INSURANCE LAW AMENDMENTS

2000 GENERAL SESSION

STATE OF UTAH

Sponsor: L. Steven Poulton

AN ACT RELATING TO INSURANCE; GRANTING RULEMAKING AUTHORITY; CLARIFYING LANGUAGE ADDRESSING PENALTIES FOR CERTAIN IMPROPER TRANSACTIONS OR PENALTIES; ADDRESSING INCORPORATION BY REFERENCE; ADDRESSING RESCINDING POLICIES; INCLUDING APPLICATIONS UNDER CERTAIN FORM REQUIREMENTS; AMENDING GRACE PERIOD REQUIREMENTS; ADDRESSING LIFE INSURANCE BENEFITS IN THE CASE OF SUICIDE; ADDRESSING MATERNITY BENEFITS; ADDRESSING REQUIRED DISCLOSURES OF DISABILITY INSURERS; ADDRESSING MASTECTOMY COVERAGE; ADDRESSING MENTAL HEALTH PARITY; ADDRESSING SIGNATURE REQUIREMENT FOR FORMS LISTING AGENTS; AMENDING PROVISIONS RELATED TO THE COMPREHENSIVE HEALTH INSURANCE POOL ACT; ADDRESSING SETTING RATES FOR THE POOL; ADDRESSING PREEXISTING CONDITIONS; MAKING TECHNICAL CORRECTIONS; AND PROVIDING A COORDINATION CLAUSE.

This act affects sections of Utah Code Annotated 1953 as follows:

AMENDS:

31A-4-115, as enacted by Chapter 329, Laws of Utah 1998

31A-16-111, as last amended by Chapter 131, Laws of Utah 1999

31A-18-106, as last amended by Chapter 131, Laws of Utah 1999

31A-21-105, as last amended by Chapter 204, Laws of Utah 1986

31A-21-106, as last amended by Chapter 153, Laws of Utah 1996

31A-21-201, as last amended by Chapter 230, Laws of Utah 1992

31A-22-402, as enacted by Chapter 242, Laws of Utah 1985

31A-22-404, as enacted by Chapter 242, Laws of Utah 1985

31A-22-513, as enacted by Chapter 242, Laws of Utah 1985

31A-22-613.5, as last amended by Chapter 13, Laws of Utah 1998

31A-23-219, as last amended by Chapter 293, Laws of Utah 1998

31A-25-205, as enacted by Chapter 242, Laws of Utah 1985

31A-29-111, as last amended by Chapter 329, Laws of Utah 1998

31A-29-117, as last amended by Chapter 265, Laws of Utah 1997

31A-30-107, as last amended by Chapter 329, Laws of Utah 1998

ENACTS:

31A-2-201.1, Utah Code Annotated 1953

31A-22-610.2, Utah Code Annotated 1953

31A-22-625, Utah Code Annotated 1953

31A-22-719, Utah Code Annotated 1953

31A-22-720, Utah Code Annotated 1953

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

Section 1. Section **31A-2-201.1** is enacted to read:

31A-2-201.1. General filing requirements.

Except as otherwise provided in this title, the commissioner may set by rule made in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, specific requirements for filing any of the following required by this title:

(1) a form;

(2) a rate; or

(3) a report.

Section 2. Section **31A-4-115** is amended to read:

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

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

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

(a) indicate the date the insurer intends to begin and complete its withdrawal plan; and

(b) include provisions for:

(i) meeting the insurer's contractual obligations;

(ii) providing services to its Utah policyholders and claimants; and

(iii) meeting any applicable statutory obligations.

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

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

(b) meet its contractual obligations;

(c) provide service to its Utah policyholders and claimants; and

(d) meet any applicable statutory obligations.

(4) [~~The provisions of~~] Section 31A-2-302 [~~govern~~] governs the commissioner's approval or disapproval of a plan for orderly withdrawal.

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

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

(b) the insurer:

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

(ii) intends to:

(A) withdraw from writing a line of insurance in this state; or [~~to~~]

(B) reduce its total annual premium volume by 75% or more.

(6) An insurer that withdraws from writing insurance in this state or that reduces its total annual premium volume by 75% or more in any year without having submitted a plan or receiving the commissioner's approval is subject to the civil penalties under Section 31A-2-308.

(7) An insurer that withdraws from writing all lines of insurance in this state may not resume writing insurance in this state for five years without:

(a) the approval of the commissioner; and

(b) complying with Subsection [~~31A-30-109~~] 31A-30-108(5), if applicable.

(8) The commissioner shall adopt rules necessary to implement the provisions of this section.

Section 3. Section **31A-16-111** is amended to read:

31A-16-111. Required sale of improperly acquired stock -- Penalties.

(1) If the commissioner finds that the acquiring person has not substantially complied with the requirements of this chapter in acquiring control of a domestic insurer, the commissioner may require the acquiring person to sell the acquiring person's stock of the domestic insurer in the manner specified in Subsection (2).

(2) (a) The commissioner shall effect the sale required by Subsection (1) in the manner which, under the particular circumstances, appears most likely to result in the payment of the full market value for the stock by persons who have the collective competence, experience, financial resources, and integrity to obtain approval under Subsection 31A-16-103(8).

(b) Sales made under this section are subject to approval by the Third Judicial District Court for Salt Lake County, which court has the authority to effect the terms of the sale.

(3) The proceeds from sales made under this section shall be distributed first to the person required by this section to sell the stock, but only up to the amount originally paid by the person for the securities. Additional sale proceeds shall be paid to the General Fund.

(4) The person required to sell and persons related to or affiliated with the seller may not purchase the stock at the sale conducted under this section.

(5) (a) [~~Every~~] A director or officer of an insurance holding company system [~~who~~] violates this chapter if the director or officer knowingly [~~violates,~~]:

(i) participates in[~~,~~] or assents to[~~, or who knowingly permits any of the officers or agents of the insurer to engage in transactions~~] a transaction or [~~make investments~~] investment that [~~have~~]:

(A) has not been properly reported or submitted pursuant to:

(I) Subsections 31A-16-105 (1) and (2)[~~,~~]; or

(II) Subsection 31A-16-106 (1)(b)[~~,~~]; or [~~which~~]

(B) otherwise [~~violate~~] violates this chapter[~~,~~]; or

(ii) permits any of the officers or agents of the insurer to engage in a transaction or investment described in Subsection (5)(a)(i).

