suspended,
3748 or revoked in another state, province, district, or territory;
3749 (xvi) forged another's name to:

3750 (A) an application for insurance;
3751 (B) a document related to an insurance transaction;
3752 (C) a document related to an application for a public program; or
3753 (D) a document related to an application for premium subsidies;
3754 (xvii) improperly used notes or another reference material to complete an examination
3755 for a license;
3756 (xviii) knowingly accepted insurance business from an individual who is not licensed;
3757 (xix) failed to comply with an administrative or court order imposing a child support
3758 obligation;
3759 (xx) failed to:
3760 (A) pay state income tax; or
3761 (B) comply with an administrative or court order directing payment of state income
3762 tax;
3763 (xxi) violated or permitted others to violate the federal Violent Crime Control and Law
3764 Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and therefore under 18 U.S.C. Sec. 1033 is
3765 prohibited from engaging in the business of insurance; or
3766 (xxii) engaged in a method or practice in the conduct of business that endangered the
3767 legitimate interests of customers and the public.
3768 (c) For purposes of this section, if a license is held by an agency, both the agency itself
3769 and any individual designated under the license are considered to be the holders of the license.
3770 (d) If an individual designated under the agency license commits an act or fails to
3771 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,
3772 the commissioner may suspend, revoke, or limit the license of:
3773 (i) the individual;
3774 (ii) the agency, if the agency:
3775 (A) is reckless or negligent in its supervision of the individual; or
3776 (B) knowingly participates in the act or failure to act that is the ground for suspending,
3777 revoking, or limiting the license; or
3778 (iii) (A) the individual; and
3779 (B) the agency if the agency meets the requirements of Subsection (4)(d)(ii).
3780 (5) A licensee under this chapter is subject to the penalties for acting as a licensee

3781 without a license if:
3782 (a) the licensee's license is:
3783 (i) revoked;
3784 (ii) suspended;
3785 (iii) surrendered in lieu of administrative action;
3786 (iv) lapsed; or
3787 (v) voluntarily surrendered; and
3788 (b) the licensee:
3789 (i) continues to act as a licensee; or
3790 (ii) violates the terms of the license limitation.
3791 (6) A licensee under this chapter shall immediately report to the commissioner:
3792 (a) a revocation, suspension, or limitation of the person's license in another state, the
3793 District of Columbia, or a territory of the United States;
3794 (b) the imposition of a disciplinary sanction imposed on that person by another state,
3795 the District of Columbia, or a territory of the United States; or
3796 (c) a judgment or injunction entered against that person on the basis of conduct
3797 involving:
3798 (i) fraud;
3799 (ii) deceit;
3800 (iii) misrepresentation; or
3801 (iv) a violation of an insurance law or rule.
3802 (7) (a) An order revoking a license under Subsection (4) or an agreement to surrender a
3803 license in lieu of administrative action may specify a time, not to exceed five years, within
3804 which the former licensee may not apply for a new license.
3805 (b) If no time is specified in an order or agreement described in Subsection (7)(a), the
3806 former licensee may not apply for a new license for five years from the day on which the order
3807 or agreement is made without the express approval of the commissioner.
3808 (8) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of
3809 a license issued under this chapter if so ordered by a court.
3810 (9) The commissioner shall by rule prescribe the license renewal and reinstatement
3811 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

3812 Section 40. Section **31A-26-209** is amended to read:

3813 **31A-26-209. Form and contents of license.**

3814 (1) Licenses issued under this chapter shall be in the form the commissioner prescribes
3815 and shall set forth:

3816 (a) the name, address, and the one or more telephone [~~number~~] numbers of the
3817 licensee;

3818 (b) the license classifications under Section 31A-26-204;

3819 (c) the date of license issuance; and

3820 (d) any other information the commissioner considers advisable.

3821 (2) An adjuster doing business under any other name than the adjuster's legal name
3822 shall notify the commissioner prior to using the assumed name in this state.

3823 (3) (a) An organization shall be licensed as an agency if the organization acts as:

3824 (i) an independent adjuster; or

3825 (ii) a public adjuster.

3826 (b) The agency license issued under Subsection (3)(a) shall set forth the names of all
3827 natural persons licensed under this chapter who are authorized to act in those capacities for the
3828 organization in this state.

3829 Section 41. Section **31A-26-210** is amended to read:

3830 **31A-26-210. Reports from organizations licensed as adjusters.**

3831 (1) An organization licensed as an adjuster under Section 31A-26-203 shall designate
3832 an individual who has an individual adjuster license to act on the organization's behalf in order
3833 for the licensee to do business for the organization in this state.

3834 (2) An organization licensed under this chapter shall report to the commissioner, at
3835 intervals and in the form the commissioner establishes by rule, made in accordance with Title
3836 63G, Chapter 3, Utah Administrative Rulemaking Act:

3837 (a) a new designation; and

3838 (b) a terminated designation.

3839 (3) An organization licensed under this chapter shall notify an individual licensee that
3840 the individual's designation has been terminated by the organization and of the reason for the
3841 termination at an interval and in the form the commissioner establishes by rule made in
3842 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

3843 [(3)] (4) (a) An organization licensed under this chapter shall report to the
3844 commissioner the cause of termination of a designation if:
3845 (i) the reason for termination is a reason described in Subsection 31A-26-213(5)(b); or
3846 (ii) the organization has knowledge that the individual licensee is found to have
3847 engaged in an activity described in Subsection 31A-26-213(5)(b) by:
3848 (A) a court;
3849 (B) a government body; or
3850 (C) a self-regulatory organization, which the commissioner may define by rule made in
3851 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
3852 (b) The information provided the commissioner under Subsection [(3)] (4)(a) is a
3853 private record under Title 63G, Chapter 2, Government Records Access and Management Act.
3854 (c) An organization is immune from civil action, civil penalty, or damages if the
3855 organization complies in good faith with this Subsection [(3)] (4) in reporting to the
3856 commissioner the cause of termination of a designation.
3857 (d) Notwithstanding any other provision in this section, an organization is not immune
3858 from an action or resulting penalty imposed on the reporting organization as a result of a
3859 proceeding brought by or on behalf of the department if the action is based on evidence other
3860 than the report submitted in compliance with this Subsection [(3)] (4).
3861 [(4)] (5) An organization licensed under this chapter may act in a capacity for which it
3862 is licensed only through an individual who is licensed under this chapter to act in the same
3863 capacity.
3864 [(5)] (6) An organization licensed under this chapter shall designate and report
3865 promptly to the commissioner the name of the designated responsible licensed individual who
3866 has authority to act on behalf of the organization in all matters pertaining to compliance with
3867 this title and orders of the commissioner.
3868 [(6)] (7) If an agency contracts with or designates a licensee in a report submitted under
3869 Subsection (2) or [(5)] (6), there is a rebuttable presumption that the contracted or designated
3870 licensee acts on behalf of the agency.
3871 [(7)] (8) (a) When a license is held by an organization, both the organization itself and
3872 an individual contracted or designated under the license shall, for purposes of this section, be
3873 considered to be the holders of the organization license.

3874 (b) If an individual designated under the organization license commits an act or fails to
3875 perform a duty that is a ground for suspending, revoking, or limiting the organization license,
3876 the commissioner may suspend, revoke, or limit the license of:
3877 (i) that individual;
3878 (ii) the organization, if the organization:
3879 (A) is reckless or negligent in its supervision of the individual; or
3880 (B) knowingly participates in the act or failure to act that is the ground for suspending,
3881 revoking, or limiting the license; or
3882 (iii) (A) the individual; and
3883 (B) the organization, if the organization meets the requirements of Subsection [(7)]
3884 (8)(b)(ii).
3885 Section 42. Section **31A-26-213** is amended to read:
3886 **31A-26-213. Revoking, suspending, surrendering, lapsing, limiting, or otherwise**
3887 **terminating a license -- Forfeiture -- Rulemaking for renewal or reinstatement.**
3888 (1) A license type issued under this chapter remains in force until:
3889 (a) revoked or suspended under Subsection (5);
3890 (b) surrendered to the commissioner and accepted by the commissioner in lieu of
3891 administrative action;
3892 (c) the licensee dies or is adjudicated incompetent as defined under:
3893 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
3894 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and
3895 Minors;
3896 (d) lapsed under Section 31A-26-214.5; or
3897 (e) voluntarily surrendered.
3898 (2) The following may be reinstated within one year after the day on which the license
3899 is no longer in force:
3900 (a) a lapsed license; or
3901 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may
3902 not be reinstated after the license period in which it is voluntarily surrendered.
3903 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a
3904 license, submission and acceptance of a voluntary surrender of a license does not prevent the

3905 department from pursuing additional disciplinary or other action authorized under:
3906 (a) this title; or
3907 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah
3908 Administrative Rulemaking Act.
3909 (4) A license classification issued under this chapter remains in force until:
3910 (a) the qualifications pertaining to a license classification are no longer met by the
3911 licensee; or
3912 (b) the supporting license type:
3913 (i) is revoked or suspended under Subsection (5); or
3914 (ii) is surrendered to the commissioner and accepted by the commissioner in lieu of
3915 administrative action.
3916 (5) (a) If the commissioner makes a finding under Subsection (5)(b) as part of an
3917 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the
3918 commissioner may:
3919 (i) revoke:
3920 (A) a license; or
3921 (B) a license classification;
3922 (ii) suspend for a specified period of 12 months or less:
3923 (A) a license; or
3924 (B) a license classification;
3925 (iii) limit in whole or in part:
3926 (A) a license; or
3927 (B) a license classification; [or]
3928 (iv) deny a license application[.];
3929 (v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or
3930 (vi) take a combination of actions under Subsections (5)(a)(i) through (iv) and
3931 Subsection (5)(a)(v).
3932 (b) The commissioner may take an action described in Subsection (5)(a) if the
3933 commissioner finds that the licensee:
3934 (i) is unqualified for a license or license classification under Section 31A-26-202,
3935 31A-26-203, 31A-26-204, or 31A-26-205;

3936 (ii) has violated:
3937 (A) an insurance statute;
3938 (B) a rule that is valid under Subsection 31A-2-201(3); or
3939 (C) an order that is valid under Subsection 31A-2-201(4);
3940 (iii) is insolvent, or the subject of receivership, conservatorship, rehabilitation, or other
3941 delinquency proceedings in any state;
3942 (iv) fails to pay a final judgment rendered against the person in this state within 60
3943 days after the judgment became final;
3944 (v) fails to meet the same good faith obligations in claims settlement that is required of
3945 admitted insurers;
3946 (vi) is affiliated with and under the same general management or interlocking
3947 directorate or ownership as another insurance adjuster that transacts business in this state
3948 without a license;
3949 (vii) refuses:
3950 (A) to be examined; or
3951 (B) to produce its accounts, records, and files for examination;
3952 (viii) has an officer who refuses to:
3953 (A) give information with respect to the insurance adjuster's affairs; or
3954 (B) perform any other legal obligation as to an examination;
3955 (ix) provides information in the license application that is:
3956 (A) incorrect;
3957 (B) misleading;
3958 (C) incomplete; or
3959 (D) materially untrue;
3960 (x) has violated an insurance law, valid rule, or valid order of another regulatory
3961 agency in any jurisdiction;
3962 (xi) has obtained or attempted to obtain a license through misrepresentation or fraud;
3963 (xii) has improperly withheld, misappropriated, or converted money or properties
3964 received in the course of doing insurance business;
3965 (xiii) has intentionally misrepresented the terms of an actual or proposed:
3966 (A) insurance contract; or

3967 (B) application for insurance;
3968 (xiv) has been convicted of a felony;
3969 (xv) has admitted or been found to have committed an insurance unfair trade practice
3970 or fraud;
3971 (xvi) in the conduct of business in this state or elsewhere has:
3972 (A) used fraudulent, coercive, or dishonest practices; or
3973 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;
3974 (xvii) has had an insurance license, or its equivalent, denied, suspended, or revoked in
3975 any other state, province, district, or territory;
3976 (xviii) has forged another's name to:
3977 (A) an application for insurance; or
3978 (B) a document related to an insurance transaction;
3979 (xix) has improperly used notes or any other reference material to complete an
3980 examination for an insurance license;
3981 (xx) has knowingly accepted insurance business from an individual who is not
3982 licensed;
3983 (xxi) has failed to comply with an administrative or court order imposing a child
3984 support obligation;
3985 (xxii) has failed to:
3986 (A) pay state income tax; or
3987 (B) comply with an administrative or court order directing payment of state income
3988 tax;
3989 (xxiii) has violated or permitted others to violate the federal Violent Crime Control and
3990 Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and therefore under 18 U.S.C. Sec. 1033 is
3991 prohibited from engaging in the business of insurance; or
3992 (xxiv) has engaged in methods and practices in the conduct of business that endanger
3993 the legitimate interests of customers and the public.
3994 (c) For purposes of this section, if a license is held by an agency, both the agency itself
3995 and any individual designated under the license are considered to be the holders of the license.
3996 (d) If an individual designated under the agency license commits an act or fails to
3997 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,

3998 the commissioner may suspend, revoke, or limit the license of:
3999 (i) the individual;
4000 (ii) the agency, if the agency:
4001 (A) is reckless or negligent in its supervision of the individual; or
4002 (B) knowingly participated in the act or failure to act that is the ground for suspending,
4003 revoking, or limiting the license; or
4004 (iii) (A) the individual; and
4005 (B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).
4006 (6) A licensee under this chapter is subject to the penalties for conducting an insurance
4007 business without a license if:
4008 (a) the licensee's license is:
4009 (i) revoked;
4010 (ii) suspended;
4011 (iii) limited;
4012 (iv) surrendered in lieu of administrative action;
4013 (v) lapsed; or
4014 (vi) voluntarily surrendered; and
4015 (b) the licensee:
4016 (i) continues to act as a licensee; or
4017 (ii) violates the terms of the license limitation.
4018 (7) A licensee under this chapter shall immediately report to the commissioner:
4019 (a) a revocation, suspension, or limitation of the person's license in any other state, the
4020 District of Columbia, or a territory of the United States;
4021 (b) the imposition of a disciplinary sanction imposed on that person by any other state,
4022 the District of Columbia, or a territory of the United States; or
4023 (c) a judgment or injunction entered against that person on the basis of conduct
4024 involving:
4025 (i) fraud;
4026 (ii) deceit;
4027 (iii) misrepresentation; or
4028 (iv) a violation of an insurance law or rule.

