INSURANCE LAW AMENDMENTS

2001 GENERAL SESSION

STATE OF UTAH

Sponsor: L. Steven Poulton

This act modifies the Insurance Code and related provisions by addressing issues related to the insurance business in general, health insurance, life insurance, and property insurance. The act standardizes definition of terms and makes other technical changes. The act changes terminology from "disability insurance" to "accident and health insurance." The act defines the scope and applicability of certain provisions included in this act. The act imposes certain requirements on health organizations that are imposed on insurers. The act addresses the conditions governing the issuance and renewal of certificates of authority, including allowing the commissioner to enter into interstate compacts. The act addresses the form of and information required in statements filed with the department including permitting the department to accept documents complying with National Association of Insurance Commissioners requirements instead of statutory requirements. The act addresses the requirements of minimum capital and permanent surplus as well as the amount of the deposit each authorized organization shall maintain with the commissioner. The act addresses issues related to formation, cancellation, and required provisions of insurance contracts. The act redefines the qualified assets that may be used in determining the financial condition of an insurer. The act changes the requirements for title insurance reserves. The act requires that all documents and agreements that constitute a life insurance policy shall be defined and attached to the policy. The act creates notification requirements for termination of a group or blanket life insurance policy. The act modifies the responsibilities of the Health Benefit Plan Committee. The act expands the commissioner's rulemaking responsibilities for Medicare supplemental policies. The act requires a policy summary or illustration to be delivered with a life insurance policy. The act requires, in certain circumstances, monthly reports on an accident and health rider or supplemental benefit. The act addresses maternity benefits required in a conversion policy. The act changes the requirements and restrictions on long-term care insurance policies. The act

modifies the licensing, continuing education, and examination requirements for agents, brokers, consultants, third party administrators, and independent or public adjusters. The act also addresses the termination of licenses for agents, brokers, consultants, third party administrators, and independent or public adjusters. The act expands the list of activities that qualify as unfair marketing practices. The act addresses the handling of escrow funds by title insurance agents. The act requires title insurance agents to make disclosures to loan applicants purchasing title insurance. The act addresses sharing commissions for referrals of potential customers. The act addresses continuance of coverage by health maintenance organizations. The act provides a coordination clause.

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

AMENDS:

7-9-5, as last amended by Chapter 329, Laws of Utah 1999

26-19-2, as last amended by Chapters 39 and 145, Laws of Utah 1998

26-40-104, as enacted by Chapter 360, Laws of Utah 1998

31A-1-103, as last amended by Chapter 4, Laws of Utah 1993

31A-1-301, as last amended by Chapters 130 and 131, Laws of Utah 1999

31A-2-214, as last amended by Chapter 12, Laws of Utah 1987, First Special Session

31A-4-103, as enacted by Chapter 242, Laws of Utah 1985

31A-4-113, as last amended by Chapter 258, Laws of Utah 1992

31A-5-211, as last amended by Chapter 9, Laws of Utah 1996, Second Special Session

31A-5-418, as last amended by Chapter 9, Laws of Utah 1996, Second Special Session

31A-5-703, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session

31A-6a-102, as enacted by Chapter 203, Laws of Utah 1992

31A-6a-110, as enacted by Chapter 203, Laws of Utah 1992

31A-8-101, as last amended by Chapter 261, Laws of Utah 1989

31A-8-103 (Effective 04/30/01), as last amended by Chapter 300, Laws of Utah 2000

31A-8-209, as enacted by Chapter 204, Laws of Utah 1986

31A-8-211, as last amended by Chapter 30, Laws of Utah 1992

31A-8-213, as enacted by Chapter 204, Laws of Utah 1986

31A-8-402, as last amended by Chapter 327, Laws of Utah 1990

31A-8-407, as enacted by Chapter 261, Laws of Utah 1989

31A-8-408, as last amended by Chapter 344, Laws of Utah 1995

31A-9-212 (Effective 04/30/01), as last amended by Chapter 300, Laws of Utah 2000

31A-11-102, as last amended by Chapter 10, Laws of Utah 1988, Second Special Session

31A-14-201, as last amended by Chapter 204, Laws of Utah 1986

31A-14-212, as enacted by Chapter 242, Laws of Utah 1985

31A-15-103, as last amended by Chapter 55, Laws of Utah 1999

31A-15-106, as last amended by Chapter 204, Laws of Utah 1986

31A-17-201, as last amended by Chapter 131, Laws of Utah 1999

31A-17-401, as last amended by Chapter 9, Laws of Utah 1996, Second Special Session

31A-17-402, as last amended by Chapter 305, Laws of Utah 1993

31A-17-408, as enacted by Chapter 242, Laws of Utah 1985

31A-17-504, as enacted by Chapter 305, Laws of Utah 1993

31A-17-505, as enacted by Chapter 305, Laws of Utah 1993

31A-17-507, as enacted by Chapter 305, Laws of Utah 1993

31A-17-508, as enacted by Chapter 305, Laws of Utah 1993

31A-17-509, as enacted by Chapter 305, Laws of Utah 1993

31A-17-513, as enacted by Chapter 305, Laws of Utah 1993

31A-17-601, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session

31A-17-602, as last amended by Chapter 185, Laws of Utah 1997

31A-17-603, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session

31A-17-604, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session

31A-17-605, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session

31A-17-606, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session

31A-17-607, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session

31A-17-608, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session

31A-17-609, as last amended by Chapter 131, Laws of Utah 1999

31A-17-610, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session

31A-17-613, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session

31A-18-105, as last amended by Chapter 9, Laws of Utah 1996, Second Special Session

31A-19a-101, as renumbered and amended by Chapter 130, Laws of Utah 1999

31A-21-103, as last amended by Chapter 204, Laws of Utah 1986

31A-21-104, as last amended by Chapter 190, Laws of Utah 1996

31A-21-201, as last amended by Chapter 114, Laws of Utah 2000

31A-21-301, as last amended by Chapter 230, Laws of Utah 1992

31A-21-303, as last amended by Chapter 203, Laws of Utah 1999

31A-21-307, as last amended by Chapter 68, Laws of Utah 1989

31A-21-401, as enacted by Chapter 204, Laws of Utah 1986

31A-21-402, as enacted by Chapter 204, Laws of Utah 1986

31A-21-403, as enacted by Chapter 204, Laws of Utah 1986

31A-21-404, as enacted by Chapter 204, Laws of Utah 1986

31A-21-501, as last amended by Chapter 302, Laws of Utah 1999

31A-21-502, as enacted by Chapter 132, Laws of Utah 1997

31A-21-503, as enacted by Chapter 132, Laws of Utah 1997

31A-21-505, as enacted by Chapter 132, Laws of Utah 1997

31A-22-307, as last amended by Chapter 71, Laws of Utah 1994

31A-22-403, as enacted by Chapter 242, Laws of Utah 1985

31A-22-404, as last amended by Chapter 114, Laws of Utah 2000

31A-22-415, as last amended by Chapter 39, Laws of Utah 1998

31A-22-423, as last amended by Chapter 329, Laws of Utah 1998

31A-22-510, as last amended by Chapter 91, Laws of Utah 1987

31A-22-517, as enacted by Chapter 242, Laws of Utah 1985

31A-22-518, as enacted by Chapter 242, Laws of Utah 1985

31A-22-520, as enacted by Chapter 242, Laws of Utah 1985

31A-22-600, as enacted by Chapter 242, Laws of Utah 1985

31A-22-601, as enacted by Chapter 242, Laws of Utah 1985

31A-22-602, as enacted by Chapter 242, Laws of Utah 1985

31A-22-603, as enacted by Chapter 242, Laws of Utah 1985

31A-22-604, as last amended by Chapter 1, Laws of Utah 2000

31A-22-605, as last amended by Chapter 224, Laws of Utah 1992

31A-22-606, as last amended by Chapter 316, Laws of Utah 1994

31A-22-607, as enacted by Chapter 242, Laws of Utah 1985

31A-22-608, as last amended by Chapter 91, Laws of Utah 1987

31A-22-609, as enacted by Chapter 242, Laws of Utah 1985

31A-22-610, as last amended by Chapter 206, Laws of Utah 1996

31A-22-610.2, as enacted by Chapter 114, Laws of Utah 2000

31A-22-610.5, as last amended by Chapters 102 and 137, Laws of Utah 1995

31A-22-611, as enacted by Chapter 242, Laws of Utah 1985

31A-22-612, as last amended by Chapter 204, Laws of Utah 1986

31A-22-613, as last amended by Chapter 160, Laws of Utah 2000

31A-22-613.5, as last amended by Chapter 114, Laws of Utah 2000

31A-22-614, as enacted by Chapter 242, Laws of Utah 1985

31A-22-617, as last amended by Chapter 267, Laws of Utah 2000

31A-22-619, as last amended by Chapter 316, Laws of Utah 1994

31A-22-620, as last amended by Chapter 185, Laws of Utah 1997

31A-22-623, as enacted by Chapter 6, Laws of Utah 1998

31A-22-624, as enacted by Chapter 357, Laws of Utah 1998

31A-22-626, as enacted by Chapter 248, Laws of Utah 2000

31A-22-630, as enacted by Chapter 114, Laws of Utah 2000

31A-22-701, as last amended by Chapter 143, Laws of Utah 1996

31A-22-702, as enacted by Chapter 242, Laws of Utah 1985

31A-22-703, as last amended by Chapter 329, Laws of Utah 1998

31A-22-704, as last amended by Chapter 321, Laws of Utah 1995

31A-22-705, as last amended by Chapter 261, Laws of Utah 1989

31A-22-715, as last amended by Chapter 12, Laws of Utah 1994

31A-22-716, as enacted by Chapter 327, Laws of Utah 1990

31A-22-717, as enacted by Chapter 253, Laws of Utah 1991

31A-22-720, as enacted by Chapter 114, Laws of Utah 2000

31A-22-801, as enacted by Chapter 242, Laws of Utah 1985

31A-22-802, as enacted by Chapter 242, Laws of Utah 1985

31A-22-803, as enacted by Chapter 242, Laws of Utah 1985

31A-22-804, as enacted by Chapter 242, Laws of Utah 1985

31A-22-805, as enacted by Chapter 242, Laws of Utah 1985

31A-22-806, as last amended by Chapter 204, Laws of Utah 1986

31A-22-807, as last amended by Chapter 230, Laws of Utah 1992

31A-22-808, as enacted by Chapter 242, Laws of Utah 1985

31A-22-809, as enacted by Chapter 242, Laws of Utah 1985

31A-22-1002, as last amended by Chapter 375, Laws of Utah 1997

31A-22-1101, as enacted by Chapter 242, Laws of Utah 1985

31A-22-1401, as enacted by Chapter 243, Laws of Utah 1991

31A-22-1402, as enacted by Chapter 243, Laws of Utah 1991

31A-22-1407, as last amended by Chapter 344, Laws of Utah 1995

31A-22-1409, as enacted by Chapter 243, Laws of Utah 1991

31A-22-1412, as enacted by Chapter 344, Laws of Utah 1995

31A-23-101, as enacted by Chapter 242, Laws of Utah 1985

31A-23-102, as last amended by Chapter 1, Laws of Utah 2000

31A-23-201, as last amended by Chapter 344, Laws of Utah 1995

31A-23-202, as last amended by Chapter 232, Laws of Utah 1997

31A-23-203, as last amended by Chapter 131, Laws of Utah 1999

31A-23-204, as last amended by Chapter 131, Laws of Utah 1999

31A-23-206, as last amended by Chapter 131, Laws of Utah 1999

31A-23-207, as last amended by Chapter 316, Laws of Utah 1994

31A-23-209, as last amended by Chapter 204, Laws of Utah 1986

31A-23-211.7, as enacted by Chapter 131, Laws of Utah 1999

31A-23-212, as last amended by Chapter 131, Laws of Utah 1999

31A-23-216, as last amended by Chapter 232, Laws of Utah 1997

31A-23-218, as enacted by Chapter 242, Laws of Utah 1985

31A-23-302, as last amended by Chapter 344, Laws of Utah 1995

31A-23-303, as last amended by Chapter 204, Laws of Utah 1986

31A-23-307, as last amended by Chapter 185, Laws of Utah 1997

31A-23-310, as last amended by Chapter 344, Laws of Utah 1995

31A-23-312, as last amended by Chapter 230, Laws of Utah 1992

31A-23-404, as last amended by Chapter 293, Laws of Utah 1998

31A-23-503, as last amended by Chapter 1, Laws of Utah 2000

31A-23-601, as last amended by Chapter 1, Laws of Utah 2000

31A-23-702, as enacted by Chapter 258, Laws of Utah 1992

31A-23-705, as enacted by Chapter 258, Laws of Utah 1992

31A-25-102, as enacted by Chapter 242, Laws of Utah 1985

31A-25-202, as enacted by Chapter 242, Laws of Utah 1985

31A-25-203, as enacted by Chapter 242, Laws of Utah 1985

31A-25-205, as last amended by Chapters 1 and 114, Laws of Utah 2000

31A-25-206, as enacted by Chapter 242, Laws of Utah 1985

31A-25-207, as enacted by Chapter 242, Laws of Utah 1985

31A-25-208, as enacted by Chapter 242, Laws of Utah 1985

31A-26-101, as last amended by Chapter 30, Laws of Utah 1992

31A-26-202, as last amended by Chapter 232, Laws of Utah 1997

31A-26-203, as last amended by Chapter 9, Laws of Utah 1996, Second Special Session

31A-26-204, as last amended by Chapter 131, Laws of Utah 1999

31A-26-206, as last amended by Chapter 131, Laws of Utah 1999

31A-26-207, as last amended by Chapter 204, Laws of Utah 1986

31A-26-208, as last amended by Chapter 204, Laws of Utah 1986

31A-26-209, as last amended by Chapter 204, Laws of Utah 1986

31A-26-213, as last amended by Chapter 232, Laws of Utah 1997

31A-26-302, as enacted by Chapter 242, Laws of Utah 1985

31A-28-102, as last amended by Chapter 316, Laws of Utah 1994

31A-28-103, as last amended by Chapter 316, Laws of Utah 1994

31A-28-106, as repealed and reenacted by Chapter 211, Laws of Utah 1991

31A-28-108, as last amended by Chapter 344, Laws of Utah 1995

31A-28-109, as repealed and reenacted by Chapter 211, Laws of Utah 1991

31A-28-202, as last amended by Chapter 97, Laws of Utah 1988

31A-29-103, as enacted by Chapter 232, Laws of Utah 1990

31A-29-117, as last amended by Chapter 114, Laws of Utah 2000

31A-30-103, as last amended by Chapter 265, Laws of Utah 1997

31A-30-104, as last amended by Chapter 131, Laws of Utah 1999

31A-30-106, as last amended by Chapter 267, Laws of Utah 2000

31A-30-106.5, as enacted by Chapter 321, Laws of Utah 1995

31A-30-107, as last amended by Chapters 114 and 315, Laws of Utah 2000

31A-32a-102, as enacted by Chapter 131, Laws of Utah 1999

31A-33-103.5, as last amended by Chapter 107, Laws of Utah 1998

31A-33-113, as last amended by Chapter 375, Laws of Utah 1997

34A-2-103, as last amended by Chapters 55 and 199, Laws of Utah 1999

58-67-501, as last amended by Chapter 227, Laws of Utah 1997

58-68-501, as last amended by Chapter 227, Laws of Utah 1997

59-10-114, as last amended by Chapter 257, Laws of Utah 2000

62A-11-326.1, as last amended by Chapter 145, Laws of Utah 1998

62A-11-326.2, as last amended by Chapter 145, Laws of Utah 1998

63-25a-413, as renumbered and amended by Chapter 242, Laws of Utah 1996

63-55-231, as last amended by Chapters 52 and 267, Laws of Utah 2000

67-22-1, as last amended by Chapter 117, Laws of Utah 2000

67-22-2, as last amended by Chapter 117, Laws of Utah 2000

78-14-4.5, as last amended by Chapters 30 and 240, Laws of Utah 1992

78-45-7.5, as last amended by Chapter 161, Laws of Utah 2000

ENACTS:

31A-2-217, Utah Code Annotated 1953

31A-22-424, Utah Code Annotated 1953

31A-22-522, Utah Code Annotated 1953

31A-22-631, Utah Code Annotated 1953

31A-22-632, Utah Code Annotated 1953

31A-22-1413, Utah Code Annotated 1953

31A-22-1414, Utah Code Annotated 1953

31A-23-201.5, Utah Code Annotated 1953

31A-23-317, Utah Code Annotated 1953

31A-26-215, Utah Code Annotated 1953

REPEALS AND REENACTS:

31A-27-311.5, as enacted by Chapter 170, Laws of Utah 1990

REPEALS:

31A-8-210, as last amended by Chapter 9, Laws of Utah 1996, Second Special Session

31A-8-212, as last amended by Chapter 327, Laws of Utah 1990

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

Section 1. Section **7-9-5** is amended to read:

7-9-5. Powers of credit unions.