(b) A director or officer in violation of Subsection (5)(a) shall pay, in [~~their~~] the director's or officer's individual capacity, a civil penalty of not more than $20,000 per violation[~~,~~]:

(i) upon a finding by the commissioner of a violation[~~,~~]; and

(ii) after notice and hearing before the commissioner.

[~~(b)~~] (c) In determining the amount of the civil penalty under Subsection (5)[~~(a)~~](b), the commissioner shall take into account:

(i) the appropriateness of the penalty with respect to the gravity of the violation;

(ii) the history of previous violations; and

(iii) any other matters that justice requires.

(6) (a) When it appears to the commissioner that any insurer or any director, officer, employee, or agent of the insurer, has committed a willful violation of this chapter, the commissioner may cause criminal proceedings to be instituted:

(i) (A) in the district court for the county in this state in which the principal office of the insurer is located[~~,~~]; or

(B) if the insurer has no principal office in this state, [~~then~~] in the Third District Court for Salt Lake County; and

(ii) against the insurer or the responsible director, officer, employee, or agent of the insurer.

(b) (i) An insurer that willfully violates this chapter may be fined not more than $20,000.

(ii) Any individual who willfully violates this chapter is guilty of a third degree felony, and upon conviction may be:

[~~(i)~~] (A) fined in that person's individual capacity not more than $5,000;

[~~(ii)~~] (B) imprisoned; or

[~~(iii)~~] (C) both fined and imprisoned.

(7) This section does not limit the other sanctions applicable to violations of this title under Section 31A-2-308.

Section 4. Section **31A-18-106** is amended to read:

31A-18-106. Investment limitations generally applicable.

(1) The investment limitations listed in Subsections (1)(a) through (l) apply to each insurer.

(a) (i) Except as provided in Subsection (1)(a)(ii), for investments authorized under Subsection 31A-18-105(1) that are not amortizable under applicable valuation rules, the limitation is 5% of assets.

(ii) The limitation of Subsection (1)(a)(i) and the limitation of Subsection (2) do not apply to demand deposits and certificates of deposit in solvent banks and savings and loan institutions to the extent they are insured by a federal deposit insurance agency.

(b) For investments authorized under Subsection 31A-18-105(2), the limitation is 10% of assets.

(c) For investments authorized under Subsection 31A-18-105(3), the limitation is 50% of assets.

(d) For investments authorized under Subsection 31A-18-105(4), that are considered to be investments in kinds of securities or evidences of debt pledged, those investments are subject to the class limitations applicable to the pledged securities or evidences of debt.

(e) For investments authorized under Subsection 31A-18-105(5), the limitation is 35% of assets.

(f) For investments authorized under Subsection 31A-18-105(6), the limitation is:

(i) 20% of assets for life insurers; and

(ii) 50% of assets for nonlife insurers.

(g) For investments authorized under Subsection 31A-18-105(7), the limitation is 5% of assets, except as to insurers organized and operating under Chapter 7, in which case the limitation is 25% of assets.

(h) For investments authorized under Subsection 31A-18-105(8), the limitation is 20% of assets inclusive of home office and branch office properties, except as to insurers organized and operating under Chapter 7, in which case the limitation is 35% of assets, inclusive of home office and branch office properties.

(i) For investments authorized under Subsection 31A-18-105(10), the limitation is 1% of assets.

(j) For investments authorized under Subsection 31A-18-105(11), the limitation is the greater

of that permitted or required for compliance with Section 31A-18-103.

(k) Except as provided in Subsection (1)(l), an insurer's investments in subsidiaries is limited to 50% of the insurer's total adjusted [~~capitol~~] capital. Investments by an insurer in its subsidiaries includes:

(i) the insurer's loans, advances, and contributions to its subsidiaries; and

(ii) the insurer's holding of bonds, notes, and stocks of its subsidiaries are included.

(l) Under a plan of merger approved by the commissioner, the commissioner may allow an insurer any portion of its assets invested in an insurance subsidiary. The approved plan of merger shall require the acquiring insurer to conform its accounting for investments in subsidiaries to Subsection (1)(k) within a specified period that may not exceed five years.

(2) The limits on investments listed in Subsections (2)(a) through (e) apply to each insurer.

(a) For all investments in a single entity, its affiliates, and subsidiaries, the limitation is 10% of assets, except that the limit imposed by this Subsection (2)(a) does not apply to:

(i) investments in the government of the United States or its agencies;

(ii) investments guaranteed by the government of the United States; or

(iii) investments in the insurer's insurance subsidiaries.

(b) Investments authorized by Subsection 31A-18-105(3) shall comply with the requirements listed in this Subsection (2)(b).

(i) (A) Except as provided in Subsection (2)(b)(i), the amount of any loan secured by a mortgage or deed of trust may not exceed 80% of the value of the real estate interest mortgaged, unless the excess over 80%:

(I) is insured or guaranteed by the United States, any state of the United States, any instrumentality, agency, or political subdivision of the United States, any of its states, or a combination of any of these; or

(II) insured by an insurer approved by the commissioner and qualified to insure that type of risk in this state.

(B) Mortgage loans representing purchase money mortgages acquired from the sale of real estate are not subject to the limitation of Subsection (2)(b)(i)(A).

(ii) Subject to Subsection (2)(b)(v), loans or evidences of debt secured by real estate may only be secured by unencumbered real property, or an unencumbered interest in real property that is located in the United States.

(iii) Evidence of debt secured by first mortgages or deeds of trust upon leasehold estates shall require that:

(A) the leasehold estate exceed the maturity of the loan by not less than 10% of the lease term;

(B) the real estate not be otherwise encumbered; and

(C) the mortgagee is entitled to be subrogated to all rights under the leasehold.

(iv) Subject to Subsection (2)(b)(v):

(A) participation in any mortgage loan must:

(I) be senior to other participants; and

(II) give the holder substantially the rights of a first mortgagee; or

(B) the interest of the insurer in the evidence of indebtedness must be of equal priority, to the extent of the interest, with other interests in the real property.