4029 (8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a
4030 license in lieu of administrative action may specify a time not to exceed five years within
4031 which the former licensee may not apply for a new license.
4032 (b) If no time is specified in the order or agreement described in Subsection (8)(a), the
4033 former licensee may not apply for a new license for five years without the express approval of
4034 the commissioner.
4035 (9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of
4036 a license issued under this part if so ordered by a court.
4037 (10) The commissioner shall by rule prescribe the license renewal and reinstatement
4038 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
4039 Section 43. Section **31A-30-103** is amended to read:
4040 **31A-30-103. Definitions.**
4041 As used in this chapter:
4042 (1) "Actuarial certification" means a written statement by a member of the American
4043 Academy of Actuaries or other individual approved by the commissioner that a covered carrier
4044 is in compliance with this chapter, based upon the examination of the covered carrier, including
4045 review of the appropriate records and of the actuarial assumptions and methods used by the
4046 covered carrier in establishing premium rates for applicable health benefit plans.
4047 (2) "Affiliate" or "affiliated" means a person who directly or indirectly through one or
4048 more intermediaries, controls or is controlled by, or is under common control with, a specified
4049 person.
4050 (3) "Base premium rate" means, for each class of business as to a rating period, the
4051 lowest premium rate charged or that could have been charged under a rating system for that
4052 class of business by the covered carrier to covered insureds with similar case characteristics for
4053 health benefit plans with the same or similar coverage.
4054 (4) (a) "Bona fide employer association" means an association of employers:
4055 (i) that meets the requirements of Subsection 31A-22-701(2)(b);
4056 (ii) in which the employers of the association, either directly or indirectly, exercise
4057 control over the plan;
4058 (iii) that is organized:
4059 (A) based on a commonality of interest between the employers and their employees

4060 that participate in the plan by some common economic or representation interest or genuine
4061 organizational relationship unrelated to the provision of benefits; and
4062 (B) to act in the best interests of its employers to provide benefits for the employer's
4063 employees and their spouses and dependents, and other benefits relating to employment; and
4064 (iv) whose association sponsored health plan complies with 45 C.F.R. 146.121.
4065 (b) The commissioner shall consider the following with regard to determining whether
4066 an association of employers is a bona fide employer association under Subsection (4)(a):
4067 (i) how association members are solicited;
4068 (ii) who participates in the association;
4069 (iii) the process by which the association was formed;
4070 (iv) the purposes for which the association was formed, and what, if any, were the
4071 pre-existing relationships of its members;
4072 (v) the powers, rights and privileges of employer members; and
4073 (vi) who actually controls and directs the activities and operations of the benefit
4074 programs.
4075 (5) "Carrier" means a person that provides health insurance in this state including:
4076 (a) an insurance company;
4077 (b) a prepaid hospital or medical care plan;
4078 (c) a health maintenance organization;
4079 (d) a multiple employer welfare arrangement; and
4080 (e) another person providing a health insurance plan under this title.
4081 (6) (a) Except as provided in Subsection (6)(b), "case characteristics" means
4082 demographic or other objective characteristics of a covered insured that are considered by the
4083 carrier in determining premium rates for the covered insured.
4084 (b) "Case characteristics" do not include:
4085 (i) duration of coverage since the policy was issued;
4086 (ii) claim experience; and
4087 (iii) health status.
4088 (7) "Class of business" means all or a separate grouping of covered insureds that is
4089 permitted by the commissioner in accordance with Section 31A-30-105.
4090 (8) "Covered carrier" means an individual carrier or small employer carrier subject to

4091 this chapter.
4092 (9) "Covered individual" means an individual who is covered under a health benefit
4093 plan subject to this chapter.
4094 (10) "Covered insureds" means small employers and individuals who are issued a
4095 health benefit plan that is subject to this chapter.
4096 (11) "Dependent" means an individual to the extent that the individual is defined to be
4097 a dependent by:
4098 (a) the health benefit plan covering the covered individual; and
4099 (b) Chapter 22, Part 6, Accident and Health Insurance.
4100 (12) "Established geographic service area" means a geographical area approved by the
4101 commissioner within which the carrier is authorized to provide coverage.
4102 (13) "Index rate" means, for each class of business as to a rating period for covered
4103 insureds with similar case characteristics, the arithmetic average of the applicable base
4104 premium rate and the corresponding highest premium rate.
4105 (14) "Individual carrier" means a carrier that provides coverage on an individual basis
4106 through a health benefit plan regardless of whether:
4107 (a) coverage is offered through:
4108 (i) an association;
4109 (ii) a trust;
4110 (iii) a discretionary group; or
4111 (iv) other similar groups; or
4112 (b) the policy or contract is situated out-of-state.
4113 (15) "Individual conversion policy" means a conversion policy issued to:
4114 (a) an individual; or
4115 (b) an individual with a family.
4116 (16) "New business premium rate" means, for each class of business as to a rating
4117 period, the lowest premium rate charged or offered, or that could have been charged or offered,
4118 by the carrier to covered insureds with similar case characteristics for newly issued health
4119 benefit plans with the same or similar coverage.
4120 (17) "Premium" means money paid by covered insureds and covered individuals as a
4121 condition of receiving coverage from a covered carrier, including fees or other contributions

4122 associated with the health benefit plan.

4123 (18) (a) "Rating period" means the calendar period for which premium rates

4124 established by a covered carrier are assumed to be in effect, as determined by the carrier.

4125 (b) A covered carrier may not have:

4126 (i) more than one rating period in any calendar month; and

4127 (ii) no more than 12 rating periods in any calendar year.

4128 [~~(19) "Short-term limited duration insurance" means a health benefit product that:~~]

4129 [~~(a) is not renewable; and~~]

4130 [~~(b) has an expiration date specified in the contract that is less than 364 days after the~~

4131 ~~date the plan became effective.~~]

4132 [~~(20)~~] (19) "Small employer carrier" means a carrier that provides health benefit plans

4133 covering eligible employees of one or more small employers in this state, regardless of

4134 whether:

4135 (a) coverage is offered through:

4136 (i) an association;

4137 (ii) a trust;

4138 (iii) a discretionary group; or

4139 (iv) other similar grouping; or

4140 (b) the policy or contract is situated out-of-state.

4141 Section 44. Section **31A-30-106** is amended to read:

4142 **31A-30-106. Individual premiums -- Rating restrictions -- Disclosure.**

4143 (1) Premium rates for health benefit plans for individuals under this chapter are subject

4144 to this section.

4145 (a) The index rate for a rating period for any class of business may not exceed the

4146 index rate for any other class of business by more than 20%.

4147 (b) (i) For a class of business, the premium rates charged during a rating period to

4148 covered insureds with similar case characteristics for the same or similar coverage, or the rates

4149 that could be charged to the individual under the rating system for that class of business, may

4150 not vary from the index rate by more than 30% of the index rate except as provided under

4151 Subsection (1)(b)(ii).

4152 (ii) A carrier that offers individual and small employer health benefit plans may use the

4153 small employer index rates to establish the rate limitations for individual policies, even if some
4154 individual policies are rated below the small employer base rate.
4155 (c) The percentage increase in the premium rate charged to a covered insured for a new
4156 rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of
4157 the following:
4158 (i) the percentage change in the new business premium rate measured from the first day
4159 of the prior rating period to the first day of the new rating period;
4160 (ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods
4161 of less than one year, due to the claim experience, health status, or duration of coverage of the
4162 covered individuals as determined from the rate manual for the class of business of the carrier
4163 offering an individual health benefit plan; and
4164 (iii) any adjustment due to change in coverage or change in the case characteristics of
4165 the covered insured as determined from the rate manual for the class of business of the carrier
4166 offering an individual health benefit plan.
4167 (d) (i) A carrier offering an individual health benefit plan shall apply rating factors,
4168 including case characteristics, consistently with respect to all covered insureds in a class of
4169 business.
4170 (ii) Rating factors shall produce premiums for identical individuals that:
4171 (A) differ only by the amounts attributable to plan design; and
4172 (B) do not reflect differences due to the nature of the individuals assumed to select
4173 particular health benefit [~~products~~] plans.
4174 (iii) A carrier offering an individual health benefit plan shall treat all health benefit
4175 plans issued or renewed in the same calendar month as having the same rating period.
4176 (e) For the purposes of this Subsection (1), a health benefit plan that uses a restricted
4177 network provision may not be considered similar coverage to a health benefit plan that does not
4178 use a restricted network provision, provided that use of the restricted network provision results
4179 in substantial difference in claims costs.
4180 (f) A carrier offering a health benefit plan to an individual may not, without prior
4181 approval of the commissioner, use case characteristics other than:
4182 (i) age;
4183 (ii) gender;

4184 (iii) geographic area; and
4185 (iv) family composition.
4186 (g) (i) The commissioner shall establish rules in accordance with Title 63G, Chapter 3,
4187 Utah Administrative Rulemaking Act, to:
4188 (A) implement this chapter;
4189 (B) assure that rating practices used by carriers who offer health benefit plans to
4190 individuals are consistent with the purposes of this chapter; and
4191 (C) promote transparency of rating practices of health benefit plans, except that a
4192 carrier may not be required to disclose proprietary information.
4193 (ii) The rules described in Subsection (1)(g)(i) may include rules that:
4194 (A) assure that differences in rates charged for health benefit [~~products~~] plans by
4195 carriers who offer health benefit plans to individuals are reasonable and reflect objective
4196 differences in plan design, not including differences due to the nature of the individuals
4197 assumed to select particular health benefit [~~products~~] plans; and
4198 (B) prescribe the manner in which case characteristics may be used by carriers who
4199 offer health benefit plans to individuals.
4200 (h) The commissioner shall revise rules issued for Sections 31A-22-602 and
4201 31A-22-605 regarding individual accident and health policy rates to allow rating in accordance
4202 with this section.
4203 (2) For purposes of Subsection (1)(c)(i), if a health benefit [~~product~~] plan is a health
4204 benefit [~~product~~] plan into which the covered carrier is no longer enrolling new covered
4205 insureds, the covered carrier shall use the percentage change in the base premium rate,
4206 provided that the change does not exceed, on a percentage basis, the change in the new
4207 business premium rate for the most similar health benefit product into which the covered
4208 carrier is actively enrolling new covered insureds.
4209 (3) (a) A covered carrier may not transfer a covered insured involuntarily into or out of
4210 a class of business.
4211 (b) A covered carrier may not offer to transfer a covered insured into or out of a class
4212 of business unless the offer is made to transfer all covered insureds in the class of business
4213 without regard to:
4214 (i) case characteristics;

4215 (ii) claim experience;
4216 (iii) health status; or
4217 (iv) duration of coverage since issue.
4218 (4) (a) A carrier who offers a health benefit plan to an individual shall maintain at the
4219 carrier's principal place of business a complete and detailed description of its rating practices
4220 and renewal underwriting practices, including information and documentation that demonstrate
4221 that the carrier's rating methods and practices are:
4222 (i) based upon commonly accepted actuarial assumptions; and
4223 (ii) in accordance with sound actuarial principles.
4224 (b) (i) A carrier subject to this section shall file with the commissioner, on or before
4225 April 1 of each year, in a form, manner, and containing such information as prescribed by the
4226 commissioner, an actuarial certification certifying that:
4227 (A) the carrier is in compliance with this chapter; and
4228 (B) the rating methods of the carrier are actuarially sound.
4229 (ii) A copy of the certification required by Subsection (4)(b)(i) shall be retained by the
4230 carrier at the carrier's principal place of business.
4231 (c) A carrier shall make the information and documentation described in this
4232 Subsection (4) available to the commissioner upon request.
4233 (d) Except as provided in Subsection (1)(g) or required by PPACA, a record submitted
4234 to the commissioner under this section shall be maintained by the commissioner as a protected
4235 record under Title 63G, Chapter 2, Government Records Access and Management Act.
4236 Section 45. Section **31A-30-106.1** is amended to read:
4237 **31A-30-106.1. Small employer premiums -- Rating restrictions -- Disclosure.**
4238 (1) Premium rates for small employer health benefit plans under this chapter are
4239 subject to this section.
4240 (2) (a) The index rate for a rating period for any class of business may not exceed the
4241 index rate for any other class of business by more than 20%.
4242 (b) For a class of business, the premium rates charged during a rating period to covered
4243 insureds with similar case characteristics for the same or similar coverage, or the rates that
4244 could be charged to an employer group under the rating system for that class of business, may
4245 not vary from the index rate by more than 30% of the index rate, except when catastrophic