In addition to the powers specified elsewhere in this chapter, a credit union may:

(1) make contracts;

(2) sue and be sued;

(3) acquire, lease, or hold fixed assets, including real property, furniture, fixtures, and equipment as the directors consider necessary or incidental to the operation and business of the credit union, but the value of the real property may not exceed 7% of credit union assets, unless approved by the commissioner;

(4) pledge, hypothecate, sell, or otherwise dispose of real or personal property, either in whole or in part, necessary or incidental to its operation;

(5) incur and pay necessary and incidental operating expenses;

(6) require an entrance or membership fee;

(7) receive the funds of its members in payment for:

(a) shares;

(b) share certificates;

(c) deposits;

(d) deposit certificates;

(e) share drafts;

(f) NOW accounts; and

(g) other instruments;

(8) allow withdrawal of shares and deposits, as requested by a member orally to a third party with prior authorization in writing, including, but not limited to, drafts drawn on the credit union for payment to the member or any third party, in accordance with the procedures established by the board of directors, including, but not limited to, drafts, third-party instruments, and other transaction instruments, as provided in the bylaws;

(9) charge fees for its services;

(10) extend credit to its members, at rates established in accordance with the bylaws or by the board of directors;

(11) extend credit secured by real estate;

(12) make loan participation arrangements with other credit unions, credit union organizations, or financial organizations in accordance with written policies of the board of directors, if the credit union that originates a loan for which participation arrangements are made retains an

interest of at least 10% of the loan;

(13) sell and pledge eligible obligations in accordance with written policies of the board of directors;

(14) engage in activities and programs of the federal government or this state or any agency or political subdivision of the state, when approved by the board of directors and not inconsistent with this chapter;

(15) act as fiscal agent for and receive payments on shares and deposits from the federal government, this state, or its agencies or political subdivisions not inconsistent with the laws of this state;

(16) borrow money and issue evidence of indebtedness for a loan or loans for temporary purposes in the usual course of its operations;

(17) discount and sell notes and obligations;

(18) sell all or any portion of its assets to another credit union or purchase all or any portion of the assets of another credit union;

(19) invest funds as provided in this title and in its bylaws;

(20) maintain deposits in insured depository institutions as provided in this title and in its bylaws;

(21) (a) hold membership in corporate credit unions organized under this chapter or under other state or federal statutes; and

(b) hold membership or equity interest in associations and organizations of credit unions, including credit union service organizations;

(22) declare and pay dividends on shares, contract for and pay interest on deposits, and pay refunds of interest on loans as provided in this title and in its bylaws;

(23) collect, receive, and disburse funds in connection with the sale of negotiable or nonnegotiable instruments and for other purposes that provide benefits or convenience to its members, as provided in this title and in its bylaws;

(24) make donations for the members' welfare or for civic, charitable, scientific, or educational purposes as authorized by the board of directors or provided in its bylaws;

(25) act as trustee of funds permitted by federal law to be deposited in a credit union as a deferred compensation or tax deferred device, including, but not limited to, individual retirement accounts as defined by Section 408, Internal Revenue Code;

(26) purchase reasonable [~~disability~~] accident and health insurance, including accidental death benefits, for directors and committee members through insurance companies licensed in this state as provided in its bylaws;

(27) provide reasonable protection through insurance or other means to protect board members, committee members, and employees from liability arising out of consumer legislation such as, but not limited to, truth-in-lending and equal credit laws and as provided in its bylaws;

(28) reimburse directors and committee members for reasonable and necessary expenses incurred in the performance of their duties;

(29) participate in systems which allow the transfer, withdrawal, or deposit of funds of credit unions or credit union members by automated or electronic means and hold membership in entities established to promote and effectuate these systems, if:

(a) the participation is not inconsistent with the law and rules of the department; and

(b) any credit union participating in any system notifies the department as provided by law;

(30) issue credit cards and debit cards to allow members to obtain access to their shares, deposits, and extensions of credit;

(31) provide any act necessary to obtain and maintain membership in the credit union;

(32) exercise incidental powers necessary to carry out the purpose for which a credit union is organized;

(33) undertake other activities relating to its purpose as its bylaws may provide;

(34) engage in other activities, exercise other powers, and enjoy other rights, privileges, benefits, and immunities authorized by rules of the commissioner;

(35) act as trustee, custodian, or administrator for Keogh plans, individual retirement accounts, credit union employee pension plans, and other employee benefit programs; and

(36) advertise to the general public the products and services offered by the credit union if the advertisement prominently discloses that to use the products or services of the credit union a

person is required to:

(a) be eligible for membership in the credit union; and

(b) become a member of the credit union.

Section 2. Section **26-19-2** is amended to read:

26-19-2. Definitions.

As used in this chapter:

(1) "Employee welfare benefit plan" means a medical insurance plan developed by an employer under 29 U.S.C. Section 1001, et seq., the Employee Retirement Income Security Act of 1974 as amended.

(2) "Estate" means, regarding a deceased recipient, all real and personal property or other assets included within a decedent's estate as defined in Section 75-1-201 and a decedent's augmented estate as defined in Section 75-2-203.

(3) "Insurer" includes:

(a) a group health plan as defined in Subsection 607(1) of the federal Employee Retirement Income Security Act of 1974;

(b) a health maintenance organization; and

(c) any entity offering a health service benefit plan.

(4) "Medical assistance" means:

(a) all funds expended for the benefit of a recipient under Title 26, Chapter 18, Medical Assistance Act, or under Titles XVIII and XIX, federal Social Security Act; and

(b) any other services provided for the benefit of a recipient by a prepaid health care delivery system under contract with the department.

(5) "Provider" means a person or entity who provides services to a recipient.

(6) "Recipient" means:

(a) a person who has applied for or received medical assistance from the state;

(b) the guardian, conservator, or other personal representative of a person under Subsection (6)(a) if the person is a minor or an incapacitated person; or

(c) the estate and survivors of a person under Subsection (6)(a) if the person is deceased.

(7) "State plan" means the state Medicaid program as enacted in accordance with Title XIX, federal Social Security Act.

(8) "Third party" includes:

(a) an individual, institution, corporation, public or private agency, trust, estate, insurance carrier, employee welfare benefit plan, health maintenance organization, health service organization, preferred provider organization, governmental program such as Medicare, CHAMPUS, and workers' compensation, which may be obligated to pay all or part of the medical costs of injury, disease, or disability of a recipient, unless any of these are excluded by department rule; and

(b) a spouse or a parent who:

(i) may be obligated to pay all or part of the medical costs of a recipient under law or by court or administrative order; or

(ii) has been ordered to maintain health, dental, or [~~disability~~] accident and health insurance to cover medical expenses of a spouse or dependent child by court or administrative order.

Section 3. Section **26-40-104** is amended to read:

26-40-104. Advisory Council.

(1) There is created a Utah Children's Health Insurance Program Advisory Council consisting of at least eight and no more than eleven members appointed by the executive director of the department. The term of each appointment shall be three years. The appointments shall be staggered at one-year intervals to ensure continuity of the advisory council.

(2) The advisory council shall meet at least quarterly.

(3) The membership of the advisory council shall include at least one representative from each of the following groups:

(a) child health care providers;

(b) parents and guardians of children enrolled in the program;

(c) ethnic populations other than American Indians;

(d) American Indians;

(e) the Health Policy Commission;

(f) the Utah Association of Health Care Providers;

(g) health and [~~disability~~] accident and health insurance providers; and

(h) the general public.

(4) The advisory council shall advise the department on:

(a) benefits design;

(b) eligibility criteria;

(c) outreach;

(d) evaluation; and

(e) special strategies for under-served populations.

(5) (a) (i) Members who are not government employees may not receive 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.

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

(b) (i) State government officer and employee members who do not receive salary, per diem, or expenses from their agency for their service may receive per diem and expenses incurred in the performance of their official duties from the council at the rates established by the Division of Finance under Sections 63A-3-106 and 63A-3-107.

(ii) State government officer and employee members may decline to receive per diem and expenses for their service.

Section 4. Section **31A-1-103** is amended to read:

31A-1-103. Scope and applicability of title.

(1) This title does not apply to:

(a) retainer contracts made by attorneys-at-law with individual clients with fees based on estimates of the nature and amount of services to be provided to the specific client, and similar contracts made with a group of clients involved in the same or closely related legal matters;

(b) arrangements for providing benefits that do not exceed a limited amount of consultations, advice on simple legal matters, either alone or in combination with referral services, or the promise of fee discounts for handling other legal matters;

(c) limited legal assistance on an informal basis involving neither an express contractual obligation nor reasonable expectations, in the context of an employment, membership, educational, or similar relationship; or

(d) legal assistance by employee organizations to their members in matters relating to employment.

(2) (a) This title restricts otherwise legitimate business activity.

(b) What this title does not prohibit is permitted unless contrary to other provisions of Utah law.

(3) Except as otherwise expressly provided, this title does not apply to:

(a) those activities of an insurer where state jurisdiction is preempted by Section 514 of the federal Employee Retirement Income Security Act of 1974, as amended;

(b) ocean marine insurance;

(c) death and [~~disability~~] accident and health benefits provided by an organization where the principal purpose is to achieve charitable, educational, social, or religious objectives rather than to provide death and [~~disability~~] accident and health benefits, if the organization does not incur a legal obligation to pay a specified amount and does not create reasonable expectations of receiving a specified amount on the part of an insured person;

(d) other business specified in rules adopted by the commissioner on a finding that the transaction of such business in this state does not require regulation for the protection of the interests of the residents of this state or on a finding that it would be impracticable to require compliance with this title;

(e) (i) transactions independently procured through negotiations under Section 31A-15-104;

(ii) however, the transactions described in Subsection (3)(e)(i) are subject to taxation under Section 31A-3-301;

(f) self-insurance;

(g) reinsurance;

(h) subject to Subsection (4), employee and labor union group or blanket insurance covering risks in this state if:

(i) the policyholder exists primarily for purposes other than to procure insurance;

(ii) the policyholder is not a resident of this state or a domestic corporation or does not have its principal office in this state;

(iii) no more than 25% of the certificate holders or insureds are residents of this state;

(iv) on request of the commissioner, the insurer files with the department a copy of the policy and a copy of each form or certificate; and

(v) the insurer agrees to pay premium taxes on the Utah portion of its business, as if it were authorized to do business in this state, and if the insurer provides the commissioner with the security the commissioner considers necessary for the payment of premium taxes under Title 59, Chapter 9, Taxation of Admitted Insurers; or

(i) to the extent provided in Subsection (5):

(A) a manufacturer's [~~warranties issued in the ordinary course of sale;~~] warranty; and

[~~(j) manufacturer's warranties or service contracts paid for with separate or additional consideration; or~~]

[~~(k) service contracts paid for with separate or additional consideration, issued in the ordinary course of sale, that are for the repair or maintenance of goods, other than motor vehicles, having a purchase price of $3,000 or less~~]

(B) a manufacturer's service contract.

(4) (a) After a hearing, the commissioner may order an insurer of certain group or blanket contracts to transfer the Utah portion of the business otherwise exempted under Subsection (3)(h) to an authorized insurer if the contracts have been written by an unauthorized insurer.

(b) If the commissioner finds that the conditions required for the exemption of a group or blanket insurer are not satisfied or that adequate protection to residents of this state is not provided, [~~he~~] the commissioner may require:

(i) the insurer to be authorized to do business in this state; or [~~require~~]

(ii) that any of the insurer's transactions be subject to this title.

(5) (a) As used in Subsection (3)(i) and this Subsection (5):

(i) "manufacturer's service contract" means a service contract:

(A) made available by a manufacturer of a product:

(I) on one specific product; or

(II) on products that are components of a system; and

(B) under which the manufacturer is liable for services to be provided under the service contract including, if the manufacturer's service contract designates, providing parts and labor;

(ii) "manufacturer's warranty" means the guaranty of the manufacturer of a product:

(A) (I) on one specific product; or

(II) on products that are components of a system; and

(B) under which the manufacturer is liable for services to be provided under the warranty, including, if the manufacturer's warranty designates, providing parts and labor; and

(iii) "service contract" is as defined in Section 31A-6a-101.

(b) A manufacturer's warranty may be designated as:

(i) a warranty;

(ii) a guaranty; or

(iii) a term similar to a term described in Subsection (5)(b)(i) or (ii).

(c) This title does not apply to:

(i) a manufacturer's warranty;

(ii) a manufacturer's service contract paid for with consideration that is in addition to the consideration paid for the product itself; and

(iii) a service contract that is not a manufacturer's warranty or manufacturer's service contract if:

(A) the service contract is paid for with consideration that is in addition to the consideration paid for the product itself; and

(B) the service contract is for the repair or maintenance of goods;

(C) the cost of the product is equal to an amount determined in accordance with Subsection (5)(e); and

(D) the product is not a motor vehicle.

(d) This title does not apply to a manufacturer's warranty or service contract paid for with

consideration that is in addition to the consideration paid for for the product itself regardless of whether the manufacturer's warranty or service contract is sold:

(i) at the time of the purchase of the product; or

(ii) at a time other than the time of the purchase of the product.

(e) (i) For fiscal year 2001-02, the amount described in Subsection (5)(c)(iii)(C) shall be equal to $3,700 or less.

(ii) For each fiscal year after fiscal year 2001-02, the commissioner shall annually determine whether the amount described in Subsection (5)(c)(iii)(C) should be adjusted in accordance with changes in the Consumer Price Index published by the United States Bureau of Labor Statistics selected by the commissioner by rule, between:

(A) the Consumer Price Index for the February immediately preceding the adjustment; and

(B) the Consumer Price Index for February 2001.

(iii) If under Subsection (5)(e)(ii) the commissioner determines that an adjustment should be made, the commissioner shall make the adjustment by rule.

Section 5. Section **31A-1-301** is amended to read:

31A-1-301. Definitions.

As used in this title, unless otherwise specified:

(1) (a) "Accident and health insurance" means insurance to provide protection against economic losses resulting from:

(i) a medical condition including:

(A) medical care expenses; or

(B) the risk of disability;

(ii) accident; or

(iii) sickness.

(b) "Accident and health insurance":

(i) includes a contract with disability contingencies including:

(A) an income replacement contract;

(B) a health care contract;

(C) an expense reimbursement contract;

(D) a credit accident and health contract;

(E) a continuing care contract; and

(F) long-term care contracts; and

(ii) may provide:

(A) hospital coverage;

(B) surgical coverage;

(C) medical coverage; or

(D) loss of income coverage.

(c) "Accident and health insurance" does not include workers' compensation insurance.

[~~(1)~~] (2) "Administrator" is defined in Subsection [~~(90)~~] (111).

[~~(2)~~] (3) "Adult" means a natural person who has attained the age of at least 18 years.

[~~(3)~~] (4) "Affiliate" means any person who controls, is controlled by, or is under common control with, another person. A corporation is an affiliate of another corporation, regardless of ownership, if substantially the same group of natural persons manages the corporations.

[~~(4)~~] (5) "Alien insurer" means an insurer domiciled outside the United States.

(6) "Amendment" means an endorsement to an insurance policy or certificate.

[~~(5)~~] (7) "Annuity" means an agreement to make periodical payments for a period certain or over the lifetime of one or more natural persons if the making or continuance of all or some of the series of the payments, or the amount of the payment, is dependent upon the continuance of human life.

(8) "Application" means a document:

(a) completed by an applicant to provide information about the risk to be insured; and

(b) that contains information that is used by the insurer to:

(i) evaluate risk; and

(ii) decide whether to:

(A) insure the risk under:

(I) the coverages as originally offered; or

(II) a modification of the coverage as originally offered; or

(B) decline to insure the risk.

[~~(6)~~] (9) "Articles" or "articles of incorporation" means the original articles, special laws, charters, amendments, restated articles, articles of merger or consolidation, trust instruments, and other constitutive documents for trusts and other entities that are not corporations, and amendments to any of these.

[~~(7)~~] (10) "Bail bond insurance" means a guarantee that a person will attend court when required, or will obey the orders or judgment of the court, as a condition to the release of that person from confinement.

[~~(8)~~] (11) "Binder" is defined in Section 31A-21-102.

[~~(9)~~] (12) "Board," "board of trustees," or "board of directors" means the group of persons with responsibility over, or management of, a corporation, however designated.

[~~(10)~~] (13) "Business of insurance" is defined in Subsection [~~(53)~~] (64).

[~~(11)~~] (14) "Business plan" means the information required to be supplied to the commissioner under Subsections 31A-5-204(2)(i) and (j), including the information required when these subsections are applicable by reference under:

(a) Section 31A-7-201;

(b) Section 31A-8-205; or

(c) Subsection 31A-9-205(2).

[~~(12)~~] (15) "Bylaws" means the rules adopted for the regulation or management of a corporation's affairs, however designated and includes comparable rules for trusts and other entities that are not corporations.

[~~(13)~~] (16) "Casualty insurance" means liability insurance as defined in Subsection [~~(59)~~] (70).

[~~(14)~~] (17) "Certificate" means [~~the~~] evidence of insurance given to:

(a) an insured under a group insurance policy; or

(b) a third party.

[~~(15)~~] (18) "Certificate of authority" is included within the term "license."

[~~(16)~~] (19) "Claim," unless the context otherwise requires, means a request or demand on an insurer for payment of benefits according to the terms of an insurance policy.

[~~(17)~~] (20) "Claims-made coverage" means an insurance contract or provision limiting coverage under a policy insuring against legal liability to claims that are first made against the insured while the policy is in force.

[~~(18)~~] (21) (a) "Commissioner" or "commissioner of insurance" means Utah's insurance commissioner.

(b) When appropriate, the terms listed in Subsection [~~(18)~~] (21)(a) apply to the equivalent supervisory official of another jurisdiction.

(22) (a) "Continuing care insurance" means insurance that:

(i) provides board and lodging;

(ii) provides one or more of the following services:

(A) personal services;

(B) nursing services;

(C) medical services; or

(D) other health-related services; and

(iii) provides the coverage described in Subsection (22)(a)(i) under an agreement effective:

(A) for the life of the insured; or

(B) for a period in excess of one year.

(b) Insurance is continuing care insurance regardless of whether or not the board and lodging are provided at the same location as the services described in Subsection (22)(a)(ii).

[~~(19)~~] (23) (a) "Control," "controlling," "controlled," or "under common control" means the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person. This control may be:

(i) by contract;

(ii) by common management;

(iii) through the ownership of voting securities; or

(iv) by a means other than those described in Subsections [~~(19)~~] (23)(a)(i) through (iii).

(b) There is no presumption that an individual holding an official position with another person controls that person solely by reason of the position.

(c) A person having a contract or arrangement giving control is considered to have control despite the illegality or invalidity of the contract or arrangement.

(d) There is a rebuttable presumption of control in a person who directly or indirectly owns, controls, holds with the power to vote, or holds proxies to vote 10% or more of the voting securities of another person.