(v) A fee simple or leasehold real estate or any interest in either of them is not considered to be encumbered within the meaning of this chapter by reason of any prior mortgage or trust deed held or assumed by the insurer as a lien on the property, if:

(A) the total of the mortgages or trust deeds held does not exceed 70% of the value of the property; and

(B) the security created by the prior mortgage or trust deed is a first lien.

(c) Loans permitted under Subsection 31A-18-105(4) may not exceed 75% of the market value of the collateral pledged, except that loans upon the pledge of United States government bonds may be equal to the market values of the pledge.

(d) For an equity interest in a single real estate property authorized under Subsection 31A-18-105(8), the limitation is 5% of assets.

(e) Investments authorized under Subsection 31A-18-105(10) shall be in connection with potential changes in the value of specifically identified:

(i) assets which the insurer owns; or

(ii) liabilities which the insurer has incurred.

(3) The restrictions on investments listed in Subsections (3)(a) and (b) apply to each insurer.

(a) Except for financial futures contracts and real property acquired and occupied by the insurer for home and branch office purposes, a security or other investment is not eligible for purchase or acquisition under this chapter unless it is:

(i) interest bearing or income paying; and

(ii) not then in default.

(b) A security is not eligible for purchase at a price above its market value.

(4) Computation of percentage limitations under this section:

(a) is based only upon the insurer's total qualified invested assets described in Section 31A-18-105 and this section, as these assets are valued under Section 31A-17-401; and

(b) excludes investments permitted under Section 31A-18-108 and Subsections 31A-17-203(2) and (3).

(5) An insurer may not make an investment that, because the investment does not conform to Section 31A-18-105 and this section, has the result of rendering the insurer, under Chapter 17, Part VI, Risk-Based Capital, subject to proceedings under Chapter 27.

(6) A pattern of persistent deviation from the investment diversification standards set forth in Section 31A-18-105 and this section may be grounds for a finding that the person or persons with authority to make the insurer's investment decisions are "incompetent" as used in Subsection 31A-5-410(3).

(7) Section 77r-1 of the Secondary Mortgage Market Enhancement Act of 1984 does not apply to the purchase, holding, investment, or valuation limitations of assets of insurance companies subject to this chapter.

Section 5. Section **31A-21-105** is amended to read:

31A-21-105. Representations, warranties, and conditions.

(1) (a) No statement, representation, or warranty made by any person representing the insurer in the negotiation for an individual or franchise insurance contract affects the insurer's obligations

under the policy unless it is stated in the policy or in a written application signed by the applicant. No person, except the applicant or another by his written consent, may alter the application, except for administrative purposes in a way which is clearly not ascribable to the applicant.

(b) No statement, representation, or warranty made by or on behalf of a particular certificate holder under a group policy affects the insurer's obligations under the certificate unless it is stated in the certificate or in a written document signed by the certificate holder, and a copy of it is supplied to the certificate holder.

(c) The policyholder, his assignee, the loss payee or mortgagee or lienholder under property insurance, and any person whose life or health is insured under a policy may request, in writing, from the company a copy of the application, if he did not receive the policy or a copy of it, or if the policy has been reinstated or renewed without the attachment of a copy of the original application. If the insurer does not deliver or mail a copy as requested within 30 days after receipt of the request by the insurer or its agent, or in the case of a group policy certificate holder, does not inform that person within the same period how he may inspect the policy or a copy of it and application or enrollment card or a copy of it during normal business hours at a place reasonably convenient to the certificate holder, nothing in the application or enrollment card affects the insurer's obligations under the policy to the person making the request. Each person whose life or health is insured under a group policy has the same right to request a copy of any document under Subsection (1) (b).

(2) Except as provided in Subsection (5), no misrepresentation or breach of an affirmative warranty affects the insurer's obligations under the policy unless:

(a) the insurer relies on it and it is either material or is made with intent to deceive; or

(b) the fact misrepresented or falsely warranted contributes to the loss.

(3) No failure of a condition prior to the loss and no breach of a promissory warranty affects the insurer's obligations under the policy unless it exists at the time of the loss and either increases the risk at the time of the loss or contributes to the loss. This Subsection (3) does not apply to failure to tender payment of premium.

(4) Nondisclosure of information not requested by the insurer is not a defense to an action against the insurer. Failure to correct within a reasonable time any representation that becomes

incorrect because of changes in circumstances is misrepresentation, not nondisclosure.

(5) If after issuance of a policy the insurer acquires knowledge of sufficient facts to constitute a general defense to all claims under the policy, the defense is only available if the insurer notifies the insured within 60 days after acquiring the knowledge of its intention to defend against a claim if one should arise, or within 120 days if the insurer considers it necessary to secure additional medical information and is actively seeking the information at the end of the 60 days. The insurer and insured may mutually agree to a policy rider in order to continue the policy in force with exceptions or modifications. For purposes of this Subsection (5), an insurer has acquired knowledge only if the information alleged to give rise to the knowledge was disclosed to the insurer or its agent in connection with communications or investigations associated with the insurance policy under which the subject claim arises.

(6) (a) An insurer that offers coverage to a small employer group as required by P.L. 104-91, 110 Stat. 1979, Sec. 2711(a), may not rescind a policy or individual certificate holder based on application misrepresentation unless the insurer would not have been required to issue the coverage in the absence of the misrepresentation.

(b) Subsection (6)(a) does not prevent an insurer from correcting rates if:

(i) in the absence of misrepresentation a different rate would have been required; and

(ii) the corrected rates are in compliance with Section 31A-30-106.

[~~(6)~~] (7) No trivial or transitory breach of or noncompliance with any provision of this chapter is a basis for avoiding an insurance contract.

Section 6. Section **31A-21-106** is amended to read:

31A-21-106. Incorporation by reference.

(1) (a) Except as provided in Subsection (1)(b), an insurance policy may not contain any agreement or incorporate any provision not fully set forth in the policy or in an application or other document attached to and made a part of the policy at the time of its delivery, unless the policy, application, or agreement accurately reflects the terms of the incorporated agreement, provision, or attached document.

(b) (i) A policy may by reference incorporate rate schedules and classifications of risks and

short-rate tables filed with the commissioner.

(ii) By rule or order, the commissioner may authorize incorporation by reference of provisions for administrative arrangements, premium schedules, and payment procedures for complex contracts.