4246 mental health coverage is selected as provided in Subsection 31A-22-625(2)(d).
4247 (3) The percentage increase in the premium rate charged to a covered insured for a new
4248 rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of
4249 the following:
4250 (a) the percentage change in the new business premium rate measured from the first
4251 day of the prior rating period to the first day of the new rating period;
4252 (b) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods
4253 of less than one year, due to the claim experience, health status, or duration of coverage of the
4254 covered individuals as determined from the small employer carrier's rate manual for the class of
4255 business, except when catastrophic mental health coverage is selected as provided in
4256 Subsection 31A-22-625(2)(d); and
4257 (c) any adjustment due to change in coverage or change in the case characteristics of
4258 the covered insured as determined for the class of business from the small employer carrier's
4259 rate manual.
4260 (4) (a) Adjustments in rates for claims experience, health status, and duration from
4261 issue may not be charged to individual employees or dependents.
4262 (b) Rating adjustments and factors, including case characteristics, shall be applied
4263 uniformly and consistently to the rates charged for all employees and dependents of the small
4264 employer.
4265 (c) Rating factors shall produce premiums for identical groups that:
4266 (i) differ only by the amounts attributable to plan design; and
4267 (ii) do not reflect differences due to the nature of the groups assumed to select
4268 particular health benefit [~~products~~] plans.
4269 (d) A small employer carrier shall treat all health benefit plans issued or renewed in the
4270 same calendar month as having the same rating period.
4271 (5) A health benefit plan that uses a restricted network provision may not be considered
4272 similar coverage to a health benefit plan that does not use a restricted network provision,
4273 provided that use of the restricted network provision results in substantial difference in claims
4274 costs.
4275 (6) The small employer carrier may not use case characteristics other than the
4276 following:

4277 (a) age of the employee, in accordance with Subsection (7);
4278 (b) geographic area;
4279 (c) family composition in accordance with Subsection (9);
4280 (d) for plans renewed or effective on or after July 1, 2011, gender of the employee and
4281 spouse;
4282 (e) for an individual age 65 and older, whether the employer policy is primary or
4283 secondary to Medicare; and
4284 (f) a wellness program, in accordance with Subsection (12).
4285 (7) Age limited to:
4286 (a) the following age bands:
4287 (i) less than 20;
4288 (ii) 20-24;
4289 (iii) 25-29;
4290 (iv) 30-34;
4291 (v) 35-39;
4292 (vi) 40-44;
4293 (vii) 45-49;
4294 (viii) 50-54;
4295 (ix) 55-59;
4296 (x) 60-64; and
4297 (xi) 65 and above; and
4298 (b) a standard slope ratio range for each age band, applied to each family composition
4299 tier rating structure under Subsection (9)(b):
4300 (i) as developed by the commissioner by administrative rule; and
4301 (ii) not to exceed an overall ratio as provided in Subsection (8).
4302 (8) (a) The overall ratio permitted in Subsection (7)(b)(ii) may not exceed:
4303 (i) 5:1 for plans renewed or effective before January 1, 2012; and
4304 (ii) 6:1 for plans renewed or effective on or after January 1, 2012; and
4305 (b) the age slope ratios for each age band may not overlap.
4306 (9) Except as provided in Subsection 31A-30-207(2), family composition is limited to:
4307 (a) an overall ratio of:

4308 (i) 5:1 or less for plans renewed or effective before January 1, 2012; and
4309 (ii) 6:1 or less for plans renewed or effective on or after January 1, 2012; and
4310 (b) a tier rating structure that includes:
4311 (i) four tiers that include:
4312 (A) employee only;
4313 (B) employee plus spouse;
4314 (C) employee plus a child or children; and
4315 (D) a family, consisting of an employee plus spouse, and a child or children;
4316 (ii) for plans renewed or effective on or after January 1, 2012, five tiers that include:
4317 (A) employee only;
4318 (B) employee plus spouse;
4319 (C) employee plus one child;
4320 (D) employee plus two or more children; and
4321 (E) employee plus spouse plus one or more children; or
4322 (iii) for plans renewed or effective on or after January 1, 2012, six tiers that include:
4323 (A) employee only;
4324 (B) employee plus spouse;
4325 (C) employee plus one child;
4326 (D) employee plus two or more children;
4327 (E) employee plus spouse plus one child; and
4328 (F) employee plus spouse plus two or more children.
4329 (10) If a health benefit plan is a health benefit plan into which the small employer
4330 carrier is no longer enrolling new covered insureds, the small employer carrier shall use the
4331 percentage change in the base premium rate, provided that the change does not exceed, on a
4332 percentage basis, the change in the new business premium rate for the most similar health
4333 benefit [~~product~~] plan into which the small employer carrier is actively enrolling new covered
4334 insureds.
4335 (11) (a) A covered carrier may not transfer a covered insured involuntarily into or out
4336 of a class of business.
4337 (b) A covered carrier may not offer to transfer a covered insured into or out of a class
4338 of business unless the offer is made to transfer all covered insureds in the class of business

4339 without regard to:
4340 (i) case characteristics;
4341 (ii) claim experience;
4342 (iii) health status; or
4343 (iv) duration of coverage since issue.
4344 (12) Notwithstanding Subsection (4)(b), a small employer carrier may:
4345 (a) offer a wellness program to a small employer group if:
4346 (i) the premium discount to the employer for the wellness program does not exceed
4347 20% of the premium for the small employer group; and
4348 (ii) the carrier offers the wellness program discount uniformly across all small
4349 employer groups;
4350 (b) offer a premium discount as part of a wellness program to individual employees in
4351 a small employer group:
4352 (i) to the extent allowed by federal law; and
4353 (ii) if the employee discount based on the wellness program is offered uniformly across
4354 all small employer groups; and
4355 (c) offer a combination of premium discounts for the employer and the employee,
4356 based on a wellness program, if:
4357 (i) the employer discount complies with Subsection (12)(a); and
4358 (ii) the employee discount complies with Subsection (12)(b).
4359 (13) (a) [~~Each~~] A small employer carrier shall maintain at the small employer carrier's
4360 principal place of business a complete and detailed description of its rating practices and
4361 renewal underwriting practices, including information and documentation that demonstrate that
4362 the small employer carrier's rating methods and practices are:
4363 (i) based upon commonly accepted actuarial assumptions; and
4364 (ii) in accordance with sound actuarial principles.
4365 (b) (i) [~~Each~~] A small employer carrier shall file with the commissioner on or before
4366 April 1 of each year, in a form and manner and containing information as prescribed by the
4367 commissioner, an actuarial certification certifying that:
4368 (A) the small employer carrier is in compliance with this chapter; and
4369 (B) the rating methods of the small employer carrier are actuarially sound.

4370 (ii) A copy of the certification required by Subsection (13)(b)(i) shall be retained by the
4371 small employer carrier at the small employer carrier's principal place of business.
4372 (c) A small employer carrier shall make the information and documentation described
4373 in this Subsection (13) available to the commissioner upon request.
4374 (14) (a) The commissioner shall establish rules in accordance with Title 63G, Chapter
4375 3, Utah Administrative Rulemaking Act, to:
4376 (i) implement this chapter; and
4377 (ii) assure that rating practices used by small employer carriers under this section and
4378 carriers for individual plans under Section 31A-30-106 are consistent with the purposes of this
4379 chapter.
4380 (b) The rules may:
4381 (i) assure that differences in rates charged for health benefit plans by carriers are
4382 reasonable and reflect objective differences in plan design, not including differences due to the
4383 nature of the groups or individuals assumed to select particular health benefit plans; and
4384 (ii) prescribe the manner in which case characteristics may be used by small employer
4385 and individual carriers.
4386 (15) Records submitted to the commissioner under this section shall be maintained by
4387 the commissioner as protected records under Title 63G, Chapter 2, Government Records
4388 Access and Management Act.
4389 Section 46. Section **31A-30-107** is amended to read:
4390 **31A-30-107. Renewal -- Limitations -- Exclusions -- Discontinuance and**
4391 **nonrenewal.**
4392 (1) Except as otherwise provided in this section, a small employer health benefit plan is
4393 renewable and continues in force:
4394 (a) with respect to all eligible employees and dependents; and
4395 (b) at the option of the plan sponsor.
4396 (2) A small employer health benefit plan may be discontinued or nonrenewed:
4397 (a) for a network plan, if there is no longer any enrollee under the group health plan
4398 who lives, resides, or works in:
4399 (i) the service area of the covered carrier; or
4400 (ii) the area for which the covered carrier is authorized to do business; or

4401 (b) for coverage made available in the small or large employer market only through an
4402 association, if:
4403 (i) the employer's membership in the association ceases; and
4404 (ii) the coverage is terminated uniformly without regard to any health status-related
4405 factor relating to any covered individual.
4406 (3) A small employer health benefit plan may be discontinued if:
4407 (a) a condition described in Subsection (2) exists;
4408 (b) except as prohibited by Section 31A-30-206, the plan sponsor fails to pay
4409 premiums or contributions in accordance with the terms of the contract;
4410 (c) the plan sponsor:
4411 (i) performs an act or practice that constitutes fraud; or
4412 (ii) makes an intentional misrepresentation of material fact under the terms of the
4413 coverage;
4414 (d) the covered carrier:
4415 (i) elects to discontinue offering a particular small employer health benefit [~~product~~]
4416 plan delivered or issued for delivery in this state; and
4417 (ii) (A) provides notice of the discontinuation in writing:
4418 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
4419 (II) at least 90 days before the date the coverage will be discontinued;
4420 (B) provides notice of the discontinuation in writing:
4421 (I) to the commissioner; and
4422 (II) at least three working days prior to the date the notice is sent to the affected plan
4423 sponsors, employees, and dependents of the plan sponsors or employees;
4424 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all
4425 other small employer health benefit [~~products~~] plans currently being offered by the small
4426 employer carrier in the market; and
4427 (D) in exercising the option to discontinue that product and in offering the option of
4428 coverage in this section, acts uniformly without regard to:
4429 (I) the claims experience of a plan sponsor;
4430 (II) any health status-related factor relating to any covered participant or beneficiary; or
4431 (III) any health status-related factor relating to any new participant or beneficiary who

4432 may become eligible for the coverage; or
4433 (e) the covered carrier:
4434 (i) elects to discontinue all of the covered carrier's small employer health benefit plans
4435 in:
4436 (A) the small employer market;
4437 (B) the large employer market; or
4438 (C) both the small employer and large employer markets; and
4439 (ii) (A) provides notice of the discontinuation in writing:
4440 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
4441 (II) at least 180 days before the date the coverage will be discontinued;
4442 (B) provides notice of the discontinuation in writing:
4443 (I) to the commissioner in each state in which an affected insured individual is known
4444 to reside; and
4445 (II) at least 30 working days prior to the date the notice is sent to the affected plan
4446 sponsors, employees, and the dependents of the plan sponsors or employees;
4447 (C) discontinues and nonrenews all plans issued or delivered for issuance in the
4448 market; and
4449 (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.
4450 (4) A small employer health benefit plan may be discontinued or nonrenewed:
4451 (a) if a condition described in Subsection (2) exists; or
4452 (b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's
4453 employer contribution requirements.
4454 (5) A small employer health benefit plan may be nonrenewed:
4455 (a) if a condition described in Subsection (2) exists; or
4456 (b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's
4457 minimum participation requirements.
4458 (6) (a) Except as provided in Subsection (6)(d), an eligible employee may be
4459 discontinued if after issuance of coverage the eligible employee:
4460 (i) engages in an act or practice that constitutes fraud in connection with the coverage;
4461 or
4462 (ii) makes an intentional misrepresentation of material fact in connection with the

4463 coverage.
4464 (b) An eligible employee that is discontinued under Subsection (6)(a) may reenroll:
4465 (i) 12 months after the date of discontinuance; and
4466 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
4467 to reenroll.
4468 (c) At the time the eligible employee's coverage is discontinued under Subsection
4469 (6)(a), the covered carrier shall notify the eligible employee of the right to reenroll when
4470 coverage is discontinued.
4471 (d) An eligible employee may not be discontinued under this Subsection (6) because of
4472 a fraud or misrepresentation that relates to health status.
4473 (7) For purposes of this section, a reference to "plan sponsor" includes a reference to
4474 the employer:
4475 (a) with respect to coverage provided to an employer member of the association; and
4476 (b) if the small employer health benefit plan is made available by a covered carrier in
4477 the employer market only through:
4478 (i) an association;
4479 (ii) a trust; or
4480 (iii) a discretionary group.
4481 (8) A covered carrier may modify a small employer health benefit plan only:
4482 (a) at the time of coverage renewal; and
4483 (b) if the modification is effective uniformly among all plans with that product.
4484 Section 47. Section **31A-30-107.1** is amended to read:
4485 **31A-30-107.1. Individual discontinuance and nonrenewal.**
4486 (1) (a) Except as otherwise provided in this section, a health benefit plan offered on an
4487 individual basis is renewable and continues in force:
4488 (i) with respect to all individuals or dependents; and
4489 (ii) at the option of the individual.
4490 (b) Subsection (1)(a) applies regardless of:
4491 (i) whether the contract is issued through:
4492 (A) a trust;
4493 (B) an association;

4494 (C) a discretionary group; or
4495 (D) other similar grouping; or
4496 (ii) the situs of delivery of the policy or contract.
4497 (2) A health benefit plan may be discontinued or nonrenewed:
4498 (a) for a network plan, if:
4499 (i) the individual no longer lives, resides, or works in:
4500 (A) the service area of the covered carrier; or
4501 (B) the area for which the covered carrier is authorized to do business; and
4502 (ii) coverage is terminated uniformly without regard to any health status-related factor
4503 relating to any covered individual; or
4504 (b) for coverage made available through an association, if:
4505 (i) the individual's membership in the association ceases; and
4506 (ii) the coverage is terminated uniformly without regard to any health status-related
4507 factor of covered individuals.
4508 (3) A health benefit plan may be discontinued if:
4509 (a) a condition described in Subsection (2) exists;
4510 (b) the individual fails to pay premiums or contributions in accordance with the terms
4511 of the health benefit plan, including any timeliness requirements;
4512 (c) the individual:
4513 (i) performs an act or practice that constitutes fraud in connection with the coverage; or
4514 (ii) makes an intentional misrepresentation of material fact under the terms of the
4515 coverage;
4516 (d) the covered carrier:
4517 (i) elects to discontinue offering a particular health benefit [~~product~~] plan delivered or
4518 issued for delivery in this state; and
4519 (ii) (A) provides notice of the discontinuance in writing:
4520 (I) to each individual provided coverage; and
4521 (II) at least 90 days before the date the coverage will be discontinued;
4522 (B) provides notice of the discontinuation in writing:
4523 (I) to the commissioner; and
4524 (II) at least three working days prior to the date the notice is sent to the affected

4525 individuals;

4526 (C) offers to each covered individual on a guaranteed issue basis the option to purchase

4527 all other individual health benefit [~~products~~] plans currently being offered by the covered

4528 carrier for individuals in that market; and

4529 (D) acts uniformly without regard to any health status-related factor of a covered

4530 individual or dependent of a covered individual who may become eligible for coverage; or

4531 (e) the covered carrier:

4532 (i) elects to discontinue all of the covered carrier's health benefit plans in the individual

4533 market; and

4534 (ii) (A) provides notice of the discontinuation in writing:

4535 (I) to each covered individual; and

4536 (II) at least 180 days before the date the coverage will be discontinued;

4537 (B) provides notice of the discontinuation in writing:

4538 (I) to the commissioner in each state in which an affected insured individual is known

4539 to reside; and

4540 (II) at least 30 working days prior to the date the notice is sent to the affected

4541 individuals;

4542 (C) discontinues and nonrenews all health benefit plans the covered carrier issues or

4543 delivers for issuance in the individual market; and

4544 (D) acts uniformly without regard to any health status-related factor of a covered

4545 individual or a dependent of a covered individual who may become eligible for coverage.