[~~(20)~~] (24) (a) "Corporation" means insurance corporation, except when referring to:

(i) a corporation doing business as an insurance broker, consultant, or adjuster under:

(A) Chapter 23, Insurance Marketing - Licensing Agents, Brokers, Consultants, and Reinsurance Intermediaries; and

(B) Chapter 26, Insurance Adjusters; or

(ii) a noninsurer that is part of a holding company system under Chapter 16, Insurance Holding Companies.

(b) "Stock corporation" means stock insurance corporation.

(c) "Mutual" or "mutual corporation" means a mutual insurance corporation.

[~~(21)~~] (25) "Credit [~~disability~~] accident and health insurance" means insurance on a debtor to provide indemnity for payments coming due on a specific loan or other credit transaction while the debtor is disabled.

[~~(22)~~] (26) "Credit insurance" means surety insurance under which mortgagees and other creditors are indemnified against losses caused by the default of debtors.

[~~(23)~~] (27) "Credit life insurance" means insurance on the life of a debtor in connection with a loan or other credit transaction.

[~~(24)~~] (28) "Creditor" means a person, including an insured, having any claim, whether:

(a) matured;

(b) unmatured;

(c) liquidated;

(d) unliquidated;

(e) secured;

(f) unsecured;

(g) absolute;

(h) fixed; or

(i) contingent.

[~~(25)~~] (29) (a) "Customer service representative" means a person that provides insurance services and insurance product information:

(i) for its agent, broker, or consultant employer; and

(ii) to its employer's customer, client, or organization.

(b) A customer service representative may only operate within the scope of authority of its agent, broker, or consultant employer.

(30) "Deadline" means the final date or time:

(a) imposed by:

(i) statute;

(ii) rule; or

(iii) order; and

(b) by which a required filing or payment must be received by the department.

[~~(26)~~] (31) "Deemer clause" means a provision under this title under which upon the occurrence of a condition precedent, the commissioner is deemed to have taken a specific action. If the statute so provides, the condition precedent may be the commissioner's failure to take a specific
action.

[~~(27)~~] (32) "Degree of relationship" means the number of steps between two persons determined by counting the generations separating one person from a common ancestor and then counting the generations to the other person.

[~~(28)~~] (33) "Department" means the Insurance Department.

[~~(29)~~] (34) "Director" means a member of the board of directors of a corporation.

[~~(30) "Disability insurance" means insurance written to:~~]

[~~(a) indemnify for losses and expenses resulting from accident or sickness;~~]

[~~(b) provide payments to replace income lost from accident or sickness; and~~]

[~~(c) pay for services resulting directly from accident or sickness, including medical, surgical, hospital, and other ancillary expenses.~~]

(35) "Disability" means a physiological or psychological condition that partially or totally limits an individual's ability to:

(a) perform the duties of:

(i) that individual's occupation; or

(ii) any occupation for which the individual is reasonably suited by education, training, or experience; or

(b) perform two or more of the following basic activities of daily living:

(i) eating;

(ii) toileting;

(iii) transferring;

(iv) bathing; or

(v) dressing.

[~~(31)~~] (36) "Domestic insurer" means an insurer organized under the laws of this state.

[~~(32)~~] (37) "Domiciliary state" means the state in which an insurer:

(a) is incorporated;

(b) is organized; or

(c) in the case of an alien insurer, enters into the United States.

[~~(33)~~] (38) "Employee benefits" means one or more benefits or services provided employees or their dependents.

[~~(34)~~] (39) (a) "Employee welfare fund" means a fund:

(i) established or maintained, whether directly or through trustees, by:

(A) one or more employers;

(B) one or more labor organizations; or

(C) a combination of employers and labor organizations; and

(ii) that provides employee benefits paid or contracted to be paid, other than income from

investments of the fund, by or on behalf of an employer doing business in this state or for the benefit of any person employed in this state.

(b) "Employee welfare fund" includes a plan funded or subsidized by user fees or tax revenues.

(40) "Endorsement" means a written agreement attached to a policy or certificate to modify one or more of the provisions of the policy or certificate.

[~~(35)~~] (41) "Excludes" is not exhaustive and does not mean that other things are not also excluded. The items listed are representative examples for use in interpretation of this title.

(42) "Expense reimbursement insurance" means insurance:

(a) written to provide payments for expenses relating to hospital confinements resulting from illness or injury; and

(b) written:

(i) as a daily limit for a specific number of days in a hospital; and

(ii) to have a one or two day waiting period following a hospitalization.

[~~(36)~~] (43) "Fidelity insurance" means insurance guaranteeing the fidelity of persons holding positions of public or private trust.

(44) (a) "Filed" means that a filing is:

(i) submitted to the department in accordance with any applicable statute, rule, or filing order;

(ii) received by the department within the time period provided in the applicable statute, rule, or filing order; and

(iii) accompanied with the applicable one or more filing fees required by:

(A) Section 31A-3-103; or

(B) rule.

(b) "Filed" does not include a filing that is rejected by the department because it is not submitted in accordance with Subsection (44)(a).

(45) "Filing," when used as a noun, means an item required to be filed with the department including:

(a) a policy;

(b) a rate;

(c) a form;

(d) a document;

(e) a plan;

(f) a manual;

(g) an application;

(h) a report;

(i) a certificate;

(j) an endorsement;

(k) an actuarial certification;

(l) a licensee annual statement;

(m) a licensee renewal application; or

(n) an advertisement.

[~~(37)~~] (46) "First party insurance" means an insurance policy or contract in which the insurer agrees to pay claims submitted to it by the insured for the insured's losses.

[~~(38)~~] (47) "Foreign insurer" means an insurer domiciled outside of this state, including an alien insurer.

[~~(39)~~] (48) (a) "Form" means a policy, certificate, or application prepared for general use.

(b) "Form" does not include a document specially prepared for use in an individual case.

[~~(40)~~] (49) "Franchise insurance" means individual insurance policies provided through a mass marketing arrangement involving a defined class of persons related in some way other than through the purchase of insurance.

(50) "Health care" means any of the following intended for use in the diagnosis, treatment, mitigation, or prevention of a human ailment or impairment:

(a) professional services;

(b) personal services;

(c) facilities;

(d) equipment;

(e) devices;

(f) supplies; or

(g) medicine.

[~~(41)~~] (51) (a) "Health care insurance" or "health insurance" means [~~disability~~] insurance providing [~~benefits solely of medical, surgical, hospital, or other ancillary services or payment of medical, surgical, hospital, or other ancillary expenses incurred.~~]:

(i) health care benefits; or

(ii) payment of incurred health care expenses.

(b) "Health care insurance" or "health insurance" does not include [~~disability~~] accident and health insurance providing benefits for:

(i) replacement of income;

(ii) short-term accident;

(iii) fixed indemnity;

(iv) credit [~~disability~~] accident and health;

(v) supplements to liability;

(vi) workers' compensation;

(vii) automobile medical payment;

(viii) no-fault automobile;

(ix) equivalent self-insurance; or

(x) any type of [~~disability~~] accident and health insurance coverage that is a part of or attached to another type of policy.

(52) "Income replacement insurance" or "disability income insurance" means insurance written to provide payments to replace income lost from accident or sickness.

[~~(42)~~] (53) "Indemnity" means the payment of an amount to offset all or part of an insured loss.

[~~(43)~~] (54) "Independent adjuster" means an insurance adjuster required to be licensed under Section 31A-26-201 who engages in insurance adjusting as a representative of insurers.

[~~(44)~~] (55) "Independently procured insurance" means insurance procured under Section 31A-15-104.

[~~(45)~~] (56) "Individual" means a natural person.

[~~(46)~~] (57) "Inland marine insurance" includes insurance covering:

(a) property in transit on or over land;

(b) property in transit over water by means other than boat or ship;

(c) bailee liability;

(d) fixed transportation property such as bridges, electric transmission systems, radio and television transmission towers and tunnels; and

(e) personal and commercial property floaters.

[~~(47)~~] (58) "Insolvency" means that:

(a) an insurer is unable to pay its debts or meet its obligations as they mature;

(b) an insurer's total adjusted capital is less than the insurer's mandatory control level RBC under Subsection 31A-17-601[~~(7)~~](8)(c); or

(c) an insurer is determined to be hazardous under this title.

[~~(48)~~] (59) (a) "Insurance" means:

(i) an arrangement, contract, or plan for the transfer of a risk or risks from one or more persons to one or more other persons; or

(ii) an arrangement, contract, or plan for the distribution of a risk or risks among a group of persons that includes the person seeking to distribute that person's risk.

(b) "Insurance" includes:

(i) risk distributing arrangements providing for compensation or replacement for damages or loss through the provision of services or benefits in kind;

(ii) contracts of guaranty or suretyship entered into by the guarantor or surety as a business and not as merely incidental to a business transaction; and

(iii) plans in which the risk does not rest upon the person who makes the arrangements, but with a class of persons who have agreed to share it.

[~~(49)~~] (60) "Insurance adjuster" means a person who directs the investigation, negotiation,

or settlement of a claim under an insurance policy other than life insurance or an annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.

[~~(50)~~] (61) "Interinsurance exchange" is defined in Subsection [~~(81)~~] (100).

[~~(51)~~] (62) Except as provided in Subsection [~~31A-23-102(2)~~] 31A-23-201.5(1), "insurance agent" or "agent" means a person who represents insurers in soliciting, negotiating, or placing insurance.

[~~(52)~~] (63) Except as provided in Subsection [~~31A-23-102(2)~~] 31A-23-201.5(1), "insurance broker" or "broker" means a person who:

(a) acts in procuring insurance on behalf of an applicant for insurance or an insured; and

(b) does not act on behalf of the insurer except by collecting premiums or performing other ministerial acts.

[~~(53)~~] (64) "Insurance business" or "business of insurance" includes:

(a) providing health care insurance, as defined in Subsection [~~(41)~~] (51), by organizations that are or should be licensed under this title;

(b) providing benefits to employees in the event of contingencies not within the control of the employees, in which the employees are entitled to the benefits as a right, which benefits may be provided either:

(i) by single employers or by multiple employer groups; or

(ii) through trusts, associations, or other entities;

(c) providing annuities, including those issued in return for gifts, except those provided by persons specified in Subsections 31A-22-1305(2) and (3);

(d) providing the characteristic services of motor clubs as outlined in Subsection [~~(65)~~] (77);

(e) providing other persons with insurance as defined in Subsection [~~(48)~~] (59);

(f) making as insurer, guarantor, or surety, or proposing to make as insurer, guarantor, or surety, any contract or policy of title insurance;

(g) transacting or proposing to transact any phase of title insurance, including solicitation, negotiation preliminary to execution, execution of a contract of title insurance, insuring, and transacting matters subsequent to the execution of the contract and arising out of it, including

reinsurance; and

(h) doing, or proposing to do, any business in substance equivalent to Subsections [~~(53)~~] (64)(a) through (g) in a manner designed to evade the provisions of this title.

[~~(54)~~] (65) Except as provided in Subsection [~~31A-23-102(2)~~] 31A-23-201.5(1), "insurance consultant" or "consultant" means a person who:

(a) advises other persons about insurance needs and coverages;

(b) is compensated by the person advised on a basis not directly related to the insurance placed; and

(c) is not compensated directly or indirectly by an insurer, agent, or broker for advice given.

[~~(55)~~] (66) "Insurance holding company system" means a group of two or more affiliated persons, at least one of whom is an insurer.

[~~(56)~~] (67) (a) "Insured" means a person to whom or for whose benefit an insurer makes a promise in an insurance policy and includes:

(i) policyholders;

(ii) subscribers;

(iii) members; and

(iv) beneficiaries.

(b) The definition in Subsection [~~(56)~~] (67)(a) applies only to this title and does not define the meaning of this word as used in insurance policies or certificates.

[~~(57)~~] (68) (a) (i) "Insurer" means any person doing an insurance business as a principal including:

(A) fraternal benefit societies;

(B) issuers of gift annuities other than those specified in Subsections 31A-22-1305(2) and (3);

(C) motor clubs;

(D) employee welfare plans; and

(E) any person purporting or intending to do an insurance business as a principal on that person's own account.

(ii) "Insurer" does not include a governmental entity, as defined in Section 63-30-2, to the extent it is engaged in the activities described in Section 31A-12-107.

(b) "Admitted insurer" is defined in Subsection [~~(94)~~] (115)(b).

(c) "Alien insurer" is defined in Subsection [~~(4)~~] (5).

(d) "Authorized insurer" is defined in Subsection [~~(94)~~] (115)(b).

(e) "Domestic insurer" is defined in Subsection [~~(31)~~] (36).

(f) "Foreign insurer" is defined in Subsection [~~(38)~~] (47).

(g) "Nonadmitted insurer" is defined in Subsection [~~(94)~~] (115)(a).

(h) "Unauthorized insurer" is defined in Subsection [~~(94)~~] (115)(a).

[~~(58)~~] (69) (a) Except as provided in Section 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for specified legal expenses.

(b) "Legal expense insurance" includes arrangements that create reasonable expectations of enforceable rights, but it does not include the provision of, or reimbursement for, legal services incidental to other insurance coverages.

[~~(59)~~] (70) (a) "Liability insurance" means insurance against liability:

(i) for death, injury, or disability of any human being, or for damage to property, exclusive of the coverages under:

(A) Subsection [~~(62)~~] (74) for medical malpractice insurance;

(B) Subsection [~~(77)~~] (92) for professional liability insurance; and

(C) Subsection [~~(97)~~] (118) for workers' compensation insurance;

(ii) for medical, hospital, surgical, and funeral benefits to persons other than the insured who are injured, irrespective of legal liability of the insured, when issued with or supplemental to insurance against legal liability for the death, injury, or disability of human beings, exclusive of the coverages under:

(A) Subsection [~~(62)~~] (74) for medical malpractice insurance;

(B) Subsection [~~(77)~~] (92) for professional liability insurance; and

(C) Subsection [~~(97)~~] (118) for workers' compensation insurance;

(iii) for loss or damage to property resulting from accidents to or explosions of boilers, pipes,

pressure containers, machinery, or apparatus;

(iv) for loss or damage to any property caused by the breakage or leakage of sprinklers, water pipes and containers, or by water entering through leaks or openings in buildings; or

(v) for other loss or damage properly the subject of insurance not within any other kind or kinds of insurance as defined in this chapter, if such insurance is not contrary to law or public policy.

(b) "Liability insurance" includes:

(i) vehicle liability insurance as defined in Subsection [~~(95)~~] (116);

(ii) residential dwelling liability insurance as defined in Subsection [~~(83)~~] (102); and

(iii) making inspection of, and issuing certificates of inspection upon, elevators, boilers, machinery, and apparatus of any kind when done in connection with insurance on them.

[~~(60)~~] (71) "License" means the authorization issued by the insurance commissioner under this title to engage in some activity that is part of or related to the insurance business. It includes certificates of authority issued to insurers.

[~~(61)~~] (72) (a) "Life insurance" means insurance on human lives and insurances pertaining to or connected with human life.

(b) The business of life insurance includes:

(i) granting death benefits;

[~~(i)~~] (ii) granting annuity benefits;

[~~(ii)~~] (iii) granting endowment benefits;

[~~(iii)~~] (iv) granting additional benefits in the event of death by accident [~~or accidental means~~];

[~~(iv)~~] (v) granting additional benefits to safeguard the policy against lapse in the event of [~~the total and permanent~~] disability [~~of the insured~~]; and

[~~(v)~~] (vi) providing optional methods of settlement of proceeds.

(73) (a) "Long-term care insurance" means an insurance policy or rider advertised, marketed, offered, or designated to provide coverage:

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

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

(A) expenses incurred;

(B) indemnity;

(C) prepayment; or

(D) another method;

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

(A) diagnostic;

(B) preventative;

(C) therapeutic;

(D) rehabilitative;

(E) maintenance; or

(F) personal care; and

(iv) that may be issued by:

(A) an insurer;

(B) a fraternal benefit society;

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

(II) a medical service corporation;

(D) a prepaid health plan;

(E) a health maintenance organization; or

(F) an entity similar to the entities described in Subsections (73)(a)(iv)(A) through (E) to the extent that the entity is otherwise authorized to issue life or health care insurance.

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

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

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

(B) a life insurance policy or rider;

(ii) a policy or rider that provides for payment of benefits based on:

(A) cognitive impairment; or

(B) functional capacity; or

(iii) a qualified long-term care insurance contract.

(c) "Long-term care insurance" does not include:

(i) a policy that is offered primarily to provide basic Medicare supplement coverage;

(ii) basic hospital expense coverage;

(iii) basic medical/surgical expense coverage;

(iv) hospital confinement indemnity coverage;

(v) major medical expense coverage;

(vi) income replacement or related asset-protection coverage;

(vii) accident only coverage;

(viii) coverage for a specified:

(A) disease; or

(B) accident;

(ix) limited benefit health coverage; or

(x) a life insurance policy that accelerates the death benefit to provide the option of a lump sum payment:

(A) if neither the benefits nor eligibility is conditioned on the receipt of long-term care; and

(B) the coverage is for one or more the following qualifying events:

(I) terminal illness;

(II) medical conditions requiring extraordinary medical intervention; or

(III) permanent institutional confinement.

[~~(62)~~] (74) "Medical malpractice insurance" means insurance against legal liability incident to the practice and provision of medical services other than the practice and provision of dental services.

[~~(63)~~] (75) "Member" means a person having membership rights in an insurance corporation.

[~~(64)~~] (76) "Minimum capital" or "minimum required capital" means the capital that must be constantly maintained by a stock insurance corporation as required by statute.

[~~(65)~~] (77) "Motor club" means a person:

(a) licensed under:

(i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;

(ii) Chapter 11, Motor Clubs; or

(iii) Chapter 14, Foreign Insurers; and

(b) that promises for an advance consideration to provide for a stated period of time:

(i) legal services under Subsection 31A-11-102(1)(b);

(ii) bail services under Subsection 31A-11-102(1)(c); or

(iii) trip reimbursement, towing services, emergency road services, stolen automobile services, a combination of these services, or any other services given in Subsections 31A-11-102(1)(b) through (f).