(c) (i) A policy of title insurance insuring the mortgage or deed of trust of an institutional lender may, if requested by an institutional lender, incorporate by reference generally applicable policy terms that are contained in a specifically identified policy that has been filed with the commissioner.

(ii) As used in Subsection (1)(c)(i), "institutional lender" means a person that regularly engages in the business of making loans secured by real estate.

(d) A policy may incorporate by reference the following by citing in the policy:

(i) a federal law or regulation;

(ii) a state law or rule; or

(iii) a public directive of a federal or state agency.

(2) Except as provided in Subsection (3) or (4), or as otherwise mandated by law, no purported modification of a contract during the term of the policy affects the obligations of a party to the contract unless the modification is in writing and agreed to by the party against whose interest the modification operates.

(3) Subsection (2) does not prevent a change in coverage under group contracts resulting from:

(a) provisions of an employer eligibility rule;

(b) the terms of a collective bargaining agreement; or

(c) provisions in federal Employee Retirement Income Security Act plan documents.

(4) Subsection (2) does not prevent a premium increase at any renewal date that is applicable uniformly to all comparable persons.

Section 7. Section **31A-21-201** is amended to read:

31A-21-201. Filing and approval of forms.

(1) [~~No~~] (a) A form subject to Subsection 31A-21-101 (1), except as exempted under Subsections 31A-21-101 (2) through [~~31A-21-101~~] (6), may not be used, sold, or offered for sale

unless it has been filed with the commissioner.

(b) A form is considered filed with the commissioner when [~~it has been received by~~] the commissioner [~~with~~] receives:

(i) the form;

(ii) the applicable filing fee as prescribed under Section 31A-3-103 [~~together with~~]; and

(iii) the applicable transmittal forms as required by the commissioner.

(2) In filing a form for use in this state the insurer is responsible for assuring that the form is in compliance with this title and rules adopted by the commissioner.

(3) (a) The commissioner may disapprove a form at any time upon a finding that:

(i) it is:

(A) inequitable[~~,~~];

(B) unfairly discriminatory[~~,~~];

(C) misleading[~~,~~];

(D) deceptive[~~,~~];

(E) obscure[~~,~~];

(F) unfair[~~,~~];

(G) encourages misrepresentation[~~,~~]; or [~~is~~]

(H) not in the public interest;

(ii) it provides benefits or contains other provisions that endanger the solidity of the insurer;

(iii) in the case of the basic policy and the application for a basic policy, [~~though not applicable to riders and endorsements,~~] it fails to provide the exact name of the insurer and its state of domicile; [~~or~~]

(iv) it violates a statute or a rule adopted by the commissioner[~~,~~]; or

(v) it is otherwise contrary to law.

(b) Subsection (3)(a)(iii) does not apply to riders and endorsements to a basic policy.

[~~(b)~~] (c) (i) Whenever the commissioner disapproves a form under Subsection (3)(a), the commissioner may order that, on or before a date not less than 15 days after the order, the use of the form be discontinued.

(ii) Once a form has been disapproved, it may not be used unless appropriate changes are filed with and approved by the commissioner. [~~The~~]

(iii) Whenever the commissioner disapproves a form under Subsection (3)(a), the commissioner may [~~also~~] require the insurer to disclose contract deficiencies to existing policyholders.

[~~(c)~~] (d) The commissioner's disapproval under this Subsection (3) shall be in writing and constitutes an order. The order shall state the reasons for disapproval.

(4) (a) If, after a hearing, the commissioner determines that it is in the public interest, [~~he~~] the commissioner may require by rule or order that certain forms be subject to the commissioner's approval prior to their use.

(b) The rule or order described in Subsection (4)(a) shall prescribe the filing procedures for [~~such~~] the forms if different than stated in this section.

(c) The types of forms [~~which~~] that may be addressed under Subsection (4)(a) include:

(i) forms for a particular class of insurance[~~,~~];

(ii) forms for a specific line of insurance[~~,~~];

(iii) a specific type of form[~~,~~]; or

(iv) forms for a specific market segment.

Section 8. Section **31A-22-402** is amended to read:

31A-22-402. Grace period.

(1) (a) Every life insurance policy other than a group policy shall contain a provision entitling the policyholder to a grace period within which the payment of any premium may be made after the first [~~may be made~~] payment of any premium.

(b) During the grace period described in Subsection (1)(a), the policy continues in full force.

(2) The grace period required by Subsection (1) may not be less than [~~30~~]:

(a) 31 days[~~,~~]; or [~~less than~~]

(b) four weeks for policies whose premiums are payable more frequently than monthly.

(3) The insurer may impose an interest charge during the grace period not in excess of the interest rate:

(a) set by the policy for policy loans[~~,~~]; or

(b) in the absence of [~~that~~] a provision described in Subsection (3)(a), a rate set by the commissioner by rule. [~~The~~]

(4) If a claim arises under the policy during the grace period, an insurer may deduct from the policy proceeds:

(a) the amount of any premium due or overdue[~~, together with~~];

(b) interest at the rate provided in this section[~~,~~]; and

(c) any deferred installment of the annual premium[~~, may be deducted from the policy proceeds if a claim arises under the policy during the grace period~~].

Section 9. Section **31A-22-404** is amended to read:

31A-22-404. Suicide.

(1) (a) Suicide is not a defense to a claim under a life insurance policy that has been in force as to a policyholder or certificate holder for two years from the date the coverage is effective, whether:

(i) the suicide was voluntary or involuntary [~~and whether~~]; or

(ii) the insured was sane or insane. [~~However, if~~]

(b) If a suicide occurs within the two-year period described in Subsection (1)(a), the insurer shall pay to the beneficiary an amount not less than the premium paid for the life insurance policy.

(2) (a) If after a life insurance policy is in effect the policy allows the insured[~~, after the policy's issuance and for an additional premium,~~] to obtain a death benefit [~~which~~] that is larger than when the policy was originally [~~issued, then~~] effective for an additional premium, the payment of the additional increment of benefit may be [~~denied on the ground of suicide, if the policy so provides, until two years after the incremental increase of benefits is in effect~~] limited in the event of a suicide within a two-year period beginning on the date the increment increase takes effect.