4546 Section 48. Section **31A-37-102** is amended to read:

4547 **31A-37-102. Definitions.**

4548 As used in this chapter:

4549 (1) (a) "Affiliated company" means a business entity that because of common

4550 ownership, control, operation, or management is in the same corporate or limited liability

4551 company system as:

4552 [~~(a)~~] (i) a parent;

4553 [~~(b)~~] (ii) an industrial insured; or

4554 [~~(c)~~] (iii) a member organization.

4555 (b) Notwithstanding Subsection (1)(a), the commissioner may issue an order finding

4556 that a business entity is not an affiliated company.

4557 (2) "Alien captive insurance company" means an insurer:

4558 (a) formed to write insurance business for [a parent or affiliate of the insurer; and]:

4559 (i) with respect to an insurer:

4560 (A) a parent;

4561 (B) an affiliate;

4562 (C) an industrial insured;

4563 (D) a controlled unaffiliated business;

4564 (E) a member organization of an entity described in Subsections (2)(a)(i)(A) through

4565 (D); or

4566 (F) any combination of Subsections (2)(a)(i)(A) through (E);

4567 (ii) one or more:

4568 (A) captive insurance companies;

4569 (B) insurers described in Subsection (2)(a)(i);

4570 (C) other insurers to the extent that the insurance business is for risks pertaining to an

4571 insurer described in Subsection (2)(a)(ii)(A) or (B) or for an entity described in Subsections

4572 (2)(a)(i)(A) through (E); or

4573 (D) any combination of Subsections (2)(a)(ii)(A) through (C); or

4574 (iii) any combination of Subsections (2)(a)(i) and (ii);

4575 (b) licensed pursuant to the laws of an alien or foreign jurisdiction that imposes

4576 statutory or regulatory standards:

4577 (i) on a business entity transacting the business of insurance in the alien or foreign

4578 jurisdiction; and

4579 (ii) in a form acceptable to the commissioner.

4580 (3) "Association" means a legal association of two or more persons that has been in

4581 continuous existence for at least one year if:

4582 (a) the association or its member organizations:

4583 (i) own, control, or hold with power to vote all of the outstanding voting securities of

4584 an association captive insurance company incorporated as a stock insurer; or

4585 (ii) have complete voting control over an association captive insurance company

4586 incorporated as a mutual insurer;

4587 (b) the association's member organizations collectively constitute all of the subscribers
4588 of an association captive insurance company formed as a reciprocal insurer; or
4589 (c) the association or its member organizations have complete voting control over an
4590 association captive insurance company formed as a limited liability company.
4591 (4) "Association captive insurance company" means a business entity that insures risks
4592 of:
4593 (a) a member organization of the association;
4594 (b) an affiliate of a member organization of the association; and
4595 (c) the association.
4596 (5) "Branch business" means an insurance business transacted by a branch captive
4597 insurance company in this state.
4598 (6) "Branch captive insurance company" means an alien captive insurance company
4599 that has a certificate of authority from the commissioner to transact the business of insurance in
4600 this state through a captive insurance company that is domiciled outside of this state.
4601 (7) "Branch operation" means a business operation of a branch captive insurance
4602 company in this state.
4603 (8) "Captive insurance company" means any of the following formed or holding a
4604 certificate of authority under this chapter:
4605 (a) a branch captive insurance company;
4606 (b) a pure captive insurance company;
4607 (c) an association captive insurance company;
4608 (d) a sponsored captive insurance company;
4609 (e) an industrial insured captive insurance company, including an industrial insured
4610 captive insurance company formed as a risk retention group captive in this state pursuant to the
4611 provisions of the Federal Liability Risk Retention Act of 1986;
4612 (f) a pool captive insurance company;
4613 [~~(f)~~] (g) a special purpose captive insurance company; or
4614 [~~(g)~~] (h) a special purpose financial captive insurance company.
4615 (9) "Commissioner" means Utah's Insurance Commissioner or the commissioner's
4616 designee.
4617 (10) "Common ownership and control" means that two or more captive insurance

4618 companies are owned or controlled by the same person or group of persons as follows:
4619 (a) in the case of a captive insurance company that is a stock corporation, the direct or
4620 indirect ownership of 80% or more of the outstanding voting stock of the stock corporation;
4621 (b) in the case of a captive insurance company that is a mutual corporation, the direct
4622 or indirect ownership of 80% or more of the surplus and the voting power of the mutual
4623 corporation;
4624 (c) in the case of a captive insurance company that is a limited liability company, the
4625 direct or indirect ownership by the same member or members of 80% or more of the
4626 membership interests in the limited liability company; or
4627 (d) in the case of a sponsored captive insurance company, a protected cell is a separate
4628 captive insurance company owned and controlled by the protected cell's participant, only if:
4629 (i) the participant is the only participant with respect to the protected cell; and
4630 (ii) the participant is the sponsor or is affiliated with the sponsor of the sponsored
4631 captive insurance company through common ownership and control.
4632 (11) "Consolidated debt to total capital ratio" means the ratio of Subsection (11)(a) to
4633 (b).
4634 (a) This Subsection (11)(a) is an amount equal to the sum of all debts and hybrid
4635 capital instruments including:
4636 (i) all borrowings from depository institutions;
4637 (ii) all senior debt;
4638 (iii) all subordinated debts;
4639 (iv) all trust preferred shares; and
4640 (v) all other hybrid capital instruments that are not included in the determination of
4641 consolidated GAAP net worth issued and outstanding.
4642 (b) This Subsection (11)(b) is an amount equal to the sum of:
4643 (i) total capital consisting of all debts and hybrid capital instruments as described in
4644 Subsection (11)(a); and
4645 (ii) shareholders' equity determined in accordance with generally accepted accounting
4646 principles for reporting to the United States Securities and Exchange Commission.
4647 (12) "Consolidated GAAP net worth" means the consolidated shareholders' or
4648 members' equity determined in accordance with generally accepted accounting principles for

4649 reporting to the United States Securities and Exchange Commission.
4650 (13) "Controlled unaffiliated business" means a business entity:
4651 (a) (i) in the case of a pure captive insurance company or pool captive insurance
4652 company, that is not in the corporate or limited liability company system of a parent or the
4653 parent's affiliate; or
4654 (ii) in the case of an industrial insured captive insurance company, that is not in the
4655 corporate or limited liability company system of an industrial insured or an affiliated company
4656 of the industrial insured;
4657 (b) (i) in the case of a pure captive insurance company or pool captive insurance
4658 company, that has a contractual relationship with a parent or affiliate; or
4659 (ii) in the case of an industrial insured captive insurance company, that has a
4660 contractual relationship with an industrial insured or an affiliated company of the industrial
4661 insured; and
4662 (c) whose risks that are or will be insured by a pure captive insurance company, an
4663 industrial insured captive insurance company, or both are managed [~~by one of the following~~] in
4664 accordance with Subsection 31A-37-106(1)(j) by:
4665 (i) (A) a pure captive insurance company; or
4666 [~~(ii)~~] (B) an industrial insured captive insurance company[.]; or
4667 (ii) a parent or affiliate of:
4668 (A) a pure captive insurance company; or
4669 (B) an industrial insured captive insurance company.
4670 (14) "Department" means the Insurance Department.
4671 (15) "Industrial insured" means an insured:
4672 (a) that produces insurance:
4673 (i) by the services of a full-time employee acting as a risk manager or insurance
4674 manager; or
4675 (ii) using the services of a regularly and continuously qualified insurance consultant;
4676 (b) whose aggregate annual premiums for insurance on all risks total at least $25,000;
4677 and
4678 (c) that has at least 25 full-time employees.
4679 (16) "Industrial insured captive insurance company" means a business entity that:

4680 (a) insures risks of the industrial insureds that comprise the industrial insured group;
4681 and
4682 (b) may insure the risks of:
4683 (i) an affiliated company of an industrial insured; or
4684 (ii) a controlled unaffiliated business of:
4685 (A) an industrial insured; or
4686 (B) an affiliated company of an industrial insured.
4687 (17) "Industrial insured group" means:
4688 (a) a group of industrial insureds that collectively:
4689 (i) own, control, or hold with power to vote all of the outstanding voting securities of
4690 an industrial insured captive insurance company incorporated or organized as a limited liability
4691 company as a stock insurer; or
4692 (ii) have complete voting control over an industrial insured captive insurance company
4693 incorporated or organized as a limited liability company as a mutual insurer;
4694 (b) a group that is:
4695 (i) created under the Product Liability Risk Retention Act of 1981, 15 U.S.C. Sec. 3901
4696 et seq., as amended, as a corporation or other limited liability association; and
4697 (ii) taxable under this title as a:
4698 (A) stock corporation; or
4699 (B) mutual insurer; or
4700 (c) a group that has complete voting control over an industrial captive insurance
4701 company formed as a limited liability company.
4702 (18) "Member organization" means a person that belongs to an association.
4703 (19) "Parent" means a person that directly or indirectly owns, controls, or holds with
4704 power to vote more than 50% of:
4705 (a) the outstanding voting securities of a pure captive insurance company; or
4706 (b) the pure captive insurance company, if the pure captive insurance company is
4707 formed as a limited liability company.
4708 (20) "Participant" means an entity that is insured by a sponsored captive insurance
4709 company:
4710 (a) if the losses of the participant are limited through a participant contract to the assets

4711 of a protected cell; and
4712 (b)(i) the entity is permitted to be a participant under Section 31A-37-403; or
4713 (ii) the entity is an affiliate of an entity permitted to be a participant under Section
4714 31A-37-403.
4715 (21) "Participant contract" means a contract by which a sponsored captive insurance
4716 company:
4717 (a) insures the risks of a participant; and
4718 (b) limits the losses of the participant to the assets of a protected cell.
4719 (22) "Pool captive insurance company" means a business entity that is reinsured in
4720 whole or in part by:
4721 (a) at least three captive insurance companies or three alien captive insurance
4722 companies; or
4723 (b) a combination of at least three entities that are either a captive insurance company
4724 or alien captive insurance company.
4725 [~~(22)~~] (23) "Protected cell" means a separate account established and maintained by a
4726 sponsored captive insurance company for one participant.
4727 [~~(23)~~] (24) "Pure captive insurance company" means a business entity that insures risks
4728 of a parent or affiliate of the business entity.
4729 [~~(24)~~] (25) "Special purpose financial captive insurance company" is as defined in
4730 Section 31A-37a-102.
4731 [~~(25)~~] (26) "Sponsor" means an entity that:
4732 (a) meets the requirements of Section 31A-37-402; and
4733 (b) is approved by the commissioner to:
4734 (i) provide all or part of the capital and surplus required by applicable law in an amount
4735 of not less than $350,000, which amount the commissioner may increase by order if the
4736 commissioner considers it necessary; and
4737 (ii) organize and operate a sponsored captive insurance company.
4738 [~~(26)~~] (27) "Sponsored captive insurance company" means a captive insurance
4739 company:
4740 (a) in which the minimum capital and surplus required by applicable law is provided by
4741 one or more sponsors;

4742 (b) that is formed or holding a certificate of authority under this chapter;
4743 (c) that insures the risks of a separate participant through the contract; and
4744 (d) that segregates each participant's liability through one or more protected cells.
4745 [~~(27)~~] (28) "Treasury rates" means the United States Treasury strip asked yield as
4746 published in the Wall Street Journal as of a balance sheet date.
4747 Section 49. Section **31A-37-106** is amended to read:
4748 **31A-37-106. Authority to make rules -- Authority to issue orders.**
4749 (1) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the
4750 commissioner may adopt rules to:
4751 (a) determine circumstances under which a branch captive insurance company is not
4752 required to be a pure captive insurance company;
4753 (b) require a statement, document, or information that a captive insurance company
4754 shall provide to the commissioner to obtain a certificate of authority;
4755 (c) determine a factor a captive insurance company shall provide evidence of under
4756 Subsection 31A-37-202(4)[~~(c)~~](b);
4757 (d) prescribe one or more capital requirements for a captive insurance company in
4758 addition to those required under Section 31A-37-204 based on the type, volume, and nature of
4759 insurance business transacted by the captive insurance company;
4760 (e) waive or modify a requirement for public notice and hearing for the following by a
4761 captive insurance company:
4762 (i) merger;
4763 (ii) consolidation;
4764 (iii) conversion;
4765 (iv) mutualization;
4766 (v) redomestication; or
4767 (vi) acquisition;
4768 (f) approve the use of one or more reliable methods of valuation and rating for:
4769 (i) an association captive insurance company;
4770 (ii) a sponsored captive insurance company; or
4771 (iii) an industrial insured group;
4772 (g) prohibit or limit an investment that threatens the solvency or liquidity of:

4773 (i) a pure captive insurance company; [~~or~~]
4774 (ii) an industrial insured captive insurance company; or
4775 (iii) a pool captive insurance company;
4776 (h) determine the financial reports a sponsored captive insurance company shall
4777 annually file with the commissioner;
4778 (i) prescribe the required forms and reports under Section 31A-37-501; and
4779 (j) establish one or more standards to ensure that:
4780 (i) one of the following is able to exercise control of the risk management function of a
4781 controlled unaffiliated business to be insured by a pure captive insurance company:
4782 (A) a parent; or
4783 (B) an affiliated company of a parent; [~~or~~]
4784 (ii) one of the following is able to exercise control of the risk management function of
4785 a controlled unaffiliated business to be insured by an industrial insured captive insurance
4786 company:
4787 (A) an industrial insured; or
4788 (B) an affiliated company of the industrial insured[~~.~~]; or
4789 (iii) one or more of the following is able to exercise control of the risk management
4790 function of a controlled unaffiliated business to be insured by a pool captive insurance
4791 company:
4792 (A) with respect to the pool captive insurance company, a parent, industrial insured, or
4793 an affiliated company of an industrial insured or a parent; or
4794 (B) with respect to a reinsurer of the pool captive insurance company, a parent, an
4795 industrial insured, or an affiliated company of an industrial insured or a parent;
4796 (k) determine the financial reports a pool captive insurance company shall annually file
4797 with the commissioner; and
4798 (l) establish one or more standards to ensure that:
4799 (i) a pool captive insurance company is properly and prudently managed; and
4800 (ii) no captive insurance company holding a license from this state is involved in
4801 activities that would negatively impact the respectability, reputation, and propriety of a captive
4802 insurance license or degrade the substance of the license holder as an insurer.
4803 (2) Notwithstanding Subsection (1)(j), until the commissioner adopts the rules

4804 authorized under Subsection (1)(j), the commissioner may by temporary order grant authority
4805 to insure risks to:
4806 (a) a pure captive insurance company; [~~or~~]
4807 (b) an industrial insured captive insurance company[~~.~~]; or
4808 (c) a pool captive insurance company.
4809 (3) The commissioner may issue prohibitory, mandatory, and other orders relating to a
4810 captive insurance company as necessary to enable the commissioner to secure compliance with
4811 this chapter.
4812 Section 50. Section **31A-37-202** is amended to read:
4813 **31A-37-202. Permissive areas of insurance.**
4814 (1) (a) Except as provided in Subsection (1)(b), when permitted by its articles of
4815 incorporation, certificate of organization, or charter, a captive insurance company may apply to
4816 the commissioner for a certificate of authority to do all insurance authorized by this title except
4817 workers' compensation insurance.
4818 (b) Notwithstanding Subsection (1)(a):
4819 (i) a pure captive insurance company may not insure a risk other than a risk of:
4820 (A) [~~its~~] the pure captive insurance company's parent or affiliate; or
4821 (B) a combination of the pure captive insurance company's parent or affiliate and a
4822 controlled unaffiliated business; [~~or~~]
4823 [~~(C) a combination of Subsections (1)(b)(i)(A) and (B);~~]
4824 (ii) an association captive insurance company may not insure a risk other than a risk of:
4825 (A) an affiliate;
4826 (B) a member organization of its association; and
4827 (C) an affiliate of a member organization of its association;
4828 (iii) an industrial insured captive insurance company may not insure a risk other than a
4829 risk of:
4830 (A) an industrial insured that is part of the industrial insured group;
4831 (B) an affiliate of an industrial insured that is part of the industrial insured group; and
4832 (C) a controlled unaffiliated business of:
4833 (I) an industrial insured that is part of the industrial insured group; or
4834 (II) an affiliate of an industrial insured that is part of the industrial insured group;

4835 (iv) a pool captive insurance company may reinsure any captive insurance company or
4836 alien captive insurance company for any risk not prohibited by this chapter and as provided for
4837 in Section 31A-37-303;
4838 (v) a pool captive insurance company may not directly insure a risk other than a risk
4839 that belongs to, with respect to either or both a pool captive insurance company or a reinsurer
4840 of the pool captive insurance company, one or more of the following:
4841 (A) a parent;
4842 (B) an affiliate;
4843 (C) controlled unaffiliated business; or
4844 (D) a member organization of an entity described in Subsections (1)(b)(v)(A) through
4845 (C);
4846 [(iv)] (vi) a special purpose captive insurance company may only insure a risk of its
4847 parent;
4848 [(v)] (vii) a captive insurance company may not provide:
4849 (A) personal motor vehicle insurance coverage;
4850 (B) homeowner's insurance coverage; or
4851 (C) a component of a coverage described in this Subsection (1)(b)[(v)](vii); and
4852 [(vi)] (viii) a captive insurance company may not accept or cede reinsurance except as
4853 provided in Section 31A-37-303.
4854 (c) Notwithstanding Subsection (1)(b)[(iv)](vi), for a risk approved by the
4855 commissioner a special purpose captive insurance company may provide:
4856 (i) insurance;
4857 (ii) reinsurance; or
4858 (iii) both insurance and reinsurance.
4859 (2) To conduct insurance business in this state a captive insurance company shall:
4860 (a) obtain from the commissioner a certificate of authority authorizing it to conduct
4861 insurance business in this state;
4862 (b) hold at least once each year in this state:
4863 (i) a board of directors meeting; or
4864 [(ii) in the case of a reciprocal insurer, a subscriber's advisory committee meeting; or]
4865 [(iii)] (ii) in the case of a limited liability company, a meeting of the managers;

4866 (c) maintain in this state:
4867 (i) the principal place of business of the captive insurance company; or
4868 (ii) in the case of a branch captive insurance company, the principal place of business
4869 for the branch operations of the branch captive insurance company; and
4870 (d) except as provided in Subsection (3), appoint a resident registered agent to accept
4871 service of process and to otherwise act on behalf of the captive insurance company in this state.
4872 (3) Notwithstanding Subsection (2)(d), in the case of a captive insurance company
4873 formed as a corporation [~~or a reciprocal insurer~~], if the registered agent cannot with reasonable
4874 diligence be found at the registered office of the captive insurance company, the commissioner
4875 is the agent of the captive insurance company upon whom process, notice, or demand may be
4876 served.
4877 (4) (a) Before receiving a certificate of authority, a captive insurance company:
4878 (i) formed as a corporation shall file with the commissioner:
4879 (A) a certified copy of:
4880 (I) articles of incorporation or the charter of the corporation; and
4881 (II) bylaws of the corporation;
4882 (B) a statement under oath of the president and secretary of the corporation showing
4883 the financial condition of the corporation; and
4884 (C) any other statement or document required by the commissioner under Section
4885 31A-37-106; <u>and</u>
4886 [~~(ii) formed as a reciprocal shall:~~]
4887 [~~(A) file with the commissioner:~~]
4888 [~~(I) a certified copy of the power of attorney of the attorney-in-fact of the reciprocal;~~]
4889 [~~(II) a certified copy of the subscribers' agreement of the reciprocal;~~]
4890 [~~(III) a statement under oath of the attorney-in-fact of the reciprocal showing the~~
4891 ~~financial condition of the reciprocal; and~~]
4892 [~~(IV) any other statement or document required by the commissioner under Section~~
4893 ~~31A-37-106; and~~]
4894 [~~(B) submit to the commissioner for approval a description of the:~~]
4895 [~~(I) coverages;~~]
4896 [~~(II) deductibles;~~]

4897 [(III) coverage limits;]
4898 [(IV) rates; and]
4899 [(V) any other information the commissioner requires under Section 31A-37-106; and]
4900 [(iii)] (ii) formed as a limited liability company shall file with the commissioner:
4901 (A) a certified copy of the certificate of organization and the operating agreement of
4902 the organization;
4903 (B) a statement under oath of the president and secretary of the organization showing
4904 the financial condition of the organization;
4905 (C) evidence that the limited liability company is manager-managed; and
4906 (D) any other statement or document required by the commissioner under Section
4907 31A-37-106.
4908 [(b) (i) If there is a subsequent material change in an item in the description required
4909 under Subsection (4)(a)(ii)(B) for a reciprocal captive insurance company, the reciprocal
4910 captive insurance company shall submit to the commissioner for approval an appropriate
4911 revision to the description required under Subsection (4)(a)(ii)(B).]
4912 [(ii) A reciprocal captive insurance company that is required to submit a revision under
4913 Subsection (4)(b)(i) may not offer any additional types of insurance until the commissioner
4914 approves a revision of the description.]
4915 [(iii) A reciprocal captive insurance company shall inform the commissioner of a
4916 material change in a rate within 30 days of the adoption of the change.]
4917 [(c)] (b) In addition to the information required by Subsection (4)(a), an applicant
4918 captive insurance company shall file with the commissioner evidence of:
4919 (i) the amount and liquidity of the assets of the applicant captive insurance company
4920 relative to the risks to be assumed by the applicant captive insurance company;
4921 (ii) the adequacy of the expertise, experience, and character of the person who will
4922 manage the applicant captive insurance company;
4923 (iii) the overall soundness of the plan of operation of the applicant captive insurance
4924 company;
4925 (iv) the adequacy of the loss prevention programs for the following of the applicant
4926 captive insurance company:
4927 (A) a parent;

4928 (B) a member organization; or
4929 (C) an industrial insured; and
4930 (v) any other factor the commissioner:
4931 (A) adopts by rule under Section 31A-37-106; and
4932 (B) considers relevant in ascertaining whether the applicant captive insurance company
4933 will be able to meet the policy obligations of the applicant captive insurance company.
4934 [~~(d)~~] (c) In addition to the information required by Subsections (4)(a)[~~,~~] and (b)[~~, and~~
4935 ~~(c),~~] an applicant sponsored captive insurance company shall file with the commissioner:
4936 (i) a business plan at the level of detail required by the commissioner under Section
4937 31A-37-106 demonstrating:
4938 (A) the manner in which the applicant sponsored captive insurance company will
4939 account for the losses and expenses of each protected cell; and
4940 (B) the manner in which the applicant sponsored captive insurance company will report
4941 to the commissioner the financial history, including losses and expenses, of each protected cell;
4942 (ii) a statement acknowledging that the applicant sponsored captive insurance company
4943 will make all financial records of the applicant sponsored captive insurance company,
4944 including records pertaining to a protected cell, available for inspection or examination by the
4945 commissioner;
4946 (iii) a contract or sample contract between the applicant sponsored captive insurance
4947 company and a participant; and
4948 (iv) evidence that expenses will be allocated to each protected cell in an equitable
4949 manner.
4950 (5) (a) Information submitted pursuant to Subsection (4) is classified as a protected
4951 record under Title 63G, Chapter 2, Government Records Access and Management Act.
4952 (b) Notwithstanding Title 63G, Chapter 2, Government Records Access and
4953 Management Act, the commissioner may disclose information submitted pursuant to
4954 Subsection (4) to a public official having jurisdiction over the regulation of insurance in
4955 another state if:
4956 (i) the public official receiving the information agrees in writing to maintain the
4957 confidentiality of the information; and
4958 (ii) the laws of the state in which the public official serves require the information to be

4959 confidential.
4960 (c) This Subsection (5) does not apply to information provided by an industrial insured
4961 captive insurance company insuring the risks of an industrial insured group.
4962 (6) (a) A captive insurance company shall pay to the department the following
4963 nonrefundable fees established by the department under Sections 31A-3-103, 31A-3-304, and
4964 63J-1-504:
4965 (i) a fee for examining, investigating, and processing, by a department employee, of an
4966 application for a certificate of authority made by a captive insurance company;
4967 (ii) a fee for obtaining a certificate of authority for the year the captive insurance
4968 company is issued a certificate of authority by the department; and
4969 (iii) a certificate of authority renewal fee.
4970 (b) The commissioner may:
4971 (i) assign a department employee or retain legal, financial, and examination services
4972 from outside the department to perform the services described in:
4973 (A) Subsection (6)(a); and
4974 (B) Section 31A-37-502; and
4975 (ii) charge the reasonable cost of services described in Subsection (6)(b)(i) to the
4976 applicant captive insurance company.
4977 (7) If the commissioner is satisfied that the documents and statements filed by the
4978 applicant captive insurance company comply with this chapter, the commissioner may grant a
4979 certificate of authority authorizing the company to do insurance business in this state.
4980 (8) A certificate of authority granted under this section expires annually and shall be
4981 renewed by July 1 of each year.
4982 Section 51. Section **31A-37-204** is amended to read:
4983 **31A-37-204. Paid-in capital -- Other capital.**
4984 (1) (a) The commissioner may not issue a certificate of authority to a company
4985 described in Subsection (1)(c) unless the company possesses and thereafter maintains
4986 unimpaired paid-in capital and unimpaired paid-in surplus of:
4987 (i) in the case of a pure captive insurance company, not less than $250,000;
4988 (ii) in the case of an association captive insurance company [~~incorporated as a stock~~
4989 ~~insurer~~], not less than $750,000;

4990 (iii) in the case of an industrial insured captive insurance company incorporated as a
4991 stock insurer, not less than $700,000;
4992 (iv) in the case of a pool captive insurance company, not less than $250,000;
4993 [(iv)] (v) in the case of a sponsored captive insurance company, not less than
4994 $1,000,000, of which a minimum of $350,000 is provided by the sponsor; or
4995 [(v)] (vi) in the case of a special purpose captive insurance company, an amount
4996 determined by the commissioner after giving due consideration to the company's business plan,
4997 feasibility study, and pro-formas, including the nature of the risks to be insured.
4998 (b) The paid-in capital and surplus required under this Subsection (1) may be in the
4999 form of:
5000 (i) (A) cash; or
5001 (B) cash equivalent;
5002 (ii) an irrevocable letter of credit:
5003 (A) issued by:
5004 (I) a bank chartered by this state; or
5005 (II) a member bank of the Federal Reserve System; and
5006 (B) approved by the commissioner; [or]
5007 (iii) marketable securities as determined by [Subsections 31A-18-105(1) and (6).]
5008 Subsection (5); or
5009 (iv) some other thing of value approved by the commissioner, for a period not to
5010 exceed 45 days, to facilitate the formation of a captive insurance company in this state pursuant
5011 to an approved plan of liquidation and reorganization of another captive insurance company or
5012 alien captive insurance company in another jurisdiction.
5013 (c) This Subsection (1) applies to:
5014 (i) a pure captive insurance company;
5015 (ii) a sponsored captive insurance company;
5016 (iii) a special purpose captive insurance company;
5017 (iv) an association captive insurance company [incorporated as a stock insurer; or];
5018 (v) an industrial insured captive insurance company [incorporated as a stock insurer.];
5019 or
5020 (vi) a pool captive insurance company.