[~~(66)~~] (78) "Mutual" means mutual insurance corporation.

[~~(67)~~] (79) "Nonparticipating" means a plan of insurance under which the insured is not entitled to receive dividends representing shares of the surplus of the insurer.

[~~(68)~~] (80) "Ocean marine insurance" means insurance against loss of or damage to:

(a) ships or hulls of ships;

(b) goods, freight, cargoes, merchandise, effects, disbursements, profits, moneys, securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia interests, or other cargoes in or awaiting transit over the oceans or inland waterways;

(c) earnings such as freight, passage money, commissions, or profits derived from transporting goods or people upon or across the oceans or inland waterways; or

(d) a vessel owner or operator as a result of liability to employees, passengers, bailors, owners of other vessels, owners of fixed objects, customs or other authorities, or other persons in connection with maritime activity.

[~~(69)~~] (81) "Order" means an order of the commissioner.

(82) "Outline of coverage" means a summary that explains an accident and health insurance policy.

[~~(70)~~] (83) "Participating" means a plan of insurance under which the insured is entitled to receive dividends representing shares of the surplus of the insurer.

[~~(71)~~] (84) "Person" includes an individual, partnership, corporation, incorporated or

unincorporated association, joint stock company, trust, reciprocal, syndicate, or any similar entity or combination of entities acting in concert.

[~~(72)~~] (85) (a) (i) "Policy" means any document, including attached endorsements and riders, purporting to be an enforceable contract, which memorializes in writing some or all of the terms of an insurance contract.

(ii) "Policy" includes a service contract issued by:

(A) a motor club under Chapter 11, Motor Clubs; [~~and~~]

(B) a service contract provided under Chapter 6a, Service Contracts; and

[~~(B)~~] (C) a corporation licensed under:

(I) Chapter 7, Nonprofit Health Service Insurance Corporations; or

(II) Chapter 8, Health Maintenance Organizations and Limited Health Plans.

(iii) "Policy" does not include:

(A) a certificate under a group insurance contract; or

(B) a document that does not purport to have legal effect.

(b) "Group insurance policy" means a policy covering a group of persons that is issued to a policyholder on behalf of the group, for the benefit of group members who are selected under procedures defined in the policy or in agreements which are collateral to the policy. This type of policy may include members of the policyholder's family or dependents.

(c) "Blanket insurance policy" means a group policy covering classes of persons without individual underwriting, where the persons insured are determined by definition of the class with or without designating the persons covered.

[~~(73)~~] (86) "Policyholder" means the person who controls a policy, binder, or oral contract by ownership, premium payment, or otherwise.

(87) "Policy illustration" means a presentation or depiction that includes nonguaranteed elements of a policy of life insurance over a period of years.

(88) "Policy summary" means a synopsis describing the elements of a life insurance policy.

[~~(74)~~] (89) (a) "Premium" means the monetary consideration for an insurance policy, and includes assessments, membership fees, required contributions, or monetary consideration, however

designated.

(b) Consideration paid to third party administrators for their services is not "premium," though amounts paid by third party administrators to insurers for insurance on the risks administered by the third party administrators are "premium."

[~~(75)~~] (90) "Principal officers" of a corporation means the officers designated under Subsection 31A-5-203(3).

[~~(76)~~] (91) "Proceedings" includes actions and special statutory proceedings.

[~~(77)~~] (92) "Professional liability insurance" means insurance against legal liability incident to the practice of a profession and provision of any professional services.

[~~(78)~~] (93) "Property insurance" means insurance against loss or damage to real or personal property of every kind and any interest in that property, from all hazards or causes, and against loss consequential upon the loss or damage including vehicle comprehensive and vehicle physical damage coverages, but excluding inland marine insurance and ocean marine insurance as defined under Subsections [~~(46)~~] (57) and [~~(68)~~] (80).

[~~(79)~~] (94) (a) "Public agency insurance mutual" means any entity formed by joint venture or interlocal cooperation agreement by two or more political subdivisions or public agencies of the state for the purpose of providing insurance coverage for the political subdivisions or public agencies.

(b) Any public agency insurance mutual created under this title and Title 11, Chapter 13, Interlocal Cooperation Act, is considered to be a governmental entity and political subdivision of the state with all of the rights, privileges, and immunities of a governmental entity or political subdivision of the state.

(95) "Qualified long-term care insurance contract" or "federally tax qualified long-term care insurance contract" means:

(a) an individual or group insurance contract that meets the requirements of Section 7702B(b), Internal Revenue Code; or

(b) the portion of a life insurance contract that provides long-term care insurance:

(i) (A) by rider; or

(B) as a part of the contract; and

(ii) that satisfies the requirements of Section 7702B(b) and (e), Internal Revenue Code.

(96) (a) "Rate" means:

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

(ii) for property-casualty insurance, that cost of insurance per exposure unit either expressed as:

(A) a single number; or

(B) a pure premium rate, adjusted before any application of individual risk variations based on loss or expense considerations to account for the treatment of:

(I) expenses;

(II) profit; and

(III) individual insurer variation in loss experience.

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

[~~(80)~~] (97) (a) Except as provided in Subsection [~~(80)~~] (97)(b), "rate service organization" means any person who assists insurers in rate making or filing by:

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

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

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

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

(i) an employee of an insurer;

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

(iii) a joint underwriting group; or

(iv) a natural person serving as an actuarial or legal consultant.

(98) "Rating manual" means any of the following used to determine initial and renewal policy premiums:

(a) a manual of rates;

(b) classifications;

(c) rate-related underwriting rules; and

(d) rating formulas that describe steps, policies, and procedures for determining initial and renewal policy premiums.

(99) "Received by the department" means:

(a) except as provided in Subsection (99)(b), the date delivered to and stamped received by the department, whether delivered:

(i) in person;

(ii) by a delivery service; or

(iii) electronically; and

(b) if an item with a department imposed deadline is delivered to the department by a delivery service, the delivery service's postmark date or pick-up date unless otherwise stated in:

(i) statute;

(ii) rule; or

(iii) a specific filing order.

[~~(81)~~] (100) "Reciprocal" or "interinsurance exchange" means any unincorporated association of persons:

(a) operating through an attorney-in-fact common to all of them; and

(b) exchanging insurance contracts with one another that provide insurance coverage on each other.

[~~(82)~~] (101) "Reinsurance" means an insurance transaction where an insurer, for consideration, transfers any portion of the risk it has assumed to another insurer. In referring to reinsurance transactions, this title sometimes refers to:

(a) the insurer transferring the risk as the "ceding insurer"; and

(b) the insurer assuming the risk as the:

(i) "assuming insurer"; or

(ii) "assuming reinsurer."

[~~(83)~~] (102) "Residential dwelling liability insurance" means insurance against liability resulting from or incident to the ownership, maintenance, or use of a residential dwelling that is a detached single family residence or multifamily residence up to four units.

[~~(84)~~] (103) "Retrocession" means reinsurance with another insurer of a liability assumed under a reinsurance contract. A reinsurer "retrocedes" when it reinsures with another insurer part of a liability assumed under a reinsurance contract.

(104) "Rider" means an endorsement to:

(a) an insurance policy; or

(b) an insurance certificate.

[~~(85)~~] (105) (a) "Security" means any:

(i) note;

(ii) stock;

(iii) bond;

(iv) debenture;

(v) evidence of indebtedness;

(vi) certificate of interest or participation in any profit-sharing agreement;

(vii) collateral-trust certificate;

(viii) preorganization certificate or subscription;

(ix) transferable share;

(x) investment contract;

(xi) voting trust certificate;

(xii) certificate of deposit for a security;

(xiii) certificate of interest of participation in an oil, gas, or mining title or lease or in payments out of production under such a title or lease;

(xiv) commodity contract or commodity option;

(xv) any certificate of interest or participation in, temporary or interim certificate for, receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed in Subsections [~~(85)~~] (105)(a)(i) through (xiv); or

(xvi) any other interest or instrument commonly known as a security.

(b) "Security" does not include:

(i) any insurance or endowment policy or annuity contract under which an insurance

company promises to pay money in a specific lump sum or periodically for life or some other specified period; or

(ii) a burial certificate or burial contract.

[~~(86)~~] (106) "Self-insurance" means any arrangement under which a person provides for spreading its own risks by a systematic plan.

(a) Except as provided in this Subsection [~~(86)~~] (106), self-insurance does not include an arrangement under which a number of persons spread their risks among themselves.

(b) Self-insurance does include an arrangement by which a governmental entity, as defined in Section 63-30-2, undertakes to indemnify its employees for liability arising out of the employees' employment.

(c) Self-insurance does include an arrangement by which a person with a managed program of self-insurance and risk management undertakes to indemnify its affiliates, subsidiaries, directors, officers, or employees for liability or risk which is related to the relationship or employment.

(d) Self-insurance does not include any arrangement with independent contractors.

(107) "Short-term care insurance" means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage that is similar to long-term care insurance but that provides coverage for less than 12 consecutive months for each covered person.

[~~(87)~~] (108) (a) "Subsidiary" of a person means an affiliate controlled by that person either directly or indirectly through one or more affiliates or intermediaries.

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

[~~(88)~~] (109) Subject to Subsection [~~(48)~~] (59)(b), "surety insurance" includes:

(a) a guarantee against loss or damage resulting from failure of principals to pay or perform their obligations to a creditor or other obligee;

(b) bail bond insurance; and

(c) fidelity insurance.

[~~(89)~~] (110) (a) "Surplus" means the excess of assets over the sum of paid-in capital and

liabilities.

(b) (i) "Permanent surplus" means the surplus of a mutual insurer that has been designated by the insurer as permanent.

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

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

(c) "Excess surplus" means:

(i) for life or [~~disability insurers, as defined in Subsection 31A-17-601(3),~~] accident and health insurers, health organizations, and property and casualty insurers[~~,~~] as defined in [~~Subsection~~] Section 31A-17-601[~~(4)~~], the lesser of:

(A) that amount of an insurer's or health organization's total adjusted capital, as defined in Subsection [~~(92)~~] (113), that exceeds the product of:

(I) 2.5; and

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

(B) that amount of an insurer's or health organization's total adjusted capital, as defined in Subsection [~~(92)~~] (113), that exceeds the product of:

(I) 3.0; and

(II) the authorized control level RBC as defined in Subsection 31A-17-601[~~(7)~~](8)(a); and

(ii) for monoline mortgage guaranty insurers, financial guaranty insurers, and title insurers, that amount of an insurer's paid-in-capital and surplus that exceeds the product of:

(A) 1.5; and

(B) the insurer's total adjusted capital required by Subsection 31A-17-609(1).

[~~(90)~~] (111) "Third party administrator" or "administrator" means any person who collects charges or premiums from, or who, for consideration, adjusts or settles claims of residents of the state in connection with insurance coverage, annuities, or service insurance coverage, except:

(a) a union on behalf of its members;

(b) a person [~~exempt as a trust under Section 514 of~~] administering any:

(i) pension plan subject to the federal Employee Retirement Income Security Act of 1974;

(ii) governmental plan as defined in Section 414(d), Internal Revenue Code; or

(iii) nonelecting church plan as described in Section 410(d), Internal Revenue Code;

(c) an employer on behalf of the employer's employees or the employees of one or more of the subsidiary or affiliated corporations of the employer;

(d) an insurer licensed under Chapter 5, 7, 8, 9, or 14, but only [~~with respect to insurance issued by the insurer~~] for a line of insurance for which the insurer holds a license in this state; or

(e) a person licensed or exempt from licensing under Chapter 23 or 26 whose activities are limited to those authorized under the license the person holds or for which the person is exempt.

[~~(91)~~] (112) "Title insurance" means the insuring, guaranteeing, or indemnifying of owners of real or personal property or the holders of liens or encumbrances on that property, or others interested in the property against loss or damage suffered by reason of liens or encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity or unenforceability of any liens or encumbrances on the property.

[~~(92)~~] (113) "Total adjusted capital" means the sum of an insurer's or health organization's statutory capital and surplus as determined in accordance with:

(a) the statutory accounting applicable to the annual financial statements required to be filed under Section 31A-4-113; and

(b) any other items provided by the RBC instructions, as RBC instructions is defined in [~~Subsection~~] Section 31A-17-601[~~(6)~~].

[~~(93)~~] (114) (a) "Trustee" means "director" when referring to the board of directors of a corporation.

(b) "Trustee," when used in reference to an employee welfare fund, means an individual, firm, association, organization, joint stock company, or corporation, whether acting individually or jointly and whether designated by that name or any other, that is charged with or has the overall management of an employee welfare fund.

[~~(94)~~] (115) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted insurer"

means an insurer:

(i) not holding a valid certificate of authority to do an insurance business in this state; or

(ii) transacting business not authorized by a valid certificate.

(b) "Admitted insurer" or "authorized insurer" means an insurer:

(i) holding a valid certificate of authority to do an insurance business in this state; and

(ii) transacting business as authorized by a valid certificate.

[~~(95)~~] (116) "Vehicle liability insurance" means insurance against liability resulting from or incident to ownership, maintenance, or use of any land vehicle or aircraft, exclusive of vehicle comprehensive and vehicle physical damage coverages under Subsection [~~(78)~~] (93).

[~~(96)~~] (117) "Voting security" means a security with voting rights, and includes any security convertible into a security with a voting right associated with it.

[~~(97)~~] (118) "Workers' compensation insurance" means:

(a) insurance for indemnification of employers against liability for compensation based on:

(i) compensable accidental injuries; and

(ii) occupational disease disability;

(b) employer's liability insurance incidental to workers compensation insurance and written in connection with it; and

(c) insurance assuring to the persons entitled to workers compensation benefits the compensation provided by law.

Section 6. Section **31A-2-214** is amended to read:

31A-2-214. Market assistance programs -- Joint underwriting associations.

(1) (a) If the commissioner finds that in any part of this state a line of insurance is not generally available in the marketplace or that it is priced in such a manner as to severely limit its availability, and that the public interest requires it, [~~he~~] the commissioner may by rule implement a market assistance program whereby all licensed insurers and agents may pool their information as to the available markets.

(b) Insurers doing business in this state may, at their own instance or at the request of the commissioner, prepare and submit to the commissioner, for [~~his~~] the commissioner's approval and

adoption, voluntary plans providing any line of insurance coverage for all or any part of this state in which this insurance is not generally available in the voluntary market or is priced in such a manner as to severely limit its availability and in which the public interest requires the availability of this coverage.

(2) (a) If the commissioner finds after notice and hearing that a market assistance program formed under Subsection (1)(a) or (b) has not met the needs it was intended to address, [~~he~~] the commissioner may by rule form a joint underwriting association to make available the insurance to applicants who are in good faith entitled to but unable to procure this insurance through ordinary methods.

(b) The commissioner shall allow any market assistance program formed under Subsection (1)(a) or (b) a minimum of 30 days operation before [~~he~~] the commissioner forms a joint underwriting association. The commissioner may not adopt a rule forming a joint underwriting association unless [~~he~~] the commissioner finds as a result of the hearing that:

(i) a certain coverage is not available or that the price for that coverage is no longer commensurate with the risk in this state; and

(ii) the coverage is:

(A) vital to the economic health of this state[~~, is~~];

(B) vital to the quality of life in this state[~~, is~~];

(C) vital in maintaining competition in insurance in this state[~~;~~]; or

(D) the number of people affected is significant enough to justify its creation.

[~~(b)~~] (c) The commissioner may not adopt a rule forming a joint underwriting association under Subsection (2)(a) on the basis that applicants for particular lines of insurance are unable to pay a premium that is commensurate with the risk involved or that the number of applicants or people affected is too small to justify its creation.

[~~(c)~~] (d) Each joint underwriting association formed under Subsection (2)(a) shall require participation by all insurers licensed and engaged in writing that line of insurance or any component of that line of insurance within this state.

[~~(d)~~] (e) Each association formed under Subsection (2)(a) shall:

(i) give consideration to:

(A) the need for adequate and readily accessible coverage;

(B) alternative methods of improving the market affected;

(C) the preference of the insurers and agents;

(D) the inherent limitations of the insurance mechanism;

(E) the need for reasonable underwriting standards; and

(F) the requirement of reasonable loss prevention measures;

(ii) establish procedures that will create minimum interference with the voluntary market;

(iii) allocate the burden imposed by the association equitably and efficiently among the insurers doing business in this state;

(iv) establish procedures for applicants and participants to have grievances reviewed by an impartial body;

(v) provide for the method of classifying risks and making and filing applicable rates; and

(vi) specify:

(A) the basis of participation of insurers and agents in the association;

(B) the conditions under which risks must be accepted; and

(C) the commission rates to be paid for insurance business placed with the association.

[~~(e)~~] (f) Any deficit in an association in any year shall be recouped by rate increases for the association, applicable prospectively. Any surplus in excess of the loss reserves of the association in any year shall be distributed either by rate decreases or by distribution to the members of the association on a pro-rata basis.

(3) Notwithstanding [~~the provisions of~~] Subsection (2), the commissioner may not create a joint underwriting association under [~~that subsection~~] Subsection (2) for:

(a) life insurance[~~,~~];

(b) annuities[~~, disability~~];

(c) accident and health insurance[~~,~~];

(d) ocean marine insurance[~~,~~];

(e) medical malpractice insurance[~~,~~];

(f) earthquake insurance[~~,~~];

(g) workers' compensation insurance[~~,~~];

(h) public agency insurance mutuals[~~,~~]; or

(i) private passenger automobile liability insurance.

(4) Every insurer and agent participating in a joint underwriting association adopted by the commissioner under Subsection (2) shall provide the services prescribed by the association to any person seeking coverage of the kind available in the plan, including full information about the requirements and procedures for obtaining coverage with the association.

(5) If the commissioner finds that the lack of cooperating insurers or agents in an area makes the functioning of the association difficult, [~~he~~] the commissioner may order the association to:

(a) establish branch service offices[~~,~~];

(b) make special contracts for provision of the service[~~,~~]; or

(c) take other appropriate steps to ensure that service is available.