(b) If a suicide occurs within the two-year period described in Subsection (2)(a), the insurer shall pay to the beneficiary an amount not less than the additional premium paid for the additional increment of benefit.

(3) This section does not apply to:

(a) policies insuring against death by accident only[~~, nor to~~]; or

(b) the accident or double indemnity provisions of an insurance policy.

Section 10. Section **31A-22-513** is amended to read:

31A-22-513. Grace period.

(1) (a) Every group life insurance policy shall contain a provision that the policyholder is entitled to a grace period of not less than [~~30~~] 31 days for the payment of any premium due except the first payment of premium.

(b) During the grace period described in Subsection (1)(a) the death benefit coverage continues in force, unless the policyholder gives the insurer written notice of discontinuance:

(i) in advance of the date of discontinuance; and

(ii) in accordance with the policy terms.

(2) The policy may require the policyholder to pay the pro rata premium for the time the policy is in force during the grace period.

Section 11. Section **31A-22-610.2** is enacted to read:

31A-22-610.2. Maternity stay minimum limits.

(1) (a) If an insured has coverage for maternity benefits, the policy may not be limited to a less than a 48-hour benefit for both mother and newborn with a normal vaginal delivery.

(b) If an insured has coverage for maternity benefits, the policy may not be limited to a less than 96-hour benefit for both mother and newborn with a caesarean section delivery.

(2) Subsection (1) applies to a disability insurer who offers maternity coverage.

Section 12. Section **31A-22-613.5** is amended to read:

31A-22-613.5. Price and value comparisons of health insurance.

(1) This section applies generally to all health insurance policies and health maintenance organization contracts.

(2) (a) Immediately after the effective date of this section, the commissioner shall appoint a Health Benefit Plan Committee.

(b) The committee shall be composed of representatives of carriers, employers, employees, health care providers, consumers, and producers[~~,~~].

(c) A member of the committee shall be appointed to a four-year [~~terms~~] term.

[~~(c)~~] (d) Notwithstanding the requirements of Subsection (2)[~~(b)~~](c), the commissioner shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of committee members are staggered so that approximately half of the committee is appointed every two years.

(3) When a vacancy occurs in the membership for any reason, the replacement shall be appointed for the unexpired term.

(4) (a) Members shall receive no compensation or benefits for their services, but may receive per diem and expenses incurred in the performance of the member's official duties at the rates established by the Division of Finance under Sections 63A-3-106 and 63A-3-107.

(b) Members may decline to receive per diem and expenses for their service.

(5) (a) The committee shall:

(i) serve as an advisory committee to the commissioner; and [~~shall~~]

(ii) recommend [~~services to be covered, copays, deductibles, levels of coinsurance, annual out-of-pocket maximums, exclusions, and limitations~~] for two or more designated health care plans to be marketed in the state[~~.~~]:

(A) services to be covered;

(B) copays;

(C) deductibles;

(D) levels of coinsurance;

(E) annual out-of-pocket maximums;

(F) exclusions; and

(G) limitations.

[~~(a)~~] (b) The plans recommended by the committee may include reasonable benefit differentials applicable to participating and nonparticipating providers.

[~~(b)~~] (c) The plans recommended by the committee [~~shall~~] may not prohibit the use of the following cost management techniques by an insurer:

(i) preauthorization of health care services;

(ii) concurrent review of health care services;

(iii) case management of health care services;

(iv) retrospective review of medical appropriateness;

(v) selective contracting with hospitals, physicians, and other health care providers to the extent permitted by law; and

(vi) other reasonable techniques intended to manage health care costs.

[~~(c)~~] (d) The committee shall submit the plans to the commissioner within 180 days after the appointment of the committee in accordance with this section.

[~~(d)~~] (e) The commissioner shall adopt two or more health benefit plans within 60 days after the committee submits recommendations.

[~~(e)~~] (f) (i) If the committee fails to submit recommendations to the commissioner within 180 days after appointment, the commissioner shall, within 90 days, develop two or more designated health benefit plans.

(ii) The commissioner shall, after notice and hearing, adopt two or more designated health benefit plans.

(iii) The commissioner shall provide incentives for personal management of health care expenses by adopting:

(A) one plan that applies deductibles in the amount of $1,500; and

(B) another plan that applies deductibles in the amount of $2,500. [~~These~~]

(iv) The plans described in Subsection (5)(f)(iii) may include:

(A) illustrations and explanations showing the premium savings generated by the high deductibles being applied to a medical savings account for the insured [~~which~~] that can be used to pay:

(I) medical expenses up to the plan deductible [~~and/or~~];

(II) any other medical expenses not covered by the insurance[~~,~~]; or

(III) both the medical expenses described in Subsections (5)(f)(iv)(A)(I) and (II); and

(B) an explanation that any funds in the savings account belong to the insured.

[~~(f)~~] (g) The commissioner may reconvene a Health Benefit Plan Committee in accordance with Subsections (2) and (5) to recommend revisions to the designated benefit plans adopted by the

commissioner.

(6) (a) Within 180 days after the adoption of the designated benefit plans by the commissioner, or any changes in the designated plans, an insurer offering health insurance policies for sale in this state shall, at the request of a potential buyer, offer the current designated plans at a premium based on factors such as that buyer's previous claims experience, group size, demographic characteristics, and health status.

(b) This section does not prohibit an insurer from refusing to insure, under any plan, a person or group. However, if the insurer offers any policy or contract to that person or group, the insurer [~~must~~] shall offer the designated plans.

(7) The designated benefit plans, described in Subsection (5) are intended to facilitate price and value comparisons by consumers. The designated benefit plans are not minimum standards for health insurance policies. An insurer offering the designated benefit plans may offer policies that provide more or less coverage than the designated benefit plans.

(8) (a) The commissioner shall convene or reconvene a Health Benefit Plan Committee for the purpose of developing a Basic Health Care Plan to be offered under the open enrollment provisions of Chapter 30.

(b) The commissioner shall adopt a Basic Health Care Plan within 60 days after the committee submits recommendations, or if the committee fails to submit recommendations to the commissioner within 180 days after appointment, the commissioner shall, within 90 days, adopt a Basic Health Care Plan.