5021 (2) (a) The commissioner may, under Section 31A-37-106, prescribe additional capital
5022 based on the type, volume, and nature of insurance business transacted.
5023 (b) The capital prescribed by the commissioner under this Subsection (2) may be in the
5024 form of:
5025 (i) cash;
5026 (ii) an irrevocable letter of credit issued by:
5027 (A) a bank chartered by this state; or
5028 (B) a member bank of the Federal Reserve System; or
5029 (iii) marketable securities as determined by [~~Subsections 31A-18-105(1) and (6)~~]
5030 Subsection (5).
5031 (3) (a) Except as provided in Subsection (3)(c), a branch captive insurance company, as
5032 security for the payment of liabilities attributable to branch operations, shall, through its branch
5033 operations, establish and maintain a trust fund:
5034 (i) funded by an irrevocable letter of credit or other acceptable asset; and
5035 (ii) in the United States for the benefit of:
5036 (A) United States policyholders; and
5037 (B) United States ceding insurers under:
5038 (I) insurance policies issued; or
5039 (II) reinsurance contracts issued or assumed.
5040 (b) The amount of the security required under this Subsection (3) shall be no less than:
5041 (i) the capital and surplus required by this chapter; and
5042 (ii) the reserves on the insurance policies or reinsurance contracts, including:
5043 (A) reserves for losses;
5044 (B) allocated loss adjustment expenses;
5045 (C) incurred but not reported losses; and
5046 (D) unearned premiums with regard to business written through branch operations.
5047 (c) Notwithstanding the other provisions of this Subsection (3)[~~,~~]:
5048 (i) the commissioner may permit a branch captive insurance company that is required
5049 to post security for loss reserves on branch business by its reinsurer to reduce the funds in the
5050 trust account required by this section by the same amount as the security posted if the security
5051 remains posted with the reinsurer[~~.~~]; and

5052 (ii) a branch captive insurance company that is the result of the licensure of an alien
5053 captive insurance company that is not formed in an alien jurisdiction is not subject to the
5054 requirements of this Subsection (3).
5055 (4) (a) A captive insurance company may not pay the following without the prior
5056 approval of the commissioner:
5057 (i) a dividend out of capital or surplus in excess of the limits under Section
5058 16-10a-640; or
5059 (ii) a distribution with respect to capital or surplus in excess of the limits under Section
5060 16-10a-640.
5061 (b) The commissioner shall condition approval of an ongoing plan for the payment of
5062 dividends or other distributions on the retention, at the time of each payment, of capital or
5063 surplus in excess of:
5064 (i) amounts specified by the commissioner under Section 31A-37-106; or
5065 (ii) determined in accordance with formulas approved by the commissioner under
5066 Section 31A-37-106.
5067 [(5) Notwithstanding Subsection (1), a captive insurance company organized as a
5068 reciprocal insurer under this chapter may not be issued a certificate of authority unless the
5069 captive insurance company possesses and maintains unimpaired paid-in surplus of $1,000,000.]
5070 [(6) (a) The commissioner may prescribe additional unimpaired paid-in surplus based
5071 upon the type, volume, and nature of the insurance business transacted.]
5072 [(b) The unimpaired paid-in surplus required under this Subsection (6) may be in the
5073 form of an irrevocable letter of credit issued by:]
5074 [(i) a bank chartered by this state; or]
5075 [(ii) a member bank of the Federal Reserve System.]
5076 (5) For purposes of this section, marketable securities means:
5077 (a) a bond or other evidence of indebtedness of a governmental unit in the United
5078 States or Canada or any instrumentality of the United States or Canada; or
5079 (b) securities:
5080 (i) traded on one or more of the following exchanges in the United States:
5081 (A) New York;
5082 (B) American; or

5083 (C) NASDAQ;
5084 (ii) when no particular security, or a substantially related security, applied toward the
5085 required minimum capital and surplus requirement of Subsection (1) represents more than 50%
5086 of the minimum capital and surplus requirement; and
5087 (iii) when no group of up to four particular securities, consolidating substantially
5088 related securities, applied toward the required minimum capital and surplus requirement of
5089 Subsection (1) represents more than 90% of the minimum capital and surplus requirement.
5090 (6) Notwithstanding Subsection (5), to protect the solvency and liquidity of a captive
5091 insurance company, the commissioner may reject the application of specific assets or amounts
5092 of specific assets to satisfying the requirement of Subsection (1).
5093 Section 52. Section **31A-37-301** is amended to read:
5094 **31A-37-301. Formation.**
5095 (1) A pure captive insurance company, a pool captive insurance company, or a
5096 sponsored captive insurance company formed as a stock insurer shall be incorporated as a stock
5097 insurer with the capital of the pure captive insurance company, a pool captive insurance
5098 company, or a sponsored captive insurance company:
5099 (a) divided into shares; and
5100 (b) held by the stockholders of the pure captive insurance company, a pool captive
5101 insurance company, or a sponsored captive insurance company.
5102 (2) A pure captive insurance company, a pool captive insurance company, or a
5103 sponsored captive insurance company formed as a limited liability company shall be organized
5104 as a members' interest insurer with the capital of the pure captive insurance company or
5105 sponsored captive insurance company:
5106 (a) divided into interests; and
5107 (b) held by the members of the pure captive insurance company, a pool captive
5108 insurance company, or a sponsored captive insurance company.
5109 (3) An association captive insurance company or an industrial insured captive
5110 insurance company may be:
5111 (a) incorporated as a stock insurer with the capital of the association captive insurance
5112 company or industrial insured captive insurance company:
5113 (i) divided into shares; and

5114 (ii) held by the stockholders of the association captive insurance company or industrial
5115 insured captive insurance company;
5116 (b) incorporated as a mutual insurer without capital stock, with a governing body
5117 elected by the member organizations of the association captive insurance company or industrial
5118 insured captive insurance company; or
5119 [~~(c) organized as a reciprocal.~~]
5120 (c) organized as a limited liability company with the capital of the association captive
5121 insurance company or industrial insured captive insurance company:
5122 (i) divided into interests; and
5123 (ii) held by the members of the association captive insurance company or industrial
5124 insured captive insurance company.
5125 (4) A captive insurance company formed as a corporation may not have fewer than
5126 three incorporators of whom one shall be a resident of this state.
5127 (5) A captive insurance company formed as a limited liability company may not have
5128 fewer than three organizers of whom one shall be a resident of this state.
5129 (6) (a) Before a captive insurance company formed as a corporation files the
5130 corporation's articles of incorporation with the Division of Corporations and Commercial
5131 Code, the incorporators shall obtain from the commissioner a certificate finding that the
5132 establishment and maintenance of the proposed corporation will promote the general good of
5133 the state.
5134 (b) In considering a request for a certificate under Subsection (6)(a), the commissioner
5135 shall consider:
5136 (i) the character, reputation, financial standing, and purposes of the incorporators;
5137 (ii) the character, reputation, financial responsibility, insurance experience, and
5138 business qualifications of the officers and directors;
5139 (iii) any information in:
5140 (A) the application for a certificate of authority; or
5141 (B) the department's files; and
5142 (iv) other aspects that the commissioner considers advisable.
5143 (7) (a) Before a captive insurance company formed as a limited liability company files
5144 the limited liability company's certificate of organization with the Division of Corporations and

5145 Commercial Code, the limited liability company shall obtain from the commissioner a
5146 certificate finding that the establishment and maintenance of the proposed limited liability
5147 company will promote the general good of the state.
5148 (b) In considering a request for a certificate under Subsection (7)(a), the commissioner
5149 shall consider:
5150 (i) the character, reputation, financial standing, and purposes of the organizers;
5151 (ii) the character, reputation, financial responsibility, insurance experience, and
5152 business qualifications of the managers;
5153 (iii) any information in:
5154 (A) the application for a certificate of authority; or
5155 (B) the department's files; and
5156 (iv) other aspects that the commissioner considers advisable.
5157 (8) (a) A captive insurance company formed as a corporation shall file with the
5158 Division of Corporations and Commercial Code:
5159 (i) the captive insurance company's articles of incorporation;
5160 (ii) the certificate issued pursuant to Subsection (6); and
5161 (iii) the fees required by the Division of Corporations and Commercial Code.
5162 (b) The Division of Corporations and Commercial Code shall file both the articles of
5163 incorporation and the certificate described in Subsection (6) for a captive insurance company
5164 that complies with this section.
5165 (9) (a) A captive insurance company formed as a limited liability company shall file
5166 with the Division of Corporations and Commercial Code:
5167 (i) the captive insurance company's certificate of organization;
5168 (ii) the certificate issued pursuant to Subsection (7); and
5169 (iii) the fees required by the Division of Corporations and Commercial Code.
5170 (b) The Division of Corporations and Commercial Code shall file both the certificate
5171 of organization and the certificate described in Subsection (7) for a captive insurance company
5172 that complies with this section.
5173 (10) (a) The organizers of a captive insurance company formed as a reciprocal insurer
5174 shall obtain from the commissioner a certificate finding that the establishment and maintenance
5175 of the proposed association will promote the general good of the state.

5176 (b) In considering a request for a certificate under Subsection (10)(a), the
5177 commissioner shall consider:
5178 (i) the character, reputation, financial standing, and purposes of the incorporators;
5179 (ii) the character, reputation, financial responsibility, insurance experience, and
5180 business qualifications of the officers and directors;
5181 (iii) any information in:
5182 (A) the application for a certificate of authority; or
5183 (B) the department's files; and
5184 (iv) other aspects that the commissioner considers advisable.
5185 (11) (a) An alien captive insurance company that has received a certificate of authority
5186 to act as a branch captive insurance company shall obtain from the commissioner a certificate
5187 finding that:
5188 (i) the home [~~state~~] jurisdiction of the alien captive insurance company imposes
5189 statutory or regulatory standards in a form acceptable to the commissioner on companies
5190 transacting the business of insurance in that state; and
5191 (ii) after considering the character, reputation, financial responsibility, insurance
5192 experience, and business qualifications of the officers and directors of the alien captive
5193 insurance company, and other relevant information, the establishment and maintenance of the
5194 branch operations will promote the general good of the state.
5195 (b) After the commissioner issues a certificate under Subsection (11)(a) to an alien
5196 captive insurance company, the alien captive insurance company may register to do business in
5197 this state.
5198 (12) At least one of the members of the board of directors of a captive insurance
5199 company formed as a corporation shall be a resident of this state.
5200 (13) At least one of the managers of a limited liability company shall be a resident of
5201 this state.
5202 [~~(14) At least one of the members of the subscribers' advisory committee of a captive~~
5203 ~~insurance company formed as a reciprocal insurer shall be a resident of this state.~~]
5204 [~~(15)~~] (14) (a) A captive insurance company formed as a corporation under this chapter
5205 has the privileges and is subject to the provisions of the general corporation law as well as the
5206 applicable provisions contained in this chapter.