(6) The association may issue policies for a period of one year. If, at the end of any one year period, the commissioner determines that the market conditions justify the continued existence of the association, [~~he~~] the commissioner may reauthorize its existence. In reauthorizing the association, the commissioner shall follow the procedure set forth in Subsection (2).

Section 7. Section **31A-2-217** is enacted to read:

31A-2-217. Coordination with other states.

(1) (a) Subject to Subsection (1)(b), the commissioner, by rule, may adopt one or more agreements with another governmental regulatory agency, within and outside of this state, or with the National Association of Insurance Commissioners to address:

(i) licensing of insurance companies;

(ii) licensing of agents;

(iii) regulation of premium rates and policy forms; and

(iv) regulation of insurer insolvency and insurance receiverships.

(b) An agreement described in Subsection (1)(a), may authorize the commissioner to modify a requirement of this title if the commissioner determines that the requirements under the agreement

provide protections similar to or greater than the requirements under this title.

(2) (a) The commissioner may negotiate an interstate compact that addresses issuing certificates of authority, if the commissioner determines that:

(i) each state participating in the compact has requirements for issuing certificates of authority that provide protections similar to or greater than the requirements of this title; or

(ii) the interstate compact contains requirements for issuing certificates of authority that provide protections similar to or greater than the requirements of this title.

(b) If an interstate compact described in Subsection (2)(a) is adopted by the Legislature, the commissioner may issue certificates of authority to insurers in accordance with the terms of the interstate compact.

(3) If any provision of this title conflicts with a provision of the annual statement instructions or the National Association of Insurance Commissioners Accounting Practices and Procedures Manual, the commissioner may, by rule, resolve the conflict in favor of the annual statement instructions or the National Association of Insurance Commissioners Accounting Practices and Procedures Manual.

(4) The commissioner may, by rule, accept the information prescribed by the National Association of Insurance Commissioners instead of the documents required to be filed with an application for a certificate of authority under:

(a) Section 31A-4-103, 31A-5-204, 31A-8-205, or 31A-14-201; or

(b) rules made by the commissioner.

(5) Before November 30, 2001, the commissioner shall report to the Business, Labor, and Economic Development Interim Committee regarding the status of:

(a) any agreements entered into under Subsection (1);

(b) any interstate compact entered into under Subsection (2); and

(c) any rule made under Subsections (3) and (4).

(6) This section shall be repealed in accordance with Section 63-55-231.

Section 8. Section **31A-4-103** is amended to read:

31A-4-103. Certificate of authority.

(1) Each certificate of authority issued by the commissioner shall specify:

(a) the name of the insurer[,];

(b) the kinds of insurance it is authorized to transact in Utah[,]; and

(c) any other information the commissioner requires.

(2) A certificate of authority issued under this chapter remains in force until, under Subsection (3), the certificate of authority is:

(a) revoked;

(b) suspended; or

(c) limited.

(3) (a) After an adjudicative proceeding under Title 63, Chapter 46b, Administrative Procedures Act, the commissioner may revoke, suspend, or limit in whole or in part the certificate of authority of any insurer if:

(i) the insurer is found to have:

(A) failed to pay when due any fee due under Section 31A-3-103;

(B) violated or failed to comply with:

(I) this title;

(II) a rule made under Subsection 31A-2-201(3); or

(III) an order issued under Subsection 31A-2-201(4); or

(ii) the insurer's methods and practices in the conduct of business endanger the legitimate interests of customers and the public.

(b) An order suspending or limiting a certificate of authority issued under this chapter shall specify:

(i) the period of the suspension or limitation, which in no event may be in excess of 12 months;

(ii) the conditions and limitations imposed on the insurer during the suspension or limitation; and

(iii) the conditions and procedures for reinstatement from suspension or limitation.

(4) Subject to the requirements of this section and in accordance with Title 63, Chapter 46a,

Utah Administrative Rulemaking Act, the commissioner shall by rule prescribe procedures to renew or reinstate a certificate of authority.

(5) An insurer under this chapter whose certificate of authority is suspended or revoked, but that continues to act as an authorized insurer, is subject to the penalties for acting as an insurer without a certificate of authority.

(6) Any insurer holding a certificate of authority in this state shall immediately report to the commissioner a suspension or revocation of that insurer's certificate of authority in any:

(a) state;

(b) the District of Columbia; or

(c) a territory of the United States.

(7) (a) An order revoking a certificate of authority under Subsection (3) may specify a time within which the former authorized insurer may not apply for a new certificate of authority, except that the time may not exceed five years from the date the certificate of authority is revoked.

(b) If no time is specified in an order revoking a certificate of authority under Subsection (3), the former authorized insurer may not apply for a new certificate of authority for five years from the date the certificate of authority is revoked without express approval by the commissioner.

(8) (a) Subject to Subsection (8)(b), the insurer shall pay all fees under Section 31A-3-103 that would have been payable if the certificate of authority had not been suspended or revoked, unless the commissioner, in accordance with rule, waives the payment of the fees by no later than the day of:

(i) a suspension under Subsection (3) of an insurer's certificate of authority ends; or

(ii) a new certificate of authority is issued to an insurer whose certificate of authority is revoked under Subsection (3).

(b) If a new certificate of authority is issued more than three years after the revocation of a similar certificate of authority, this Subsection (8) applies only to the fees that would have accrued during the three years immediately following the revocation.

Section 9. Section **31A-4-113** is amended to read:

31A-4-113. Annual statements.

(1) (a) Each authorized insurer shall annually, on or before March 1, file with the commissioner a true statement of its financial condition, transactions, and affairs as of December 31 of the preceding year. [~~This~~]

(b) The statement required by Subsection (1)(a) shall be:

(i) verified by the oaths of at least two of the insurer's principal officers[~~.~~]; and

(ii) in the general form and provide the information as prescribed by the commissioner by rule.

(c) The commissioner may, for good cause shown, extend the date for filing the statement[~~. The~~] required by Subsection (1)(a), except that the deadline for filing fee payment may not be extended.

[~~(2) The statement shall be in the general form and provide the information as prescribed by rule of the commissioner. In the absence of a statute providing otherwise, the statement shall be prepared in accordance with the annual statement instructions and the Accounting Practices and Procedures Manual which is published by the National Association of Insurance Commissioners.~~]

[~~(3)~~] (2) The annual statement of an alien insurer shall:

(a) relate only to its transactions and affairs in the United States unless the commissioner requires otherwise[~~. The statement shall~~]; and

(b) be verified by:

(i) the insurer's United States manager; or [~~by its~~]

(ii) the insurer's authorized officers.

Section 10. Section **31A-5-211** is amended to read:

31A-5-211. Minimum capital or permanent surplus requirements.

(1) (a) Except as provided in Subsections (4) and (5), insurers being organized or operating under this chapter shall maintain minimum capital or permanent surplus for a mutual, in amounts specified in Subsection (2).

(b) The certificate of authority issued under Section 31A-5-212 does not permit an insurer to transact types of insurance for which the insurer does not have the required minimum capital or permanent surplus for a mutual, in at least the amounts specified under Subsection (2).

(c) The types of insurance under this section are defined in Section 31A-1-301. Minimum capital and permanent surplus requirements under this section are based upon all types of insurance transacted by the insurer in any and all areas which it operates, whether or not only a portion of those types of insurance is or is to be transacted in this state.

(2) The minimum capital, or permanent surplus for a nonassessable mutual, is as follows for the indicated types of insurance:

(a) life, annuity, [~~disability~~] accident and health, or any combination of these $400,000

(b) subject to an aggregate maximum of $1,000,000 for more than one of the following types of coverages:

(i) property insurance 200,000

(ii) surety insurance 300,000

(iii) bail bonds insurance only 100,000

(iv) marine and transportation insurance 200,000

(v) vehicle liability insurance, residential dwelling liability insurance, or both 400,000

(vi) liability insurance 600,000

(vii) workers' compensation insurance 300,000

(c) title insurance 200,000

(d) professional liability insurance, excluding medical malpractice 700,000

(e) professional liability, including medical malpractice 1,000,000

(f) all types of insurance, except life, annuity, or title 2,000,000

(3) Prior to beginning operations, an insurer licensed under this chapter shall have total adjusted capital in excess of the company action level RBC as defined in Subsection 31A-17-601[~~(7)~~](8)(b).

(4) (a) Subject to Subsections (4)(b) and (4)(c), an insurer holding a valid certificate of authority to transact insurance in this state prior to July 1, 1986, continues to be authorized to transact the same kinds of insurance as permitted by that certificate of authority, if the insurer maintains not less than the amount of minimum capital or permanent surplus required for that

authority under the laws of this state in force immediately prior to July 1, 1986.

(b) If, after July 1, 1986, an insurer ever has minimum capital or permanent surplus that meets or exceeds the requirements of Subsections (2) and (3), then Subsection (4)(a) is inapplicable to that insurer and it shall comply with Subsections (2) and (3).

(c) Any insurer satisfying the minimum capital or permanent surplus requirement through application of Subsection (4)(a) shall comply with Subsections (2) and (3) by July 1, 1990.

(d) Beginning July 1, 1987, former county mutuals shall comply with the capital and surplus requirements of this section.

(5) (a) An assessable mutual may be organized under this chapter, but it may not issue life insurance or annuities. An assessable mutual need not have a permanent surplus if the assessment liability of its policyholders is unlimited and all insurance policies clearly state that. If assessments are limited to a specified amount or a specified multiple of annual advance premiums, the minimum permanent surplus is the amount that would be required under Subsections (2) and (3) if the corporation were not assessable, reduced by an amount that reasonably reflects the value of the policyholders' assessment liability in satisfying the financial needs of the corporation. The liability of members in an assessable mutual is joint and several up to the limits provided by the articles of incorporation or this title.

(b) (i) Except as provided in Subsections (5)(c) and (d), no certificate of authority may be issued to an assessable mutual until it has at least 400 bona fide applications for insurance from not less than 400 separate applicants, on separate risks located in this state, in each of the classes of business upon which assessments may be separately levied. A full year's premium shall be paid with each application and the aggregate premium is at least $50,000 for each class.

(ii) If at any time while the corporation is an assessable mutual, the business plan is amended to include an additional class of business on which assessments may be separately levied, identical requirements of Subsection (5)(b)(i) are applicable to each additional class.

(c) Five or more employers may join in the formation of an assessable mutual to write only workers' compensation insurance if, instead of the requirements of Subsection (5)(b), policies are simultaneously put into effect that cover at least 1,500 employees, with no single employer having

more than 1/5 of the employees insured by the assessable mutual. A full year's premium shall be paid by each employer, aggregating at least $200,000.

(d) The number and amount of required initial applications and premium payments may be reduced by substituting surplus for the applications or premium payments. The commissioner shall determine the reduction in required initial applications and premium payments that is appropriate for a given amount of surplus. The insurer shall continue to be assessable until conversion under Subsection 31A-5-508(1) to a nonassessable mutual.

(6) The capital or permanent surplus requirements of Subsection (2) apply to persons seeking certificates of authority under this chapter to write reinsurance. This subsection may not be construed as requiring reinsurers to obtain a certificate of authority. However, Section 31A-17-404 imposes alternate safety prerequisites to reserve credit being granted for reinsurance ceded to a reinsurer without a certificate of authority.

Section 11. Section **31A-5-418** is amended to read:

31A-5-418. Dividends and other distributions.

(1) Subject to the requirements of Section 16-10a-842 and Subsection 31A-16-106(2), a stock corporation may make distributions under Section 16-10a-640 if all the following conditions are satisfied:

(a) A dividend may not be paid that would reduce the insurer's total adjusted capital below the insurer's company action level RBC as defined in Subsection 31A-17-601[~~(7)~~](8)(b).

(b) Except as to excess surplus, or unless the commissioner issues an order allowing otherwise, a dividend may not be paid that exceeds the insurer's net gain from operations or net income for the period ending December 31 of the preceding year.

(2) Title 67, Chapter 4a, Unclaimed Property Act, applies to unclaimed dividends and distributions in insurance corporations.

Section 12. Section **31A-5-703** is amended to read:

31A-5-703. Nonrenewals, cancellations, or revisions of ceded reinsurance agreements.

(1) (a) A nonrenewal, cancellation, or revision of ceded reinsurance agreements is not subject to the reporting requirements of Section 31A-5-701 if:

(i) the nonrenewal, cancellation, or revision is not material; or

(ii) with respect to a property and casualty business, the insurer's total ceded written premium [~~represents~~], on an annualized basis, is less than 10% of its total written premium for direct and assumed business; or

(iii) with respect to a life, annuity, and [~~disability~~] accident and health business, the total reserve credit taken for business ceded [~~represents~~], on an annualized basis, is less than 10% of the statutory reserve requirement prior to a cession.

(b) For purposes of this part, a material nonrenewal, cancellation, or revision is one that affects:

(i) with respect to a property and casualty business:

(A) more than 50% of the insurer's total ceded written premium; or

(B) more than 50% of the insurer's total ceded indemnity and loss adjustment reserves;

(ii) with respect to a life, annuity, and [~~disability~~] accident and health business, more than 50% of the total reserve credit taken for business ceded, on an annualized basis, as indicated in the insurer's most recent annual statement; or

(iii) with respect to either property and casualty or life, annuity, or [~~disability~~] accident and health business[~~, is either of the following events~~]:

(A) an authorized reinsurer representing more than 10% of a total cession is replaced by one or more unauthorized reinsurers; or

(B) previously established collateral requirements have been reduced or waived as respects one or more unauthorized reinsurers representing collectively more than 10% of a total cession.

(2) (a) The following information is required to be disclosed in any report filed pursuant to Section 31A-5-701 of a material nonrenewal, cancellation, or revision of a ceded reinsurance agreement:

(i) the effective date of the nonrenewal, cancellation, or revision;

(ii) the description of the transaction with an identification of the initiator of the transaction;

(iii) the purpose of, or reason for the transaction; and

(iv) if applicable, the identity of the replacement reinsurers.

(b) (i) Insurers are required to report all material nonrenewals, cancellations, or revisions of ceded reinsurance agreements on a nonconsolidated basis unless the insurer:

(A) is part of a consolidated group of insurers that uses a pooling arrangement or 100% reinsurance agreement that affects the solvency and integrity of the insurer's reserves; and

(B) ceded substantially all of its direct and assumed business to the pool.

(ii) An insurer is considered to have ceded substantially all of its direct and assumed business to a pool if:

(A) the insurer has less than $1,000,000 total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement; and

(B) the net income of the business not subject to the pooling arrangement represents less than 5% of the insurer's capital and surplus.

Section 13. Section **31A-6a-102** is amended to read:

31A-6a-102. Scope and purposes.

(1) The purposes of this chapter are to:

(a) create a legal framework within which service contracts may be sold in this state;

(b) encourage innovation in the marketing and development of more economical and effective ways of providing services under service contracts, while placing the risk of innovation on the service contract providers rather than on consumers; and

(c) permit and encourage fair and effective competition among different systems of providing and paying for these services.

(2) Service contracts may not be issued, sold, or offered for sale in this state unless the provider has complied with this chapter. [~~Subsections 31A-1-103(3)(i), (j), and (k) limit the application of this chapter to certain persons engaged in a limited manner in providing extended warranties or service contracts.~~]

(3) This chapter applies only to a service contract not otherwise exempted from this title by Section 31A-1-103.

Section 14. Section **31A-6a-110** is amended to read:

31A-6a-110. Rulemaking.

(1) Pursuant to Title 63, Chapter 46a, Utah Administrative Rulemaking Act, the commissioner may make rules necessary to assist in the enforcement of this chapter.

(2) The commissioner may by rule or order, after a hearing, exempt certain service contract providers or service contract providers for a specific class of service contracts that are not otherwise exempt under [~~Subsections~~] Subsection 31A-1-103(3)[~~(i), (j), or (k),~~] from any provision of this title. The commissioner may order substitute requirements on a finding that a particular provision of this title is not necessary for the protection of the public or that the substitute requirement is reasonably certain to provide equivalent protection to the public.

Section 15. Section **31A-8-101** is amended to read:

31A-8-101. Definitions.

For purposes of this chapter:

(1) "Basic health care services" means:

(a) emergency care[~~,~~];

(b) inpatient hospital and physician care[~~,~~];

(c) outpatient medical services[~~,~~]; and

(d) out-of-area coverage.

(2) "Director of health" means the executive director of the Department of Health or his authorized representative.

(3) "Enrollee" means [~~any~~] an individual:

(a) who has entered into a contract with [~~a health maintenance~~] an organization for health care; or

(b) in whose behalf [~~such~~] an arrangement for health care has been made.

(4) "Health care" [~~means professional or personal services, facilities, equipment, devices, supplies, or medicine, intended for use in the diagnosis, treatment, mitigation, or prevention of any human ailment or impairment~~] is as defined in Section 31A-1-301.

(5) "Health maintenance organization" means any person[~~,~~]:

(a) other than:

(i) an insurer licensed under Chapter 7; or

(ii) an individual who contracts to render professional or personal services that [~~he~~] the individual directly performs [~~himself, which:~~]; and

(b) that:

[~~(a)~~] (i) furnishes at a minimum, either directly or through arrangements with others, basic health care services to an enrollee in return for prepaid periodic payments agreed to in amount prior to the time during which the health care may be furnished; and

[~~(b)~~] (ii) is obligated to the enrollee to arrange for or to directly provide available and accessible health care.

(6) (a) "Limited health plan" means, except as limited under Subsection (6)(b), any person who furnishes, either directly or through arrangements with others, [~~the~~] services:

(i) of:

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

(B) optometrists[~~,~~];

(C) physical therapists[~~,~~];

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

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

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

(G) chiropractic physicians[~~,~~];

(H) naturopathic physicians[~~,~~];

(I) osteopathic physicians[~~,~~];

(J) social workers[~~,~~];

(K) family counselors[~~,~~];

(L) other health care providers[~~,~~]; or

(M) reasonable combinations of [~~these,~~] the services described in this Subsection (1)(a)(i);

(ii) to an enrollee;

(iii) in return for prepaid periodic payments agreed to in amount prior to the time during which the services may be furnished[~~,~~]; and [~~who is~~]

(iv) for which the person is obligated to the enrollee to arrange for or directly provide

available and accessible the services described in this Subsection (6)(a).