(c) (i) Before adoption of a plan under Subsection (8)(b), the commissioner shall submit the proposed Basic Health Care Plan to the Health and Human Services Interim Committee for review and recommendations.

(ii) After the commissioner adopts the Basic Health Care Plan, the Health and Human Services Interim Committee:

(A) shall provide legislative oversight of the Basic Health Care Plan; and

(B) may recommend legislation to modify the Basic Health Care Plan adopted by the commissioner.

(d) The committee's recommendations for the Basic Health Care Plan shall be advisory to the commissioner.

(9) (a) The commissioner shall promote informed consumer behavior and responsible health insurance and health plans by requiring an insurer issuing health insurance policies or health maintenance organization contracts to provide to all enrollees, prior to enrollment in the health benefit plan or health insurance policy, written disclosure of:

(i) restrictions or limitations on prescription drugs and biologics including the use of a formulary and generic substitution[~~. If a formulary is used, the drugs included and the patented drugs not included, and any conditions which exist as a precedent to coverage shall be made readily available to prospective enrollees and evidence of the fact of that disclosure shall be maintained by the insurer~~]; and

(ii) coverage limits under the plan.

(b) [~~An~~] In addition to the requirements of Subsections (9)(a) and (d), an insurer described in Subsection (9)(a) shall [~~also~~] submit the written disclosure required by this Subsection (9) to the commissioner:

(i) annually[~~,~~]; and

(ii) anytime [~~thereafter when~~] the insurer amends any of the following described in Subsection (9)(a):

(A) treatment policies[~~,~~];

(B) practice standards[~~, or~~];

(C) restrictions [~~described in Subsection (8)(a)~~]; or

(D) coverage limits of the insurer's health benefit plan or health insurance policy.

(c) The commissioner may adopt rules to implement the disclosure requirements of this Subsection (9), taking into account:

(i) business confidentiality of the insurer[~~,~~];

(ii) definitions of terms[~~,~~]; and

(iii) the method of disclosure to enrollees.

(d) If under Subsection (9)(a)(i) a formulary is used, the insurer shall make available to

prospective enrollees and maintain evidence of the fact of the disclosure of:

(i) the drugs included;

(ii) the patented drugs not included; and

(iii) any conditions that exist as a precedent to coverage.

(10) (a) The commissioner shall annually publish a table comparing the rates charged by insurers for the designated health plans and other health insurance plans in this state.

(b) The comparison required by Subsection (10)(a) shall list:

(i) the top 20 insurers writing the greatest volume by premium dollar per calendar year; and

(ii) others requesting inclusion in the comparison.

(c) In conjunction with the rate comparison described in this Subsection (10), the commissioner shall publish for each of the listed health insurers a table comparing the complaints filed and the combined loss and expense ratio as described in Subsections 31A-2-208.5(2) and (3).

Section 13. Section **31A-22-625** is enacted to read:

31A-22-625. Mastectomy coverage.

(1) If an insured has coverage that provides medical and surgical benefits with respect to a mastectomy, it shall provide coverage, with consultation of the attending physician and the patient, for:

(a) reconstruction of the breast on which the mastectomy has been performed;

(b) surgery and reconstruction of the breast on which the mastectomy was not performed to produce symmetrical appearance; and

(c) prostheses and physical complications with regards to all stages of mastectomy, including lymphedemas.

(2) (a) This section does not prevent a disability insurer from imposing cost-sharing measures for health benefits relating to this coverage, if cost-sharing measures are not greater than those imposed on any other medical condition.

(b) For purposes of this Subsection (2), cost-sharing measures include imposing a deductible or coinsurance requirement.

(3) Written notice of the availability of the coverage described in Subsection (1) shall be

delivered to the participant:

(a) upon enrollment; and

(b) annually after the enrollment.

Section 14. Section **31A-22-719** is enacted to read:

31A-22-719. Mastectomy coverage.

(1) A group policy subject to Section 31A-22-625 may not deny a person's eligibility or continued eligibility to enroll or renew coverage under the terms of the group policy plan solely for the purpose of avoiding the requirements of this section or Section 31A-22-625.

(2) A group policy subject to Section 31A-22-625 may not do any of the following to induce a provider to provide care to an insured in a manner inconsistent with this section or Section 31A-22-625:

(a) penalize or otherwise reduce or limit the reimbursement of an attending provider; or

(b) provide incentives to an attending provider whether or not the incentives are monetary.

Section 15. Section **31A-22-720** is enacted to read:

31A-22-720. Mental health parity.

(1) (a) A group disability plan offered by an insurer shall comply with Subsection (1)(b) if the group disability plan:

(i) applies an aggregate lifetime limit to plan payments for medical or surgical services covered by the group disability plan; and

(ii) provides a mental health benefit.

(b) A group disability plan described in Subsection (1)(a) shall:

(i) include in the aggregate lifetime limit for medical or surgical services covered by the group disability plan the payments made under the plan for mental health services; or

(ii) establish a separate aggregate lifetime limit to plan payments for mental health services covered by the group disability plan, but only if the dollar amount of the aggregate lifetime limit for mental health services covered by that plan is equal to or greater than the dollar amount of the aggregate lifetime limit for medical or surgical services covered by that plan.

(2) (a) A group disability plan offered by an insurer shall comply with Subsection (2)(b) if

the group disability plan:

(i) applies an annual limit to plan payments for medical or surgical services covered by the group disability plan; and

(ii) provides a mental health benefit.

(b) A group disability plan described in Subsection (2)(a) shall:

(i) include in the annual limit for medical or surgical services covered by the group disability plan the payments made under the plan for mental health services; or

(ii) establish a separate annual limit to plan payments for mental health services covered by the group disability plan, but only if the dollar amount of the annual limit for mental health services covered by that plan is equal to or greater than the dollar amount of the annual limit for medical or surgical services covered by that plan.

(3) This section does not prohibit a group disability plan offered by an insurer from:

(a) using other forms of cost containment not prohibited under Subsection (1); or

(b) applying requirements that make distinctions between acute care and chronic care.

(4) This section does not apply to:

(a) benefits for:

(i) substance abuse; or

(ii) chemical dependency; or

(b) disability benefits or plans paid under Title XVII or XIX of the Social Security Act.