5207 (b) If a conflict exists between a provision of the general corporation law and a
5208 provision of this chapter, this chapter shall control.
5209 (c) Except as provided in Subsection [(15)] (14)(d), the provisions of this title
5210 pertaining to a merger, consolidation, conversion, mutualization, and redomestication apply in
5211 determining the procedures to be followed by a captive insurance company in carrying out any
5212 of the transactions described in those provisions.
5213 (d) Notwithstanding Subsection [(15)] (14)(c), the commissioner may waive or modify
5214 the requirements for public notice and hearing in accordance with rules adopted under Section
5215 31A-37-106.
5216 (e) If a notice of public hearing is required, but no one requests a hearing, the
5217 commissioner may cancel the public hearing.
5218 [(16)] (15) (a) A captive insurance company formed as a limited liability company
5219 under this chapter has the privileges and is subject to [Title 48, Chapter 2c, Utah Revised
5220 Limited Liability Company Act, or] Title 48, Chapter 3a, Utah Revised Uniform Limited
5221 Liability Company Act[, as appropriate pursuant to Section 48-3a-1405], as well as the
5222 applicable provisions in this chapter.
5223 (b) If a conflict exists between a provision of the limited liability company law and a
5224 provision of this chapter, this chapter controls.
5225 (c) The provisions of this title pertaining to a merger, consolidation, conversion,
5226 mutualization, and redomestication apply in determining the procedures to be followed by a
5227 captive insurance company in carrying out any of the transactions described in those
5228 provisions.
5229 (d) Notwithstanding Subsection [(16)] (15)(c), the commissioner may waive or modify
5230 the requirements for public notice and hearing in accordance with rules adopted under Section
5231 31A-37-106.
5232 (e) If a notice of public hearing is required, but no one requests a hearing, the
5233 commissioner may cancel the public hearing.
5234 [(17) (a) A captive insurance company formed as a reciprocal insurer under this chapter
5235 has the powers set forth in Section 31A-4-114 in addition to the applicable provisions of this
5236 chapter.]
5237 [(b) If a conflict exists between the provisions of Section 31A-4-114 and the provisions

5238 ~~of this chapter with respect to a captive insurance company, this chapter shall control.~~]

5239 [~~(c) To the extent a reciprocal insurer is made subject to other provisions of this title~~

5240 ~~pursuant to Section 31A-14-208, the provisions are not applicable to a reciprocal insurer~~

5241 ~~formed under this chapter unless the provisions are expressly made applicable to a captive~~

5242 ~~insurance company under this chapter.~~]

5243 [~~(d) In addition to the provisions of this Subsection (17), a captive insurance company~~

5244 ~~organized as a reciprocal insurer that is an industrial insured group has the privileges of Section~~

5245 ~~31A-4-114 in addition to applicable provisions of this title.~~]

5246 [~~(18)~~] (16) (a) The articles of incorporation or bylaws of a captive insurance company

5247 formed as a corporation may not authorize a quorum of a board of directors to consist of fewer

5248 than one-third of the fixed or prescribed number of directors as provided in Section

5249 16-10a-824.

5250 (b) The certificate of organization of a captive insurance company formed as a limited

5251 liability company may not authorize a quorum of a board of managers to consist of fewer than

5252 one-third of the fixed or prescribed number of directors required in Section 16-10a-824.

5253 Section 53. Section **31A-37-302** is amended to read:

5254 **31A-37-302. Investment requirements.**

5255 (1) (a) Except as provided in Subsection (1)(b), an association captive insurance

5256 company, a sponsored captive insurance company, and an industrial insured group shall

5257 comply with the investment requirements contained in this title.

5258 (b) Notwithstanding Subsection (1)(a) and any other provision of this title, the

5259 commissioner may approve the use of alternative reliable methods of valuation and rating

5260 under Section 31A-37-106 for:

5261 (i) an association captive insurance company;

5262 (ii) a sponsored captive insurance company; or

5263 (iii) an industrial insured group.

5264 (2) (a) Except as provided in Subsection (2)(b), a pure captive insurance company, a

5265 pool captive insurance company, or an industrial insured captive insurance company is not

5266 subject to any restrictions on allowable investments contained in this title.

5267 (b) Notwithstanding Subsection (2)(a), the commissioner may, under Section

5268 31A-37-106, prohibit or limit an investment that threatens the solvency or liquidity of:

5269 (i) a pure captive insurance company; [~~or~~]
5270 (ii) a pool captive insurance company; or
5271 [~~(ii)~~] (iii) an industrial insured captive insurance company.
5272 (3) (a) (i) Except as provided in Subsection (3)(a)(ii), a captive insurance company may
5273 not make loans to:
5274 (A) the parent company of the captive insurance company; or
5275 (B) an affiliate of the captive insurance company.
5276 (ii) Notwithstanding Subsection (3)(a)(i), a pure captive insurance company may make
5277 loans to:
5278 (A) the parent company of the pure captive insurance company; or
5279 (B) an affiliate of the pure captive insurance company.
5280 (b) A loan under Subsection (3)(a):
5281 (i) may be made only on the prior written approval of the commissioner; and
5282 (ii) shall be evidenced by a note in a form approved by the commissioner.
5283 (c) A pure captive insurance company may not make a loan from the paid-in capital
5284 required under Subsection 31A-37-204(1).
5285 Section 54. Section **31A-37-303** is amended to read:
5286 **31A-37-303. Reinsurance.**
5287 (1) A captive insurance company may cede risks to any insurance company approved
5288 by the commissioner. A captive insurance company may provide reinsurance, as authorized in
5289 this title, on risks ceded for the benefit of a parent, affiliate, or controlled unaffiliated business.
5290 (2) (a) A captive insurance company may take credit for reserves on risks or portions of
5291 risks ceded to reinsurers if the captive insurance company complies with Section 31A-17-404,
5292 31A-17-404.1, 31A-17-404.3, or 31A-17-404.4 or if the captive insurance company complies
5293 with other requirements as the commissioner may establish by rule made in accordance with
5294 Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
5295 (b) Unless the reinsurer is in compliance with Section 31A-17-404, 31A-17-404.1,
5296 31A-17-404.3, or 31A-17-404.4 or a rule adopted under Subsection (2)(a), a captive insurance
5297 company may not take credit for:
5298 (i) reserves on risks ceded to a reinsurer; or
5299 (ii) portions of risks ceded to a reinsurer.

5300 Section 55. Section **31A-37-304** is amended to read:

5301 **31A-37-304. Rating organization.**

5302 (1) A captive insurance company is not required to join a rating organization.

5303 (2) Notwithstanding Subsection (1), the commissioner may by rule, made in

5304 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, require a pool

5305 captive insurance company to be rated by a rating organization designated by the rule.

5306 Section 56. Section **31A-37-305** is amended to read:

5307 **31A-37-305. Contributions to guaranty or insolvency fund prohibited.**

5308 (1) A captive insurance company[, including a captive insurance company organized as

5309 a reciprocal insurer under this chapter,] may not join or contribute financially to any of the

5310 following in this state:

5311 (a) a plan;

5312 (b) a pool;

5313 (c) an association;

5314 (d) a guaranty fund; or

5315 (e) an insolvency fund.

5316 (2) A captive insurance company, the insured of a captive insurance company, the

5317 parent of a captive insurance company, an affiliate of a captive insurance company, or a

5318 member organization of an association captive insurance company[, or in the case of a captive

5319 insurance company organized as a reciprocal insurer, a subscriber of the captive insurance

5320 company,] may not receive a benefit from:

5321 (a) a plan;

5322 (b) a pool;

5323 (c) an association;

5324 (d) a guaranty fund for claims arising out of the operations of the captive insurance

5325 company; or

5326 (e) an insolvency fund for claims arising out of the operations of the captive insurance

5327 company.

5328 (3) Notwithstanding Subsections (1) and (2), a captive insurance company may

5329 conduct reinsurance related transactions with a pool captive insurance company as provided in

5330 Section 31A-37-303.

5331 Section 57. Section **31A-42-201** is amended to read:

5332 **31A-42-201. Creation of risk adjuster mechanism -- Board of directors --**

5333 **Appointment -- Terms -- Quorum -- Plan preparation.**

5334 (1) There is created the "Utah Defined Contribution Risk Adjuster," a nonprofit entity

5335 within the department.

5336 (2) (a) The risk adjuster is under the direction of a board of directors composed of up to

5337 nine members described in Subsection (2)(b).

5338 (b) The board of directors shall consist of:

5339 (i) the following directors appointed by the governor with the consent of the Senate:

5340 (A) at least [~~three~~] one, but up to five, directors with actuarial experience who

5341 represent insurers[~~: (I)~~] that are participating or have committed to participate in the defined

5342 contribution arrangement market in the state; [~~and~~]

5343 [~~(II) including at least one and up to two directors who represent an insurer that has a~~

5344 ~~small percentage of lives in the defined contribution market;~~]

5345 (B) one director who represents either an individual employee or employer; and

5346 (C) one director who represents the Office of Consumer Health Services within the

5347 Governor's Office of Economic Development;

5348 (ii) one director representing the Public Employees' Benefit and Insurance Program

5349 with actuarial experience, appointed by the director of the Public Employees' Benefit and

5350 Insurance Program; and

5351 (iii) the commissioner, or a representative of the commissioner who:

5352 (A) is appointed by the commissioner; and

5353 (B) has actuarial experience.

5354 (c) The commissioner, or a representative appointed by the commissioner may vote

5355 only in the event of a tie vote.

5356 (3) (a) Except as required by Subsection (3)(b), as terms of current board members

5357 appointed by the governor expire, the governor shall appoint each new member or reappointed

5358 member to a four-year term.

5359 (b) Notwithstanding the requirements of Subsection (3)(a), the governor shall, at the

5360 time of appointment or reappointment, adjust the length of terms to ensure that the terms of

5361 board members are staggered so that approximately half of the board is appointed every two

5362 years.
5363 (c) Notwithstanding the requirements of Subsection (3)(a), a board member shall
5364 continue to serve until the board member is reappointed or replaced by another individual in
5365 accordance with this section.
5366 (4) When a vacancy occurs in the membership for any reason, the replacement shall be
5367 appointed for the unexpired term in the same manner as the original appointment was made.
5368 (5) (a) A board member who is not a government employee may not receive
5369 compensation or benefits for the board member's services.
5370 (b) A state government member who is a board member because of the board member's
5371 state government position may not receive per diem or expenses for the member's service.
5372 (6) The board shall elect annually a chair and vice chair from its membership.
5373 (7) A majority of the board members is a quorum for the transaction of business.
5374 (8) The action of a majority of the members of the quorum is the action of the board.
5375 Section 58. Section **31A-44-603** is amended to read:
5376 **31A-44-603. Examinations.**
5377 (1) The department may conduct periodic on-site examinations of a provider.
5378 (2) In conducting an examination, the department or the department's staff:
5379 (a) shall have full and free access to all the provider's records; and
5380 (b) may summon and qualify as a witness, under oath, and examine, any director,
5381 officer, member, agent, or employee of the provider, and any other person, concerning the
5382 condition and affairs of the provider or a facility.
5383 (3) Books and records shall be kept for not less than three calendar years in addition to
5384 the current calendar year.
5385 [~~(3)~~] (4) The provider shall pay the reasonable costs of an examination under this
5386 section.
5387 [~~(4)~~] (5) The department may conduct an on-site examination in conjunction with an
5388 examination performed by a representative of an agency of another state.
5389 [~~(5)~~] (6) (a) The department, in lieu of an on-site examination, may accept the
5390 examination report of an agency of another state that has regulatory oversight of the provider,
5391 or a report prepared by an independent accounting firm.
5392 (b) A report accepted under Subsection [~~(5)~~] (6)(a) is considered for all purposes an

5393 official report of the department.

5394 [(6)] (7) Upon reasonable cause, the department may conduct an on-site examination of

5395 an unlicensed person to determine whether a violation of this chapter has occurred.

5396 Section 59. Section **53-2a-1102** is amended to read:

5397 **53-2a-1102. Search and Rescue Financial Assistance Program -- Uses --**

5398 **Rulemaking -- Distribution.**

5399 (1) (a) "Assistance card program" means the Utah Search and Rescue Assistance Card

5400 Program created within this section.

5401 (b) "Card" means the Search and Rescue Assistance Card issued under this section to a

5402 participant.

5403 (c) "Participant" means an individual, family, or group who is registered pursuant to

5404 this section as having a valid card at the time search, rescue, or both are provided.

5405 (d) "Program" means the Search and Rescue Financial Assistance Program created

5406 within this section.

5407 (e) (i) "Reimbursable expenses," as used in this section, means those reasonable

5408 expenses incidental to search and rescue activities.

5409 (ii) "Reimbursable expenses" include:

5410 (A) rental for fixed wing aircraft, helicopters, snowmobiles, boats, and generators;

5411 (B) replacement and upgrade of search and rescue equipment;

5412 (C) training of search and rescue volunteers;

5413 (D) costs of providing workers' compensation benefits for volunteer search and rescue

5414 team members under Section 67-20-7.5; and

5415 (E) any other equipment or expenses necessary or appropriate for conducting search

5416 and rescue activities.

5417 (iii) "Reimbursable expenses" do not include any salary or overtime paid to any person

5418 on a regular or permanent payroll, including permanent part-time employees of any agency of

5419 the state.

5420 (f) "Rescue" means search services, rescue services, or both search and rescue services.

5421 (2) There is created the Search and Rescue Financial Assistance Program within the

5422 division.