(b) "Limited health plan" does not include:

(i) a health maintenance organization;

(ii) an insurer licensed under Chapter 7; or

(iii) an individual who contracts to render professional or personal services that he performs himself.

(7) (a) "Nonprofit organization" or "nonprofit corporation" means an organization no part of the income of which is distributable to its members, trustees, or officers, or a nonprofit cooperative association, except in a manner allowed under Section 31A-8-406.

(b) "Nonprofit health maintenance organization" and "nonprofit limited health plan" are used when referring specifically to one of the types of organizations with "nonprofit" status.

(8) "Organization" means health maintenance organization and limited health plan, unless used in the context of:

(a) "organization permit," in which case see Sections 31A-8-204 and 31A-8-206[~~,~~]; or [~~unless used in the context of~~]

(b) "organization expenses," in which case see Section 31A-8-208.

(9) "Participating provider" means a provider as defined in Subsection (10) who, under [~~an express or implied~~] a contract with the health maintenance organization, has agreed to provide health care services to enrollees with an expectation of receiving payment, directly or indirectly, from the health maintenance organization, other than copayment.

(10) "Provider" means any person who furnishes health care directly to the enrollee and who is licensed or otherwise authorized to furnish this care in this state.

(11) "Uncovered expenditures" means the costs of health care services that are covered by an organization for which an enrollee is liable in the event of the organization's insolvency.

(12) "Unusual or infrequently used health services" means those health services which are projected to involve fewer than 10% of the organization's enrollees' encounters with providers, measured on an annual basis over the organization's entire enrollment.

Section 16. Section **31A-8-103 (Effective 04/30/01)** is amended to read:

31A-8-103 (Effective 04/30/01). Applicability to other provisions of law.

(1) (a) Except for exemptions specifically granted under this title, [~~organizations are~~] an organization is subject to regulation under all of the provisions of this title.

(b) Notwithstanding any provision of this title, [~~organizations~~] an organization licensed under this chapter [~~are~~] is:

(i) wholly exempt from [~~the provisions of~~] Chapters 7, 9, 10, 11, 12, 13, 19, and 28[~~. In addition, organizations are~~] and not subject to:

[~~(a)~~] (A) Chapter 3, except for Part I;

[~~(b)~~] (B) Section 31A-4-107;

[~~(c)~~] (C) Chapter 5, except for provisions specifically made applicable by this chapter;

[~~(d)~~] (D) Chapter 14, except for provisions specifically made applicable by this chapter;

[~~(e) Chapters~~] (E) Chapter 17 [~~and 18~~], except:

(I) Part VI; or

(II) as made applicable by the commissioner by rule consistent with this chapter; [~~and~~]

(F) Chapter 18, except as made applicable by the commissioner by rule consistent with this chapter; and

[~~(f)~~] (G) Chapter 22, except for Parts VI, VII, and XII.

(2) The commissioner may by rule waive other specific provisions of this title that [~~he~~] the commissioner considers inapplicable to health maintenance organizations or limited health plans, upon a finding that [~~such a~~] the waiver will not endanger the interests of:

(a) enrollees[~~,~~];

(b) investors[~~,~~]; or

(c) the public.

(3) Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, and Title 16, Chapter 10a, Utah Revised Business Corporation Act, do not apply to [~~organizations~~] an organization except as specifically made applicable by:

(a) this chapter;

(b) a provision referenced under this chapter; or

(c) a rule adopted by the commissioner to deal with corporate law issues of health maintenance organizations that are not settled under this chapter.

(4) (a) Whenever in this chapter [~~a section, subsection, or paragraph of~~], Chapter 5, or Chapter 14 is made applicable to [~~organizations~~] an organization, the application is:

(i) of those provisions that apply to a mutual [~~corporations~~] corporation if the organization is nonprofit; and

(ii) of those that apply to a stock [~~corporations~~] corporation if the organization is for profit. [~~Whenever a provision under~~]

(b) When Chapter 5 or 14 is made applicable to [~~organizations~~] an organization under this chapter, "mutual" means nonprofit organization.

(5) Solicitation of enrollees by an organization is not a violation of any provision of law relating to solicitation or advertising by health professionals if that solicitation is made in accordance with [~~the provisions of~~]:

(a) this chapter; and

(b) Chapter 23.

(6) Nothing in this title prohibits any health maintenance organization from meeting the requirements of any federal law that enables the health maintenance organization to:

(a) receive federal funds; or [~~to~~]

(b) obtain or maintain federal qualification status.

(7) Except as provided in Section 31A-8-501, [~~organizations are~~] an organization is exempt from statutes in this title or department rules that restrict or limit [~~their~~] its freedom of choice in contracting with or selecting health care providers, including Section 31A-22-618.

(8) [~~Organizations are exempt from~~] the assessment or payment of premium taxes imposed by Sections 59-9-101 through 59-9-104.

Section 18. Section **31A-8-209** is amended to read:

31A-8-209. Minimum capital or minimum permanent surplus.

(1) [~~Health~~] A health maintenance [~~organizations~~] organization being organized or operating under this chapter shall have and maintain a minimum capital or minimum permanent surplus of

$100,000.

[~~(2) Limited health plans being organized or operating under this chapter shall have and maintain a minimum capital or permanent surplus in an amount determined under Subsection 31A-8-210 (9).~~]

[~~(3) For purposes of measuring compliance with Section 31A-8-210, to the extent an organization has capital or permanent surplus in excess of its required minimum capital, or in excess of its required minimum permanent surplus, the excess shall be counted as surplus.~~]

(2) (a) The minimum required capital or minimum permanent surplus for a limited health plan:

(i) is at least $10,000; and

(ii) may not exceed $100,000.

(b) The initial minimum required capital or minimum permanent surplus for a limited health plan required by Subsection (2)(a) shall be set by the commissioner, after:

(i) a hearing; and

(ii) consideration of:

(A) the services to be provided by the limited health plan;

(B) the size and geographical distribution of the population the limited health plan anticipates serving;

(C) the nature of the limited health plan's arrangements with providers; and

(D) the arrangements, agreements, and relationships in place or reasonably anticipated with respect to:

(I) insolvency insurance;

(II) reinsurance;

(III) lenders subordinating to the interests of enrollees and trade creditors;

(IV) personal and corporate financial guarantees;

(V) provider withholds and assessments;

(VI) surety bonds;

(VII) hold harmless agreements in provider contracts; and

(VIII) other arrangements, agreements, and relationships impacting the security of enrollees.

(c) Upon a material change in the scope or nature of a limited health plan's operations, the commissioner may, after a hearing, alter the limited health plan's minimum required capital or minimum permanent surplus.

(3) Before beginning operations, a health maintenance organization licensed under this chapter shall have total adjusted capital in excess of the company action level RBC as defined in Subsection 31A-17-601(8)(b).

(4) Each health maintenance organization authorized to do business in this state shall maintain assets in an amount equal to the total of the health maintenance organization's:

(a) liabilities;

(b) minimum capital or minimum permanent surplus required by Subsection (1) or (2); and

(c) the company action level RBC as defined in Subsection 31A-17-601(8)(b).

(5) As a prerequisite to receiving an original certificate of authority to do business in this state, a health maintenance organization shall have initial surplus at least $400,000 in excess of the capital and surplus required by Subsection (4).

[~~(4)~~] (6) The commissioner may allow the minimum capital or permanent surplus account of an organization to be designated by some other name.

(7) A pattern of persistent deviation from the accounting and investment standards under this section may be grounds for the commissioner to find that the one or more persons with authority to make the organization's accounting or investment decisions are incompetent for purposes of Subsection 31A-5-410(3).

Section 19. Section **31A-8-211** is amended to read:

31A-8-211. Deposit.

(1) Except as provided in Subsection (2), each health maintenance organization authorized in this state shall maintain a deposit with the commissioner under Section 31A-2-206 in an amount equal to the sum of:

(a) the health maintenance organization's minimum capital or minimum permanent surplus [~~plus~~] requirement of Subsection 31A-8-209(1) or (2); and

(b) 50% of [~~compulsory surplus.~~] the greater of:

(i) $900,000;

(ii) 2% of the annual premium revenues as reported on the most recent annual financial statement filed with the commissioner; or

(iii) an amount equal to the sum of three months uncovered health care expenditures as reported on the most recent financial statement filed with the commissioner.

(2) [~~A~~] (a) After a hearing the commissioner may exempt a health maintenance organization from the deposit requirement of Subsection (1) if:

(i) the commissioner determines that the enrollees' interests are adequately protected;

(ii) the health maintenance organization [~~which~~] has been continuously authorized to do business in this state for at least five years[~~,~~]; and [~~which~~]

(iii) the health maintenance organization has $5,000,000 surplus [~~over and above~~] in excess of its [~~compulsory surplus in an amount specified in Subsection (3), may, after a hearing, be exempted from the deposit requirement of Subsection (1) if the commissioner determines that the enrollees' interests are adequately protected~~] company action level RBC as defined in Subsection 31A-17-601(8)(b).

(b) The commissioner may rescind [~~such~~] an exemption given under Subsection (2)(a).

[~~(3) No health maintenance organization may be exempted under Subsection (2) from the deposit requirement unless:~~]

[~~(a) disregarding assets described in Subsection 31A-8-210 (8)(a), the health maintenance organization has $1,000,000 of surplus in excess of the amount required to satisfy its compulsory surplus requirement; or~~]

[~~(b) the health maintenance organization has $5,000,000 surplus in excess of the amount required to satisfy its compulsory surplus requirement.~~]

(3) (a) Each limited health plan authorized in this state shall maintain a deposit with the commissioner under Section 31A-2-206 in an amount equal to the minimum capital or permanent surplus plus 50% of the greater of:

(i) .5 times minimum required capital; or

(ii) (A) during the first year of operation, 10% of the limited health plan's projected uncovered expenditures for the first year of operation;

(B) during the second year of operation, 12% of the limited health plan's projected uncovered expenditures for the second year of operation;

(C) during the third year of operation, 14% of the limited health plan's projected uncovered expenditures for the third year of operation;

(D) during the fourth year of operation, 18% of the limited health plan's projected expenditures during the fourth year of operation; or

(E) during the fifth year of operation, and during all subsequent years, 20% of the limited health plan's projected uncovered expenditures for the previous 12 months.

(b) Projections of future uncovered expenditures shall be established in a manner that is approved by the commissioner.

Section 20. Section **31A-8-213** is amended to read:

31A-8-213. Certificate of authority.

(1) [~~The~~] An organization may apply for a certificate of authority at any time prior to the expiration of its organization permit. The application shall include:

(a) a detailed statement by a principal officer about any material changes that have taken place or are likely to take place in the facts on which the issuance of the organization permit was based[~~,~~]; and

(b) if any material changes are proposed in the business plan, the information about the changes that would be required if an organization permit were then being applied for.

(2) The commissioner shall issue a certificate of authority, if [~~he~~] the commissioner finds that:

(a) the [~~organization satisfies~~] organization's capital and surplus complies with the requirements of [~~Sections~~] Section 31A-8-209 [~~and 31A-8-210~~] as to the operations proposed under the new certificate of authority;

(b) there is no basis for revoking the organization permit under Section 31A-8-207;

(c) the deposit required by Section 31A-8-211 has been made;

(d) the organization satisfies the requirements of Section 31A-8-104; and

[~~(e) the organization satisfies the surplus requirement of Subsection 31A-8-210 (4) or (5), whichever applies; and~~]

[~~(f)~~] (e) all other applicable requirements of the law have been met.

(3) The certificate of authority shall specify any limits imposed by the commissioner upon the organization's business or methods of operation, including the general types of health care services the organization is authorized to provide.

(4) Upon the issuance of the certificate of authority:

(a) the board shall authorize and direct the issuance of certificates for shares, bonds, or notes subscribed to under the organization permit, and of insurance policies upon qualifying applications obtained under the organization permit; and

(b) the commissioner shall authorize the release to the organization of all funds held in escrow under Section 31A-5-208, as adopted by Section 31A-8-206.

(5) (a) An organization may at any time apply to the commissioner for a new or amended certificate of authority altering the limits on its business or methods of operation. The application shall contain or be accompanied by that information reasonably required by the commissioner under Subsections 31A-5-204(2) and 31A-8-205(2). The commissioner shall issue the new certificate as requested if [~~he~~] the commissioner finds that the organization continues to satisfy the requirements specified under Subsection (2).

(b) If the commissioner issues a summary order under Section 31A-27-201 against an organization, [~~he~~] the commissioner may also revoke the organization's certificate and issue a new one with any limitation he considers necessary.

Section 21. Section **31A-8-402** is amended to read:

31A-8-402. Contract cancellation or nonrenewal.

(1) An enrollee may not be cancelled or nonrenewed except for:

[~~(a) failure to pay the charge for the enrollment or coverage;~~]

[~~(b)~~] (a) violation of reasonable, published policies of the organization;

[~~(c)~~] (b) unreasonable refusal to comply with care or treatment prescribed by the health care

personnel of the organization; or

[~~(d) such other reasons as the commissioner may specify by rule.~~]

(c) nonpayment of a premium or contribution;

(d) a fraudulent act or an intentional misrepresentation of a material fact under the terms of the coverage committed by the plan sponsor or covered individual under the plan;

(e) a violation of participation or contribution rules;

(f) termination of the plan where the issuer is ceasing to offer coverage in the market according to:

(i) regulations required under the Health Insurance Portability and Accountability Act of 1996 42 U.S.C. 1301, et seq.; and

(ii) Subsections 31A-2-201(3), 31A-4-115(8), and 31A-30-106(1)(k); or

(g) the enrollee moving to outside of the service area.

(2) Every organization authorized under this chapter shall provide its enrollees an opportunity, at least once each year, to:

(a) enroll again with the organization; or

(b) choose another source through which they may secure health care services or benefits.

(3) This section does not prohibit reasonable underwriting classifications for the purpose of establishing rates nor does it prohibit experience rating.

(4) (a) The requirement in [~~Part VII of~~] Chapter 22, Part VII, Group Accident and Health Insurance, that a conversion policy be available for certain persons who are no longer entitled to group coverage does not require an organization to provide a conversion policy to a person residing outside of the organization's service area.

(b) The commissioner may, by rule or order, define the scope of an organization's service area.

Section 22. Section **31A-8-407** is amended to read:

31A-8-407. Written contracts -- Limited liability of enrollee.

(1) (a) Every contract between [~~a health maintenance~~] an organization and a participating provider of health care services shall be in writing and shall set forth that [~~in the event the health~~

~~maintenance~~] if the organization:

(i) fails to pay for health care services as set forth in the contract, the enrollee [~~shall~~] may not be liable to the provider for any sums owed by the [~~health maintenance~~] organization[.]; and

(ii) the organization becomes insolvent, the rehabilitator or liquidator may require the participating provider of health care services to:

(A) continue to provide health care services under the contract between the participating provider and the organization until the later of:

(I) 90 days from the date of the filing of a petition for rehabilitation or the petition for liquidation; or

(II) the date the term of the contract ends; and

(B) subject to Subsection (1)(c), reduce the fees the participating provider is otherwise entitled to receive from the organization under the contract between the participating provider and the organization during the time period described in Subsection (1)(a)(ii)(A).

(b) If the conditions of Subsection (1)(c) are met, the participating provider shall:

(i) accept the reduced payment as payment in full; and

(ii) relinquish the right to collect additional amounts from the insolvent organization's enrollee.

(c) Notwithstanding Subsection (1)(a)(ii)(B):

(i) the rehabilitator or liquidator may not reduce a fee to less than 75% of the regular fee set forth in the participating provider contract; and

(ii) the enrollee shall continue to pay the same copayments, deductibles, and other payments for services received from the participating provider that the enrollee was required to pay before the filing of:

(A) the petition for reorganization; or

(B) the petition for liquidation.

(2) [~~In the event that the participating provider contract has not been reduced to writing as required by Subsection (1) or that the contract fails to contain the required prohibition, the~~] A participating provider [~~shall~~] may not collect or attempt to collect from the enrollee sums owed by

the [~~health maintenance~~] organization or the amount of the regular fee reduction authorized under Subsection (1)(a)(ii) if the participating provider contract:

(a) is not in writing as required in Subsection (1); or

(b) fails to contain the language required by Subsection (1).

(3) (a) [~~No participating provider, or agent, trustee, or assignee thereof~~] A person listed in Subsection (3)(b) may not bill or maintain any action at law against an enrollee to collect:

(i) sums owed by the [~~health maintenance~~] organization[~~.~~]; or

(ii) the amount of the regular fee reduction authorized under Subsection (1)(a)(ii).

(b) Subsection (3)(a) applies to:

(i) a participating provider;

(ii) an agent;

(iii) a trustee; or

(iv) an assignee of a person described in Subsections (3)(b)(i) through (iii).

Section 23. Section **31A-8-408** is amended to read:

31A-8-408. Organizations offering point of service products.

Effective July 1, 1991, a health maintenance [~~organizations~~] organization offering products that permit members the option of obtaining covered services from a noncontracted provider, which is a point of service or [~~POS~~] point of sale product, shall comply with the [~~following~~] requirements[~~:~~] of Subsections (1) through (7).

(1) The cost of an encounter with a noncontracted provider is considered an uncovered expenditure as defined in Section 31A-8-101 [~~for purposes of Section 31A-8-210~~].

(2) Any organization offering to sell point of service products shall report the number of encounters with contracted and noncontracted providers to the commissioner on a monthly basis. The commissioner shall define the form, content, and due date of the report and shall require audited reports of the information on a yearly basis.

(3) An organization may not offer point of service products unless it has secured contracts with participating providers located within the organization's service area for each covered service other than those unusual or infrequently used health services that are not available from the

organization's health care providers.