(5) (a) This section does not apply to plans maintained by employers that employ less than 50 employees.

(b) For purposes of determining whether an employer is exempt under Subsection (5)(a):

(i) if the employer was not in existence throughout the preceding calendar year, the number of employees of the employer is determined based on the average number of employees that the employer is reasonably expected to employ on business days in the calendar year for which the determination is made; and

(ii) as used in this Subsection (5), "employer" includes a predecessor of the employer.

Section 16. Section **31A-23-219** is amended to read:

31A-23-219. Appointment and listing of insurance agents.

(1) As used in this section, "insurer" includes a bail bond surety [~~companies~~] as defined in Section 31A-35-102.

(2) (a) An insurer shall appoint a natural person or agency that has an insurance agent or managing general agent license to act as an insurance agent on its behalf prior to any agent doing business for the insurer in this state.

(b) All insurers shall report to the commissioner, at intervals and in the form the commissioner establishes by rule, all new appointments and all terminations of appointments.

(c) All insurers shall submit to the commissioner on or before July 1 of each odd-numbered year a list of all agent appointments then in force in this state.

(3) (a) An insurer shall report to the commissioner the cause of termination of an agent's appointment. The information provided to the commissioner shall remain confidential.

(b) An insurer is immune from civil action, civil penalty, or damages if the insurer complies in good faith with this Subsection (3) in reporting to the commissioner the cause of termination of agents' appointments.

(c) Notwithstanding any other provision in this section, an insurer is not immune from any action or resulting penalty imposed on the reporting insurer as a result of proceedings brought by or on behalf of the department if the action is based on evidence other than the report submitted in compliance with this Subsection (3).

(4) If an insurer appoints an agency as its agent, the insurer need not appoint, report, or pay appointment reporting fees for natural person agents designated on the agency's agent's license under Section 31A-23-212.

(5) (a) Each insurer shall maintain with the department[~~, on forms supplied by the department, and signed by the president and secretary of the insurer,~~] a list of natural persons with authority to appoint and remove the company's agents in this state on forms:

(i) supplied by the department; and

(ii) signed by any officer of the insurer.

(b) The insurer shall submit the [~~reports~~] list required under Subsection (5)(a) to the

commissioner pursuant to Subsection (2).

(6) If an insurer lists a licensee as its agent in reports submitted under Subsection (2), there is a rebuttable presumption that in placing a risk with the insurer the appointed licensee or any of the licensee's licensed employees acted as the insurer's agent and not as a broker.

Section 17. Section **31A-25-205** is amended to read:

31A-25-205. Financial responsibility.

(1) Every person licensed under this chapter shall, while licensed and for one year after that date, maintain an insurance policy or surety bond, issued by an authorized insurer, in an amount specified under Subsection (2), on a policy or contract form which is acceptable under Subsection (3).

(2) (a) Insurance policies or surety bonds satisfying the requirement of Subsection (1) shall be in a face amount equal to at least 10% of the total funds handled by the administrator. However, no policy or bond under this subsection may be in a face amount of less than $5,000 nor more than $500,000.

(b) In fixing the policy or bond face amount under Subsection (2)(a), the total funds handled is the greater of the premiums received or claims paid through the administrator during the previous calendar year, or, if no funds were handled during the preceding year, the total funds reasonably anticipated to be handled by the administrator during the current calendar year.

(c) This section does not prohibit any person dealing with the administrator from requiring, by contract, insurance coverage in amounts greater than required under this section.

(3) Insurance policies or surety bonds issued to satisfy Subsection (1) shall be on forms approved by the commissioner. The policies or bonds shall require the insurer to pay, up to the policy or bond face amount, any judgment obtained by participants in or beneficiaries of plans administered by the insured licensee which arise from the negligence or culpable acts of the licensee or any employee or agent of the licensee in connection with the activities described under [~~the first paragraph of Section 31A-25-101~~] Subsection 31A-1-301(90). The commissioner may require that policies or bonds issued to satisfy the requirements of this section require the insurer to give the commissioner 20 day prior notice of policy cancellation.

(4) The commissioner shall establish annual reporting requirements and forms to monitor compliance with this section.

(5) This section may not be construed as limiting any cause of action an insured would otherwise have against the insurer.

Section 18. Section **31A-29-111** is amended to read:

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

(1) (a) Except as provided in Subsection (1)(b), a person is eligible for pool coverage if:

(i) (A) the person pays the established premium; and

(B) is a resident of this state; or

(ii) is a dependent child 25 years of age or less of a person described in Subsection (1)(a)(i).

(b) Notwithstanding Subsection (1)(a), a person is not eligible for pool coverage if one of the following conditions apply:

(i) at the time of application, the person is eligible for health care benefits under Medicaid or Medicare, except as provided in Section 31A-29-112;

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

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

(B) the person demonstrates that continuous other coverage has been involuntarily terminated for any reason other than nonpayment of premium;

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

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

(v) the person is eligible for other public programs for which medical care is provided;

(vi) the person's health condition does not meet the criteria established under Subsection (4);

(vii) the person is an eligible employee or a member of an employer group that offers health insurance or a self-insurance arrangement to all its eligible employees or members; or

(viii) at the time of application, the person:

(A) is not eligible for coverage that is subject to the Health Insurance Portability and Accountability Act, P.L. 104-91, 110 Stat. 1962; and

(B) has not resided in Utah for at least 12 consecutive months preceding the date of

application.

(2) (a) Notwithstanding Subsection (1)(b)(viii), if otherwise eligible under Subsection (1), a person whose health insurance coverage from a state health risk pool with similar coverage is terminated because of nonresidency in another state may apply for coverage under the pool subject to the conditions of Subsections (1)(b)(i) through (vii).

(b) (i) [~~If the coverage is applied for~~] Coverage sought under Subsection (2)(a) shall be applied for within [~~31~~] 63 days after the termination [~~and if~~] date of the previous risk pool coverage.

(ii) If premiums are paid for the entire coverage period under the pool, the effective date of the pool's coverage shall be the date of termination of previous coverage.

(iii) If premiums are not paid back to the previous termination date, then the effective date will be determined by the pool administrator in accordance with the date of application.