5423 (3) (a) The program shall be funded from the following revenue sources:

5424 (i) any voluntary contributions to the state received for search and rescue operations;
5425 (ii) money received by the state under Subsection (11) and under Sections 23-19-42,
5426 41-22-34, and 73-18-24; and
5427 (iii) appropriations made to the program by the Legislature.
5428 (b) All money received from the revenue sources in Subsections (3)(a)(i) and (ii) shall
5429 be deposited into the General Fund as a dedicated credit to be used solely for the purposes
5430 under this section.
5431 (c) All funding for the program is nonlapsing.
5432 (4) The director shall use the money to reimburse counties for all or a portion of each
5433 county's reimbursable expenses for search and rescue operations, subject to:
5434 (a) the approval of the Search and Rescue Advisory Board as provided in Section
5435 53-2a-1104;
5436 (b) money available in the program; and
5437 (c) rules made under Subsection (7).
5438 (5) Program money may not be used to reimburse for any paid personnel costs or paid
5439 man hours spent in emergency response and search and rescue related activities.
5440 (6) The Legislature finds that these funds are for a general and statewide public
5441 purpose.
5442 (7) The division, with the approval of the Search and Rescue Advisory Board, shall
5443 make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and
5444 consistent with this section:
5445 (a) specifying the costs that qualify as reimbursable expenses;
5446 (b) defining the procedures of counties to submit expenses and be reimbursed;
5447 (c) defining a participant in the assistance card program, including:
5448 (i) individuals; and
5449 (ii) families and organized groups who qualify as participants;
5450 (d) defining the procedure for issuing a card to a participant;
5451 (e) defining excluded expenses that may not be reimbursed under the program,
5452 including medical expenses;
5453 (f) establishing the card renewal cycle for the Utah Search and Rescue Assistance Card
5454 Program;

5455 (g) establishing the frequency of review of the fee schedule;
5456 (h) providing for the administration of the program; and
5457 (i) providing a formula to govern the distribution of available money among the
5458 counties for uncompensated search and rescue expenses based on:
5459 (i) the total qualifying expenses submitted;
5460 (ii) the number of search and rescue incidents per county population;
5461 (iii) the number of victims that reside outside the county; and
5462 (iv) the number of volunteer hours spent in each county in emergency response and
5463 search and rescue related activities per county population.
5464 (8) (a) The division shall, in consultation with the Outdoor Recreation Office, establish
5465 the fee schedule of the Search and Rescue Assistance Card under Subsection 63J-1-504(6).
5466 (b) The division shall provide a discount of not less than 10% of the card fee under
5467 Subsection (8)(a) to a person who has paid a fee under Section 23-19-42, 41-22-34, or
5468 73-18-24 during the same calendar year in which the person applies to be a participant in the
5469 assistance card program.
5470 (9) (a) Counties may bill reimbursable expenses to an individual for costs incurred for
5471 the rescue of an individual, if the individual is not a participant in the Utah Search and Rescue
5472 Assistance Card Program.
5473 (b) Counties may bill a participant for reimbursable expenses for costs incurred for the
5474 rescue of the participant if the participant is found by the rescuing county to have acted
5475 recklessly or to have intentionally created a situation resulting in the need for a county to
5476 provide rescue service for the participant.
5477 (10) (a) There is created the Utah Search and Rescue Assistance Card Program. The
5478 program is located within the division.
5479 (b) The program may not be utilized to cover any expenses, such as medically related
5480 expenses, that are not reimbursable expenses related to the rescue.
5481 (11) (a) To participate in the program, a person shall purchase a Search and Rescue
5482 Assistance Card from the division by paying the fee as determined by the division in
5483 Subsection (8).
5484 (b) The money generated by the fees shall be deposited into the General Fund as a
5485 dedicated credit for the Search and Rescue Financial Assistance Program created in this

5486 section.
5487 (c) Participation and payment of fees by a person under Sections 23-19-42, 41-22-34,
5488 and 73-18-24 do not constitute purchase of a card under this section.
5489 (12) The division shall consult with the Outdoor Recreation Office regarding:
5490 (a) administration of the assistance card program; and
5491 (b) outreach and marketing strategies.
5492 (13) Pursuant to Subsection 31A-1-103(7), the Utah Search and Rescue Assistance
5493 Card Program under this section is exempt from being considered [~~an~~] insurance [~~program~~
5494 ~~under Subsection~~] as defined in Section 31A-1-301[~~(86)~~].
5495 Section 60. Section **63G-2-302** is amended to read:
5496 **63G-2-302. Private records.**
5497 (1) The following records are private:
5498 (a) records concerning an individual's eligibility for unemployment insurance benefits,
5499 social services, welfare benefits, or the determination of benefit levels;
5500 (b) records containing data on individuals describing medical history, diagnosis,
5501 condition, treatment, evaluation, or similar medical data;
5502 (c) records of publicly funded libraries that when examined alone or with other records
5503 identify a patron;
5504 (d) records received by or generated by or for:
5505 (i) the Independent Legislative Ethics Commission, except for:
5506 (A) the commission's summary data report that is required under legislative rule; and
5507 (B) any other document that is classified as public under legislative rule; or
5508 (ii) a Senate or House Ethics Committee in relation to the review of ethics complaints,
5509 unless the record is classified as public under legislative rule;
5510 (e) records received by, or generated by or for, the Independent Executive Branch
5511 Ethics Commission, except as otherwise expressly provided in Title 63A, Chapter 14, Review
5512 of Executive Branch Ethics Complaints;
5513 (f) records received or generated for a Senate confirmation committee concerning
5514 character, professional competence, or physical or mental health of an individual:
5515 (i) if, prior to the meeting, the chair of the committee determines release of the records:
5516 (A) reasonably could be expected to interfere with the investigation undertaken by the

5517 committee; or

5518 (B) would create a danger of depriving a person of a right to a fair proceeding or

5519 impartial hearing; and

5520 (ii) after the meeting, if the meeting was closed to the public;

5521 (g) employment records concerning a current or former employee of, or applicant for

5522 employment with, a governmental entity that would disclose that individual's home address,

5523 home telephone number, social security number, insurance coverage, marital status, or payroll

5524 deductions;

5525 (h) records or parts of records under Section 63G-2-303 that a current or former

5526 employee identifies as private according to the requirements of that section;

5527 (i) that part of a record indicating a person's social security number or federal employer

5528 identification number if provided under Section 31A-23a-104, 31A-25-202, 31A-26-202,

5529 58-1-301, 58-55-302, 61-1-4, or 61-2f-203;

5530 (j) that part of a voter registration record identifying a voter's:

5531 (i) driver license or identification card number;

5532 (ii) Social Security number, or last four digits of the Social Security number;

5533 (iii) email address; or

5534 (iv) date of birth;

5535 (k) a voter registration record that is classified as a private record by the lieutenant

5536 governor or a county clerk under Subsection 20A-2-104(4)(f) or 20A-2-101.1(5)(a);

5537 (l) a record that:

5538 (i) contains information about an individual;

5539 (ii) is voluntarily provided by the individual; and

5540 (iii) goes into an electronic database that:

5541 (A) is designated by and administered under the authority of the Chief Information

5542 Officer; and

5543 (B) acts as a repository of information about the individual that can be electronically

5544 retrieved and used to facilitate the individual's online interaction with a state agency;

5545 (m) information provided to the Commissioner of Insurance under:

5546 (i) Subsection 31A-23a-115[~~(2)~~](3)(a);

5547 (ii) Subsection 31A-23a-302[~~(3)~~](4); or

5548 (iii) Subsection 31A-26-210[(3)](4);
5549 (n) information obtained through a criminal background check under Title 11, Chapter
5550 40, Criminal Background Checks by Political Subdivisions Operating Water Systems;
5551 (o) information provided by an offender that is:
5552 (i) required by the registration requirements of Title 77, Chapter 41, Sex and Kidnap
5553 Offender Registry; and
5554 (ii) not required to be made available to the public under Subsection 77-41-110(4);
5555 (p) a statement and any supporting documentation filed with the attorney general in
5556 accordance with Section 34-45-107, if the federal law or action supporting the filing involves
5557 homeland security;
5558 (q) electronic toll collection customer account information received or collected under
5559 Section 72-6-118 and customer information described in Section 17B-2a-815 received or
5560 collected by a public transit district, including contact and payment information and customer
5561 travel data;
5562 (r) an email address provided by a military or overseas voter under Section
5563 20A-16-501;
5564 (s) a completed military-overseas ballot that is electronically transmitted under Title
5565 20A, Chapter 16, Uniform Military and Overseas Voters Act;
5566 (t) records received by or generated by or for the Political Subdivisions Ethics Review
5567 Commission established in Section 11-49-201, except for:
5568 (i) the commission's summary data report that is required in Section 11-49-202; and
5569 (ii) any other document that is classified as public in accordance with Title 11, Chapter
5570 49, Political Subdivisions Ethics Review Commission;
5571 (u) a record described in Subsection 53A-11a-203(3) that verifies that a parent was
5572 notified of an incident or threat; and
5573 (v) a criminal background check or credit history report conducted in accordance with
5574 Section 63A-3-201.
5575 (2) The following records are private if properly classified by a governmental entity:
5576 (a) records concerning a current or former employee of, or applicant for employment
5577 with a governmental entity, including performance evaluations and personal status information
5578 such as race, religion, or disabilities, but not including records that are public under Subsection

5579 63G-2-301(2)(b) or 63G-2-301(3)(o) or private under Subsection (1)(b);

5580 (b) records describing an individual's finances, except that the following are public:

5581 (i) records described in Subsection 63G-2-301(2);

5582 (ii) information provided to the governmental entity for the purpose of complying with

5583 a financial assurance requirement; or

5584 (iii) records that must be disclosed in accordance with another statute;

5585 (c) records of independent state agencies if the disclosure of those records would

5586 conflict with the fiduciary obligations of the agency;

5587 (d) other records containing data on individuals the disclosure of which constitutes a

5588 clearly unwarranted invasion of personal privacy;

5589 (e) records provided by the United States or by a government entity outside the state

5590 that are given with the requirement that the records be managed as private records, if the

5591 providing entity states in writing that the record would not be subject to public disclosure if

5592 retained by it;

5593 (f) any portion of a record in the custody of the Division of Aging and Adult Services,

5594 created in Section 62A-3-102, that may disclose, or lead to the discovery of, the identity of a

5595 person who made a report of alleged abuse, neglect, or exploitation of a vulnerable adult; and

5596 (g) audio and video recordings created by a body-worn camera, as defined in Section

5597 77-7a-103, that record sound or images inside a home or residence except for recordings that:

5598 (i) depict the commission of an alleged crime;

5599 (ii) record any encounter between a law enforcement officer and a person that results in

5600 death or bodily injury, or includes an instance when an officer fires a weapon;

5601 (iii) record any encounter that is the subject of a complaint or a legal proceeding

5602 against a law enforcement officer or law enforcement agency;

5603 (iv) contain an officer involved critical incident as defined in Section 76-2-408(1)(d);

5604 or

5605 (v) have been requested for reclassification as a public record by a subject or

5606 authorized agent of a subject featured in the recording.

5607 (3) (a) As used in this Subsection (3), "medical records" means medical reports,

5608 records, statements, history, diagnosis, condition, treatment, and evaluation.

5609 (b) Medical records in the possession of the University of Utah Hospital, its clinics,

5610 doctors, or affiliated entities are not private records or controlled records under Section
5611 63G-2-304 when the records are sought:
5612 (i) in connection with any legal or administrative proceeding in which the patient's
5613 physical, mental, or emotional condition is an element of any claim or defense; or
5614 (ii) after a patient's death, in any legal or administrative proceeding in which any party
5615 relies upon the condition as an element of the claim or defense.
5616 (c) Medical records are subject to production in a legal or administrative proceeding
5617 according to state or federal statutes or rules of procedure and evidence as if the medical
5618 records were in the possession of a nongovernmental medical care provider.
5619 Section 61. **Repealer.**
5620 This bill repeals:
5621 Section **31A-22-715, Alcohol and drug dependency treatment.**
5622 Section **31A-22-718, Dependent coverage.**
5623 Section **31A-37-306, Conversion or merger.**

Legislative Review Note

The Utah Legislature's Joint Rule 4-2-402 requires legislative general counsel to place a legislative review note on legislation. The Legislative Management Committee has further directed legislative general counsel to include legal analysis in the legislative review note only if legislative general counsel determines there is a high probability that a court would declare the legislation to be unconstitutional under the Utah Constitution, the United States Constitution, or both. As explained in the legal analysis below, legislative general counsel has determined, based on applicable state and federal constitutional language and current interpretations of that language in state and federal court case law, that this legislation has a high probability of being declared unconstitutional by a court.

The bill provides confidentiality protections related to certain information concerning assessment of an entity's own risk and solvency stating that specified information may not be subject to subpoena, and may not be subject to discovery or admissible in evidence in any private civil action. Another example of these confidentiality protections includes providing that the insurance commissioner or any person who received a document, material, or other information related to an own risk and solvency assessment, through examination or otherwise, while acting under the authority of the commissioner or with whom the document, material, or other information is shared pursuant to this chapter may not be permitted or required to testify in any private civil action concerning any confidential document, material, or information.

The above described confidentiality protections create rules of procedure or evidence. Utah Constitution, Article VIII, section 4 "expressly empowers the Supreme Court to 'adopt rules of procedure and evidence to be used in the courts of the state.'" *Jones v. Univ. of Utah Health Sci. Ctr,* No. 100419242 (Utah 3d Dist. Ct. Jan. 13, 2012). The Utah Supreme Court explains that "[s]tatutes are 'purely procedural only where they provide a 'different mode or form of procedure for enacting substantive rights....Procedural laws are 'concerned solely with the judicial process.'" *State v. Drej,* 233 P.3d 476, 484 (Utah 2010)(citations omitted). Although the bill provides that the information is proprietary and contains trade secrets, it creates procedural laws concerned with the judicial process. This violates separation of powers. *See Jones v. Univ. of Utah Health Sci,* No. 100419242. The Utah Supreme Court has provided that "[w]hile the Legislature has the constitutional authority to amend the Rules of Procedure and Evidence adopted by the Utah Supreme Court, it may only do so by joint resolution adopted 'upon a vote of two-thirds of all members of both houses of the Legislature.'" *Allred v. Saunders,* 342 P.3d 204, 206 n.2 (Utah 2014)(citations omitted). *See also, State v. Walker,* 358 P.3d 1120, 1122-1123 (Utah 2015). Persons can also request that the courts amend rules of procedure and evidence. The Insurance Department successfully petitioned the courts to enact rules of evidence with similar confidentiality requirements in Utah R. Evid. Rule 511, Insurance regulators. If the rules of procedure or evidence are not amended to address the confidentiality protections in this bill, there is a high probability that the confidentiality provisions would be struck down as unconstitutional.

Office of Legislative Research and General Counsel