(4) An organization may not enroll members who do not work or reside in the service area as defined by rule, except this Subsection (4) does not apply to dependents of enrollees.

(5) Any organization [~~which~~] that exceeds the 10% limit of unusual or infrequently used health services as defined in Section 31A-8-101 is subject to a forfeiture of up to $50 per encounter.

(6) [~~Organizations~~] An organization shall disclose to employees and members the existence of the 10% limit at or prior to enrollment.

(7) The commissioner shall hold hearings and adopt rules providing any additional limitations or requirements necessary to secure the public interest in conformity with this section.

Section 24. Section **31A-9-212 (Effective 04/30/01)** is amended to read:

31A-9-212 (Effective 04/30/01). Separate accounts and subsidiaries.

(1) Except as provided in Subsections (2) and (3), Sections 31A-5-217 and 31A-5-218 apply to separate accounts and subsidiaries of fraternals. If a fraternal issues contracts on a variable basis, Subsections 31A-22-902(2) and (6) and 31A-9-209(2) do not apply, except that Subsection 31A-9-209(2) applies to any benefits contained in the variable contracts which are fixed or guaranteed dollar amounts.

(2) If a fraternal engages in any insurance business other than life, [~~disability~~] accident and health, annuities, property, or liability insurance, it shall do so through a subsidiary under Section 31A-5-218.

(3) (a) A local lodge may incorporate under Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, or the corresponding law of the state where it is located, to carry out the noninsurance activities of the local lodge.

(b) Corporations may be formed under Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, to implement Subsection 31A-9-602(2).

Section 25. Section **31A-11-102** is amended to read:

31A-11-102. Activities of motor clubs.

(1) Motor clubs authorized under this chapter may provide or arrange for the following services:

(a) service as agent or broker in obtaining insurance coverage from authorized insurers, subject to Chapter 23;

(b) provision of, or payment for, legal services and costs in the defense of traffic offenses or other legal problems connected with the ownership or use of a motor vehicle, provided the maximum amount payable for any one incident is not more than 100 times the [~~the~~] annual charge for the motor club contract;

(c) guaranteed arrest bond certificates and cash bond guarantees as specified under Section 31A-11-112;

(d) payment of specified expenses resulting from an automobile accident, other than expenses for personal injury or for damage to an automobile, provided the maximum amount payable for any one accident is not more than 100 times the annual charge for the motor club contract;

(e) towing and emergency road services and theft services; and

(f) any services relating to travel not involving the transfer and distribution of risk.

(2) Unless they are also insurers under Chapter 5 or 14, motor clubs may not provide any liability or physical damage insurance or insurance of life or [~~disability~~] accident and health, whether or not related to motor vehicles.

(3) If a motor club is a separate division of a corporation, the activities of the other divisions of the corporation are not limited by this section, if the motor club division complies with Subsection 31A-11-106(3).

Section 26. Section **31A-14-201** is amended to read:

31A-14-201. Application.

[~~Any~~] (1) (a) An incorporated person, other than a foreign health maintenance organization[~~, including the United States branch of an alien insurer~~], authorized as an insurer in another jurisdiction in the United States may apply under this section for a certificate of authority as an insurer in this state. [~~This insurer~~]

(b) An alien insurer that is incorporated may apply under this section for a certificate of authority as an insurer in this state.

(2) An applicant for a certificate of authority under this section shall:

(a) use the forms prescribed by the commissioner[~~. The applicant shall~~]; and

(b) provide the information and documents the commissioner requests, including the following[~~, unless the commissioner excludes any of them because they will not be helpful in making the decision of whether to issue a certificate of authority~~]:

[~~(1)~~] (i) a copy of the applicant's articles and bylaws;

[~~(2)~~] (ii) financial statements for the most recent complete fiscal year, with an explanation of the bases of all valuations and computations, in the detail reasonably required by the commissioner;

[~~(3)~~] (iii) a summary, as detailed as the commissioner reasonably requires, of the applicant's financial history for:

(A) the preceding ten years[~~,~~]; or [~~for~~]

(B) the entire period of the applicant's existence if less than ten years;

[~~(4)~~] (iv) [~~the names of the~~] for each of the applicant's current or proposed directors and principal officers [~~and their addresses and occupations~~]:

(A) the name of the director or principal officer;

(B) the address of the director or principal officer; and

(C) the occupation for the preceding ten years of the director or principal officer;

[~~(5)~~] (v) for an alien insurer[~~,~~]:

(A) the name of its United States manager, the manager's addresses and occupations for the preceding ten years; and

(B) if the manager is a corporation, the names, addresses, and occupations of its directors and principal officers, and its most recent detailed financial statements;

[~~(6)~~] (vi) a schedule listing:

[~~(a)~~] (A) all jurisdictions in which applicant has done or has been authorized to conduct an insurance business during the preceding ten years;

[~~(b)~~] (B) all jurisdictions in which the applicant has applied for authorization to conduct an insurance business during the preceding ten years, and the dates and results of those applications;

[~~(c)~~] (C) all jurisdictions from which the applicant has withdrawn from conducting an

insurance business during the preceding ten years, and the reasons for its withdrawals; and

[~~(d)~~] (D) the name of and the circumstances surrounding any officer, director, or controlling shareholder of the corporation ever being subject to a:

[~~(i)~~] (I) felony indictment or conviction; or

[~~(ii)~~] (II) civil, criminal, or administrative action alleging fraud;

[~~(7)~~] (vii) a summary description of the applicant's present business operations, including the coverages written and the states and countries in which it does business;

[~~(8)~~] (viii) a list of any statements, reports, or other documents that have, within the last five years, been generally transmitted or distributed to or among the insurer's creditors, shareholders, members, subscribers, or policyholders;

[~~(9)~~] (ix) if the applicant has been in the insurance business for less than ten years, a summary of the past and a projection of the anticipated operating results at the end of each year of the first ten years of operation, based, where known, on actual data and otherwise on reasonable assumptions of loss experience, premium and other income, operating expenses, and acquisition costs;

[~~(10)~~] (x) a statement that organizational and promotional expenses have been paid, and that organizational procedures required by the insurer's domiciliary authority are complete;

[~~(11)~~] (xi) a statement from the domiciliary regulatory authority and the state of entry into the United States, if any, that so far as known, the applicant is sound and there are no legitimate objections to its proposed operations in this state;

[~~(12)~~] (xii) the plan for conducting an insurance business in this state, including:

[~~(a)~~] (A) the geographical area where business is to be conducted;

[~~(b)~~] (B) the types of insurance to be written;

[~~(c)~~] (C) the proposed general marketing methods;

[~~(d)~~] (D) the proposed method for establishing premium rates; and

[~~(e)~~] (E) copies of the policy and application forms to be used in this state;

[~~(13)~~] (xiii) any other information the commissioner reasonably requires;

[~~(14)~~] (xiv) authorization to the commissioner to make inquiry of any person about the

applicant, its manager under a management contract, its attorney in fact, its general agents, and any of the officers, directors, or shareholders of any of them designated by the commissioner; and

[~~(15)~~] (xv) written agreement by the applicant and any other designated persons that in the absence of actual malice, no communication made in response to any inquiry under Subsection [~~(14)~~] (2)(xiv) will subject the person making it to an action for damages for defamation brought by the applicant, the designated person, or a legal representative of either.

(3) No action for damages for defamation lies even in the absence of this agreement.

(4) Notwithstanding Subsection (2), the commissioner may exempt an applicant for a certificate of authority from providing the information described in Subsection (2) if the commissioner finds that the information will not be helpful in making the decision of whether to issue a certificate of authority.

Section 27. Section **31A-14-212** is amended to read:

31A-14-212. Changes in business plan.

(1) Within two years after the initial issuance of a certificate of authority to a foreign insurer by its domiciliary jurisdiction, the insurer may not substantially deviate from its business plan under Subsection 31A-14-201 [~~(12)~~] (2)(xii) unless notice of the proposed action is filed with the commissioner 30 days in advance of the proposed effective date.

(2) If the commissioner believes that the change proposed under Subsection (1) would be contrary to Utah law or to the interests of insureds, creditors, or the public, he may prohibit the application of the change to Utah. In his prohibitory order he shall explain why he has prohibited the change.

(3) If the commissioner finds after a hearing that the application of the proposed change outside Utah would endanger the interests of insureds, creditors, or the public in Utah, the commissioner may revoke the insurer's certificate of authority unless the insurer agrees not to make the change.

Section 28. Section **31A-15-103** is amended to read:

31A-15-103. Surplus lines insurance -- Unauthorized insurers.

(1) Notwithstanding Section 31A-15-102, a foreign insurer that has not obtained a certificate

of authority to do business in this state under Section 31A-14-202 may negotiate for and make insurance contracts with persons in this state and on risks located in this state, subject to the limitations and requirements of this section.

(2) For contracts made under this section, the insurer may, in this state, inspect the risks to be insured, collect premiums and adjust losses, and do all other acts reasonably incidental to the contract, through employees or through independent contractors.

(3) (a) Subsections (1) and (2) do not permit any person to solicit business in this state on behalf of an insurer that has no certificate of authority.

(b) Any insurance placed with a nonadmitted insurer shall be placed with a surplus lines broker licensed under Chapter 23.

(c) The commissioner may by rule prescribe how a surplus lines broker may:

(i) pay or permit the payment, commission, or other remuneration on insurance placed by the surplus lines broker under authority of the surplus lines broker's license to one holding a license to act as an insurance agent; and

(ii) advertise the availability of the surplus lines broker's services in procuring, on behalf of persons seeking insurance, contracts with nonadmitted insurers.

(4) For contracts made under this section, nonadmitted insurers are subject to Sections 31A-23-302 and 31A-26-303 and the rules adopted under those sections.

(5) A nonadmitted insurer may not issue workers' compensation insurance coverage to employers located in this state, except for stop loss coverages issued to employers securing workers' compensation under Subsection 34A-2-201(3).

(6) (a) The commissioner may by rule prohibit making contracts under Subsection (1) for a specified class of insurance if authorized insurers provide an established market for the class in this state that is adequate and reasonably competitive.

(b) The commissioner may by rule place restrictions and limitations on and create special procedures for making contracts under Subsection (1) for a specified class of insurance if there have been abuses of placements in the class or if the policyholders in the class, because of limited financial resources, business experience, or knowledge, cannot protect their own interests adequately.

(c) The commissioner may prohibit an individual insurer from making any contract under Subsection (1) and all insurance agents and brokers from dealing with the insurer if:

(i) the insurer has willfully violated this section, Section 31A-4-102, 31A-23-302, or 31A-26-303, or any rule adopted under any of these sections;

(ii) the insurer has failed to pay the fees and taxes specified under Section 31A-3-301; or

(iii) the commissioner has reason to believe that the insurer is in an unsound condition or is operated in a fraudulent, dishonest, or incompetent manner or in violation of the law of its domicile.

(d) (i) The commissioner may issue lists of unauthorized foreign insurers whose solidity the commissioner doubts, or whose practices the commissioner considers objectionable.

(ii) The commissioner shall issue lists of unauthorized foreign insurers the commissioner considers to be reliable and solid. [~~The~~]

(iii) In addition to the lists described in Subsections (7)(d)(i) and (ii), the commissioner may [~~also~~] issue other relevant evaluations of unauthorized insurers. [~~No~~]

(iv) An action [~~lies~~] may not lie against the commissioner or any employee of the department for any written or oral communication made in, or in connection with the issuance of, [~~these~~] the lists or evaluations described in this Subsection (6)(d).

(e) A foreign unauthorized insurer shall be listed on the commissioner's "reliable" list only if the unauthorized insurer:

(i) has delivered a request to the commissioner to be on the list;

(ii) has established satisfactory evidence of good reputation and financial integrity;

(iii) has delivered to the commissioner a copy of its current annual statement certified by the insurer and continues each subsequent year to file its annual statements with the commissioner within 60 days of its filing with the insurance regulatory authority where it is domiciled; [~~and~~]

(iv) (A) is in substantial compliance with the solvency standards in Chapter 17, Part VI, Risk-Based Capital, or maintains capital and surplus of at least [~~$5,000,000~~] $15,000,000, whichever is greater, and maintains in the United States an irrevocable trust fund in either a national bank or a member of the Federal Reserve System, or maintains a deposit meeting the statutory deposit

requirements for insurers in the state where it is made, which trust fund or deposit:

(I) shall be in an amount not less than [~~$1,500,000~~] $2,500,000 for the protection of all of the insurer's policyholders in the United States;

(II) may consist of cash, securities, or investments of substantially the same character and quality as those which are "qualified assets" under Section 31A-17-201; and

(III) may include as part of the trust arrangement a letter of credit that qualifies as acceptable security under Subsection 31A-17-404(3)(c)(iii); or

(B) in the case of any "Lloyd's" or other similar incorporated or unincorporated group of alien individual insurers, maintains a trust fund that:

(I) shall be in an amount not less than $50,000,000 as security to its full amount for all policyholders and creditors in the United States of each member of the group;

(II) may consist of cash, securities, or investments of substantially the same character and quality as those which are "qualified assets" under Section 31A-17-201; and

(III) may include as part of this trust arrangement a letter of credit that qualifies as acceptable security under Subsection 31A-17-404(3)(c)(iii)[~~.~~]; and

(v) for an alien insurer not domiciled in the United States or a territory of the United States, is listed on the Quarterly Listing of Alien Insurers maintained by the National Association of Insurance Commissioners International Insurers Department.

(7) A surplus lines broker may not, either knowingly or without reasonable investigation of the financial condition and general reputation of the insurer, place insurance under this section with financially unsound insurers or with insurers engaging in unfair practices, or with otherwise substandard insurers, unless the broker gives the applicant notice in writing of the known deficiencies of the insurer or the limitations on his investigation, and explains the need to place the business with that insurer. A copy of this notice shall be kept in the office of the broker for at least five years. To be financially sound, an insurer shall satisfy standards that are comparable to those applied under the laws of this state to authorized insurers. Insurers on the "doubtful or objectionable" list under Subsection (6)(d) and insurers not on the commissioner's "reliable" list under Subsection (6)[~~(d)~~](e) are presumed substandard.

(8) A policy issued under this section shall include a description of the subject of the insurance and indicate the coverage, conditions, and term of the insurance, the premium charged and premium taxes to be collected from the policyholder, and the name and address of the policyholder and insurer. If the direct risk is assumed by more than one insurer, the policy shall state the names and addresses of all insurers and the portion of the entire direct risk each has assumed. All policies issued under the authority of this section shall have attached or affixed to the policy the following statement: "The insurer issuing this policy does not hold a certificate of authority to do business in this state and thus is not fully subject to regulation by the Utah insurance commissioner. This policy receives no protection from any of the guaranty associations created under Title 31A, Chapter 28."

(9) Upon placing a new or renewal coverage under this section, the broker shall promptly deliver to the policyholder or his agent evidence of the insurance consisting either of the policy as issued by the insurer or, if the policy is not then available, a certificate, cover note, or other confirmation of insurance complying with Subsection (8).

(10) If the commissioner finds it necessary to protect the interests of insureds and the public in this state, the commissioner may by rule subject policies issued under this section to as much of the regulation provided by this title as is required for comparable policies written by authorized foreign insurers.

(11) (a) Each surplus lines transaction in this state shall be examined to determine whether it complies with:

(i) the surplus lines tax levied under Chapter 3;

(ii) the solicitation limitations of Subsection (3);

(iii) the requirement of Subsection (3) that placement be through a surplus lines broker;

(iv) placement limitations imposed under Subsections (6)(a), (b), and (c); and

(v) the policy form requirements of Subsections (8) and (10).

(b) The examination described in Subsection (11)(a) shall take place as soon as practicable after the transaction. The surplus lines broker shall submit to the examiner information necessary to conduct the examination within a period specified by rule.

(c) The examination described in Subsection (11)(a) may be conducted by the commissioner

or by an advisory organization created under Section 31A-15-111 and authorized by the commissioner to conduct these examinations. The commissioner is not required to authorize any additional advisory organizations to conduct examinations under this Subsection (11)(c). The commissioner's authorization of one or more advisory organizations to act as examiners under this subsection shall be by rule. In addition, the authorization shall be evidenced by a contract, on a form provided by the commissioner, between the authorized advisory organization and the department.

(d) The person conducting the examination described in Subsection (11)(a) shall collect a stamping fee of an amount not to exceed 1% of the policy premium payable in connection with the transaction. Stamping fees collected by the commissioner shall be deposited in the General Fund. The commissioner shall establish this fee by rule. Stamping fees collected by an advisory organization are the property of the advisory organization to be used in paying the expenses of the advisory organization. Liability for paying the stamping fee is as required under Subsection 31A-3-303(1) for taxes imposed under Section 31A-3-301. The commissioner shall adopt a rule dealing with the payment of stamping fees. If stamping fees are not paid when due, the commissioner or advisory organization may impose a penalty of 25% of the fee due, plus 1-1/2% per month from the time of default until full payment of the fee. Fees relative to policies covering risks located partially in this state shall be allocated in the same manner as under Subsection 31A-3-303(4).

(e) The commissioner, representatives of the department, advisory organizations, representatives and members of advisory organizations, authorized insurers, and surplus lines insurers are not liable for damages on account of statements, comments, or recommendations made in good faith in connection with their duties under this Subsection (11)(e) or under Section 31A-15-111.

(f) Examinations conducted under this Subsection (11) and the documents and materials related to the examinations are confidential.

Section 29. Section **31A-15-106** is amended to read:

31A-15-106. Servicing of contracts made out of state.

(1) A foreign insurer that does not have a certificate of authority to do business in this state

under Section 31A-14-202 may, in this state, collect premiums and adjust losses and do all other acts reasonably incidental to contracts made outside this state without violating this chapter. Any premiums collected under this section are subject to Section 31A-3-301.