(c) The waiting period of a person with a preexisting condition applying for coverage under this chapter shall be waived if:

(i) the waiting period was satisfied under a similar plan from another state; and

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

(3) If an eligible person applies for pool coverage within 30 days of being denied coverage by an individual carrier, the effective date for pool coverage shall be set at the first day of the month following the submission of the completed insurance application to the carrier.

(4) (a) The board shall establish and adjust, as necessary, underwriting criteria based on:

(i) health condition; and

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

(b) The commissioner may contract with one or more providers under Title 63, Chapter 56, Utah Procurement Code, to develop underwriting criteria under Subsection (4)(a).

(c) If a person is denied coverage under the criteria established in Subsection (4)(a), the pool shall issue a certificate to the applicant for coverage under Subsection 31A-30-108(3).

Section 19. Section **31A-29-117** is amended to read:

31A-29-117. Premium rates.

(1) (a) Premium charges for coverage under the pool may not be unreasonable in relation to:

(i) the benefits provided[~~,~~];

(ii) the risk experience[~~,~~]; and

(iii) the reasonable expenses provided in the coverage.

(b) Separate schedules of premium rates based on age and other appropriate demographic characteristics may apply for individual risks.

(2) A small employer carrier shall annually inform the commissioner by April 1 of the carrier's small employer index premium rates as of March 1 of the current and preceding year.

(3) (a) Premium rates in effect as of January 1, 1997, shall be adjusted on July 1, 1997, and each following July 1 [~~based on~~] may be adjusted by the board.

(b) In adjusting premium rates, the board shall:

(i) consider the average increase in small employer index rates for the five largest small employer carriers submitted under Subsection (2)[~~,~~]; and

(ii) be subject to Subsection (1).

(4) The board may establish a premium scale based on income. The highest rate may not exceed the expected claims and expenses for the individual.

(5) If a person is an eligible individual as defined in the Health Insurance Portability and Accountability Act, P.L. 104-191, 110 Stat. 1979, Sec. 2741(b), the maximum premium rate for that person may not exceed the amount permitted under P.L. 104-191, 110 Stat. 1986, Sec. 2744(c)(2)(B).

(6) All rates and rate schedules shall be submitted by the board to the commissioner for approval.

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

31A-30-107. Renewal -- Limitations -- Exclusions.

(1) A health benefit plan subject to this chapter is renewable with respect to all covered individuals at the option of the covered insured except in any of the following cases:

(a) nonpayment of the required premiums;

(b) fraud or misrepresentation of:

(i) the employer; or[;]

(ii) with respect to coverage of individual insureds, the insureds or their representatives;

(c) noncompliance with the covered carrier's minimum participation requirements;

(d) noncompliance with the covered carrier's employer contribution requirements;

(e) repeated misuse of a provider network provision; or

(f) an election by the covered carrier to nonrenew all of its health benefit plans issued to covered insureds in this state, in which case the covered carrier shall:

(i) provide advanced notice of its decision under this Subsection (1) to the commissioner in each state in which it is licensed; and

(ii) provide notice of the decision not to renew coverage to all affected covered insureds and to the commissioner in each state in which an affected insured individual is known to reside [~~at least 180 days prior to the nonrenewal of any health benefit plans by the covered carrier~~].

(2) Notice [~~to the commissioner~~] under [~~this~~] Subsection (1) shall be provided:

(a) to affected covered insureds at least 180 days prior to nonrenewal of any health benefit plans by the covered carrier; and

(b) to the commissioner at least three working days prior to the notice to the affected covered insureds.

[~~(2)~~] (3) A covered carrier that elects not to renew a health benefit plan under Subsection (1)(f) is prohibited from writing new business subject to this chapter in this state for a period of five years from the date of notice to the commissioner.

[~~(3)~~] (4) When a covered carrier is doing business subject to this chapter in one service area of this state, Subsections (1) [~~and (2)~~] through (3) apply only to the covered carrier's operations in that service area.

[~~(4)~~] (5) Health benefit plans covering covered insureds shall comply with [~~the following provisions:~~] Subsections (5)(a) and (b).

(a) (i) A health benefit plan may not deny, exclude, or limit benefits for a covered individual for losses incurred more than 12 months, or 18 months in the case of a late enrollee, as defined in P.L. 104-191, 110 Stat. 1940, Sec. 101, following the effective date of the individual's coverage due to

a preexisting condition.

(ii) A health benefit plan may not define a preexisting condition more restrictively than:

(A) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the earlier of:

(I) the enrollment date; or

(II) the effective date of coverage; or

(B) for an individual insurance policy, a pregnancy existing on the effective date of coverage.

(b) (i) A covered carrier shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in a health benefit plan for the period of time the individual was previously covered by public or private health insurance or by any other health benefit arrangement that provided benefits with respect to such services, provided that:

(A) the previous coverage was continuous to a date not more than [~~62~~] 63 days prior to the effective date of the new coverage; and

(B) the insured provides notification of previous coverage to the covered carrier within 36 months of the coverage effective date if the insurer has previously requested such notification.

(ii) The period of continuous coverage under Subsection [~~(4)~~] (5)(b)(i)(A) [~~shall~~] may not include any waiting period for the effective date of the new coverage applied by the employer or the carrier. This Subsection (5)(b)(ii) does not preclude application of any waiting period applicable to all new enrollees under [~~such~~] the plan.

Section 21. **Coordination clause.**

If this bill and S.B. 164, Medical Exclusions in Individual Health Insurance Policies, both pass, it is the intent of the Legislature that:

(a) the amendments in this bill to Section 31A-30-107 supersede the amendments to Section 31A-30-107 in S.B. 164 except that Subsections 31A-30-107(4)(a)(iii) and 31A-30-107(4)(b)(iii) in S.B. 164 shall be added as Subsections 31A-30-107(5)(a)(iii) and 31A-30-107(5)(b)(iii) in this bill; and

(b) the internal reference citations changed accordingly.

(2) If this bill and 1st Sub. H.B. 254, Insurance Department - Health Insurance Reporting

Requirements, both pass, it is the intent of the Legislature that:

(a) the amendments in this bill to Subsection 31A-22-613.5(9)(b) supersede the deletion of Subsection 31A-22-613.5(6)(b) in 1st Sub. H.B. 254; and

(b) the affected subsections be renumbered accordingly.