(2) Subsection (1) does not permit a renewal, extension, increase, or other substantial change in the terms of any contract under Subsection (1) unless:

(a) it is permitted under Section 31A-15-103;

(b) the contract is for life or [~~disability~~] accident and health insurance or annuities; or

(c) a rule adopted by the commissioner permits this action when the interests of the policyholder and the public appear to be sufficiently protected.

Section 30. Section **31A-17-201** is amended to read:

31A-17-201. Qualified assets.

(1) Except as provided under Subsections (3) and (4), only the qualified assets listed in Subsection (2) may be used in determining the financial condition of an insurer, except to the extent an insurer has shown to the commissioner that the insurer has excess surplus, as defined in Section 31A-1-301.

(2) For purposes of Subsection (1), "qualified assets" means:

[~~(a) investments, securities, properties, and loans acquired or held in accordance with Sections 31A-18-105 and 31A-18-106, and the income due and accrued on these;~~]

[~~(b) the net amount of uncollected and deferred premiums for a life insurer that carries the full annual mean tabular reserve liability;~~]

[~~(c) premiums in the course of collection, other than for life insurance, not more than 90 days past due, less commissions payable on the premiums, with the 90-day limitation being inapplicable to premiums payable directly or indirectly by the United States government or any of its instrumentalities;~~]

[~~(d) installment premiums, other than life insurance premiums, in accordance with:~~]

[~~(i) the rules adopted by the commissioner; or~~]

[~~(ii) in the absence of rules adopted by the commissioner, practices formulated or adopted by the National Association of Insurance Commissioners;~~]

[~~(e) notes and similar written obligations that are:~~]

[~~(i) not past due;~~]

[~~(ii) taken for premiums other than life insurance premiums;~~]

[~~(iii) on policies permitted to be issued on that basis; and~~]

[~~(iv) to the extent of the unearned premium reserves carried on the policies;~~]

[~~(f) amounts recoverable or receivable from reinsurers under a reinsurance contract that qualifies for reserve credit under Section 31A-17-404;~~]

[~~(g) electronic and mechanical machines constituting a data processing and accounting system, the cost of which is depreciated in full over a period of five years or less;~~]

[~~(h) tangible components of the health care delivery systems of insurers licensed under Chapter 7, with the cost of these assets having a finite useful life being depreciated in full over periods provided by rule;~~]

[~~(i) cash or currency; and~~]

(a) assets as determined to be admitted in the Accounting Practices and Procedures Manual, published by the National Association of Insurance Commissioners; and

[~~(j)~~] (b) other assets authorized by rule.

(3) (a) Subject to Subsection (5) and even if they could not otherwise be counted under this chapter, assets acquired in the bona fide enforcement of creditors' rights may be counted for the purposes of Subsection (1) and Sections 31A-18-105 and 31A-18-106:

(i) for five years after their acquisition if they are real property; and

(ii) for one year if they are not real property.

(b) (i) The commissioner may allow reasonable extensions of the periods described in Subsection (3)(a), if disposal of the assets within the periods given is not possible without substantial loss.

(ii) Extensions under Subsection (3)(b)(i) may not, as to any particular asset, exceed a total of five years.

(4) Subject to Subsection (5), and even though under this chapter the assets could not otherwise be counted, assets acquired in connection with mergers, consolidations, or bulk

reinsurance, or as a dividend or distribution of assets, may be counted for the same purposes, in the same manner, and for the same periods as assets acquired under Subsection (3).

(5) Assets described under Subsection (3) or (4) may not be counted for the purposes of Subsection (1), except to the extent they are counted as assets in determining insurer solvency under the laws of the state of domicile of the creditor or acquired insurer.

Section 31. Section **31A-17-401** is amended to read:

31A-17-401. Valuation of assets.

(1) The commissioner shall value the assets of insurers in accordance with then current insurance business practices, but not in a manner inconsistent with the provisions of this title. In valuing assets, the commissioner shall consider any method then current, formulated, or approved by the National Association of Insurance Commissioners.

(2) Assets that are not qualified assets under Subsection 31A-17-201(2) are considered to have no value in evaluating an insurer's compliance with Chapter 17, Part 6, Risk-Based Capital. Those assets may be used in evaluating the insurer's financial condition only to the extent the insurer has excess surplus.

(3) (a) Insurance subsidiaries are valued on the books of a parent insurer as follows:

(i) Except as provided under Subsections (3)(a)(iii) [~~through (vi)~~] and (iv), common stock of the subsidiary is valued on the basis of the parent insurer's percentage of ownership of the common stock multiplied by the total of the subsidiary's capital and surplus, less amounts needed to liquidate all claims to the capital and surplus which are senior to common stock. Subsection 31A-18-106(1)(k) provides applicable limitations on investments in subsidiaries.

(ii) The value of securities other than common stock issued by a subsidiary is the lesser of the present value of the future income to be derived under the securities or the amount the parent insurer would receive as a result of the securities if the subsidiary were liquidated and all creditors of the subsidiary and holders of the subsidiary's securities with senior priority were paid in full. The present value of future income derived from securities is determined by rule adopted by the commissioner. A parent insurer may attribute value to a security of its subsidiary only if the parent insurer is being paid dividends or interest on the security, and only if the parent insurer can

reasonably anticipate that dividends or interest will continue to be paid on the security.

(iii) Except as provided under [~~Subsections (3)(a)(iv) through (vi)~~] Subsection (3)(iv), any portion of the subsidiary's value permitted under Subsection (3)(a) that is represented by assets other than assets listed under Section 31A-17-201, may only be classified as excess surplus of the parent insurer, and then only to the extent the parent insurer has established that it has excess surplus under Section 31A-17-202.

(iv) For the purposes of Subsection (3)(a)(iii), assets of a newly acquired subsidiary that are the equivalent of qualified assets in the subsidiary's domiciliary state, are, for the first five years after the subsidiary's acquisition, considered to be qualified assets under Section 31A-17-201. This assumption stands even if the assets are not otherwise qualified assets under Section 31A-17-201.

[~~(v) Under a plan of merger approved by the commissioner, a newly-acquired insurance subsidiary may be valued initially at its cost to the parent insurer, or a greater or lesser value established by the commissioner. The amount in excess of the parent insurer's proportionate share of the subsidiary's capital and surplus shall be written off for regulatory purposes over a period specified by the commissioner in the commissioner's order approving the plan of merger. This period may not exceed five years. Once they are established by the commissioner, any amounts not yet written off may be counted as assets for the purposes specified under Chapter 17, Part 6, Risk-Based Capital.~~]

[~~(vi) Subject to Subsection 31A-18-106(1)(k), an insurance subsidiary that is acquired by another insurer, but not under an approved plan of merger, may be valued initially at the lesser of its cost to the parent insurer, or the parent insurer's proportionate share of the subsidiary's capital and surplus plus 10% of the parent insurer's capital and surplus. The amount in excess of the parent insurer's proportionate share of the subsidiary's capital and surplus shall be written off for regulatory purposes over a period specified by the commissioner in an order approving the acquisition. This period may not exceed ten years.~~]

[~~(vii) For subsidiaries valued under Subsection (3)(a)(v) or (3)(a)(vi), until the excess of the subsidiary's cost over the parent insurer's proportionate share of the subsidiary's capital and surplus is completely amortized, the commissioner shall semiannually review the actual performance of the~~

~~subsidiary to determine whether the amortization schedule provided by the commissioner's order is reasonable, based on the subsidiary's actual performance. The commissioner may adjust the amortization schedule based on the findings of this semiannual review.~~]

(b) A subsidiary formed or acquired to hold or manage investments that the parent insurance company might hold or manage directly, shall be valued as if the assets of the subsidiary were owned directly by the insurer in a percentage equal to the insurer's percentage of ownership of the subsidiary. The subsidiary investment limitation of Subsection 31A-18-106(1)(k) does not apply to these subsidiaries.

(c) Subsidiaries other than those described in Subsections (3)(a) and (b) shall be valued in accordance with Subsection (1). The subsidiary investment limitation under Subsection 31A-18-106(1)(k) applies to these subsidiaries in the same manner as to subsidiaries described in Subsection (3)(a).

(d) In determining an insurer's financial condition, no value is given to:

(i) any interest held by the insurer in its own stock, including debts due the insurer that are secured by the insurer's own stock; or

(ii) any proportionate interest in the insurer's own stock, including debts that are secured by the insurer's own stock, which is held by any corporation, partnership, business unit, firm, or person owned in whole or in part by the insurer.

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

Section 32. Section **31A-17-402** is amended to read:

31A-17-402. Valuation of liabilities.

The commissioner shall adopt rules specifying the liabilities required to be reported by insurers in financial statements submitted under Section 31A-2-202 and the methods of valuing them. For life insurance, those methods shall be consistent with Part 5 of this chapter, Standard Valuation Law. Title insurance reserves are provided for under Section 31A-17-408. In determining the financial condition of an insurer, liabilities include:

(l) the estimated amount necessary to pay all its unpaid losses and claims incurred on or prior to the date of statement, whether reported or unreported, together with the expense of adjustment or

settlement of the loss or claim;

(2) for life, [~~disability~~] accident and health insurance, and annuity contracts:

(a) the reserves on life insurance policies and annuity contracts in force, valued according to appropriate tables of mortality and the applicable rates of interest;

(b) the reserves for [~~disability~~] accident and health benefits, for both active and disabled lives;

(c) the reserves for accidental death benefits; and

(d) any additional reserves which may be required by the commissioner by rule, or if no rule is applicable, then in a manner consistent with the practice formulated or approved by the National Association of Insurance Commissioners with respect to those types of insurance;

(3) for insurance other than life, [~~disability~~] accident and health, and title insurance, the amount of reserves equal to the unearned portions of the gross premiums charged on policies in force, computed on a daily or monthly pro rata basis or other basis approved by the commissioner; provided that after adopting any one of the methods for computing those reserves, an insurer may not change methods without the commissioner's written consent;

(4) for ocean marine and other transportation insurance, reserves equal to 50% of the amount of premiums upon risks covering not more than one trip or passage not terminated, and computed upon a pro rata basis or, with the commissioner's consent, in accordance with methods provided under Subsection (3); and

(5) its other liabilities, including taxes, expenses, and other obligations due or accrued at the date of statement.

Section 33. Section **31A-17-408** is amended to read:

31A-17-408. Title insurance reserves.

(1) In addition to an adequate reserve for outstanding losses, a title insurance company shall either:

(a) maintain and segregate an unearned premium reserve fund of not less than 10 cents for each $1,000 face amount of retained liability under each title insurance contract or policy on a single insurance risk issued[~~, except that during each of the 20 years following the year in which the title~~

~~insurance policy or contract was issued, the reserve applicable to the contract may be reduced by 5% of the original amount of the reserve~~]; or

(b) have the commissioner review and approve a contract of reinsurance applicable to the title insurance company's policies, which contract adequately covers the exposure or risk which the unearned premium reserve would serve.

(2) The fund shall be maintained for the protection of policyholders and is not subject to the claims of stockholders or creditors other than policyholders.

Section 34. Section **31A-17-504** is amended to read:

31A-17-504. Computation of minimum standard.

Except as otherwise provided in Sections 31A-17-505, 31A-17-506, and 31A-17-513, the minimum standard for the valuation of all life insurance policies and annuity and pure endowment contracts issued prior to January 1, 1994, shall be that provided by the laws in effect immediately prior to that date. Except as otherwise provided in Sections 31A-17-505, 31A-17-506, and 31A-17-513, the minimum standard for the valuation of all such policies and contracts issued on or after January 1, 1994, shall be the commissioner's reserve valuation methods defined in Sections 31A-17-507, 31A-17-508, 31A-17-511, and 31A-17-513, 3.5% interest, or in the case of life insurance policies and contracts, other than annuity and pure endowment contracts, issued on or after June 1, 1973, 4% interest for such policies issued prior to April 2, 1980, 5.5% interest for single premium life insurance policies, and 4.5% interest for all other such policies issued on and after April 2, 1980, and the following tables:

(1) For all ordinary policies of life insurance issued on the standard basis, excluding any [~~disability~~] accident and health and accidental death benefits in such policies: the National Association of Insurance Commissioners 1941 Standard Ordinary Mortality Table for such policies issued prior to the operative date of Subsection 31A-22-408(6)(a) (that is, the Standard Nonforfeiture Law for Life Insurance), the National Association of Insurance Commissioners 1958 Standard Ordinary Mortality Table for such policies issued on or after the operative date of Subsection 31A-22-408(6)(a) and prior to the operative date of Subsection 31A-22-408(6)(d), provided that for any category of such policies issued on female risks, all modified net premiums and present values

referred to in this section may be calculated according to an age not more than six years younger than the actual age of the insured; and for such policies issued on or after the operative date of Subsection 31A-22-408(6)(d):

(a) the National Association of Insurance Commissioners 1980 Standard Ordinary Mortality Table;

(b) at the election of the company for any one or more specified plans of life insurance, the National Association of Insurance Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; or

(c) any ordinary mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by rule promulgated by the commissioner for use in determining the minimum standard of valuation for such policies.

(2) For all industrial life insurance policies issued on the standard basis, excluding any [~~disability~~] accident and health and accidental death benefits in such policies: the 1941 Standard Industrial Mortality Table for such policies issued prior to the operative date of Subsection 31A-22-408(6)(c), and for such policies issued on or after such operative date, the National Association of Insurance Commissioners 1961 Standard Industrial Mortality Table or any industrial mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by rule promulgated by the commissioner for use in determining the minimum standard of valuation for such policies.

(3) For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies:

(a) the 1937 Standard Annuity Mortality Table[~~, or~~];

(b) at the option of the company, the Annuity Mortality Table for 1949, Ultimate[~~;~~]; or

(c) any modification of either of these tables approved by the commissioner.

(4) For group annuity and pure endowment contracts, excluding any [~~disability~~] accident and health and accidental death benefits in such policies:

(a) the Group Annuity Mortality Table for 1951, any modification of such table approved by the commissioner[~~;~~]; or

(b) at the option of the company, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts.

(5) For total and permanent disability benefits in or supplementary to ordinary policies or contracts: for policies or contracts issued on or after January 1, 1966, the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit or any tables of disablement rates and termination rates adopted after 1980 by the National Association of Insurance Commissioners, that are approved by rule promulgated by the commissioner for use in determining the minimum standard of valuation for such policies; for policies or contracts issued on or after January 1, 1961, and prior to January 1, 1966, either such tables or, at the option of the company, the Class (3) Disability Table (1926); and for policies issued prior to January 1, 1961, the Class (3) Disability Table (1926). Any such table shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(6) For accidental death benefits in or supplementary to policies issued on or after January 1, 1966, the 1959 Accidental Death Benefits Table or any accidental death benefits table adopted after 1980 by the National Association of Insurance Commissioners, that is approved by rule promulgated by the commissioner for use in determining the minimum standard of valuation for such policies, for policies issued on or after January 1, 1961, and prior to January 1, 1966, either such table or, at the option of the company, the Inter-Company Double Indemnity Mortality Table; and for policies issued prior to January 1, 1961, the Inter-Company Double Indemnity Mortality Table. Either table shall be combined with a mortality table for calculating the reserves for life insurance policies.

(7) For group life insurance, life insurance issued on the substandard basis and other special benefits: such tables as may be approved by the commissioner.

Section 35. Section **31A-17-505** is amended to read:

31A-17-505. Computation of minimum standard for annuities.

(1) Except as provided in Section 31A-17-506, the minimum standard for the valuation of all individual annuity and pure endowment contracts issued on or after the operative date of this

section, as defined in Subsection (2), and for all annuities and pure endowments purchased on or after such operative date under group annuity and pure endowment contracts, shall be the commissioner's reserve valuation methods defined in Sections 31A-17-507 and 31A-17-508 and the following tables and interest rates:

(a) For individual annuity and pure endowment contracts issued prior to April 2, 1980, excluding any [~~disability~~] accident and health and accidental death benefits in such contracts: the 1971 Individual Annuity Mortality Table, or any modification of this table approved by the commissioner, and 6% interest for single premium immediate annuity contracts, and 4% interest for all other individual annuity and pure endowment contracts.

(b) For individual single premium immediate annuity contracts issued on or after April 2, 1980, excluding any [~~disability~~] accident and health and accidental death benefits in such contracts: the 1971 Individual Annuity Mortality Table or any individual annuity mortality table, adopted after 1980 by the National Association of Insurance Commissioners that is approved by rule promulgated by the commissioner for use in determining the minimum standard of valuation for such contracts, or any modification of these tables approved by the commissioner, and 7.5% interest.

(c) For individual annuity and pure endowment contracts issued on or after April 2, 1980, other than single premium immediate annuity contracts, excluding any [~~disability~~] accident and health and accidental death benefits in such contracts: the 1971 Individual Annuity Mortality Table or any individual annuity mortality table adopted after 1980 by the National Association of Insurance Commissioners, that is approved by rule promulgated by the commissioner for use in determining the minimum standard of valuation for such contracts, or any modification of these tables approved by the commissioner, and 5.5% interest for single premium deferred annuity and pure endowment contracts and 4.5% interest for all other such individual annuity and pure endowment contracts.

(d) For all annuities and pure endowments purchased prior to April 2, 1980, under group annuity and pure endowment contracts, excluding any [~~disability~~] accident and health and accidental death benefits purchased under such contracts: the 1971 Group Annuity Mortality Table or any modification of this table approved by the commissioner, and 6.5% interest.

(e) For all annuities and pure endowments purchased on or after April 2, 1980, under group

annuity and pure endowment contracts, excluding any [~~disability~~] accident and health and accidental death benefits purchased under such contracts: the 1971 Group Annuity Mortality Table, or any group annuity mortality table adopted after 1980 by the National Association of Insurance Commissioners, that is approved by rule and promulgated by the commissioner for use in determining the minimum standard of valuation for such annuities and pure endowments, or any modification of these tables approved by the commissioner, and 7.5% interest.

(2) After June 1, 1973, any company may file with the commissioner a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1979, which shall be the operative date of this section for such company, provided, if a company makes no such election, the operative date of this section for such company shall be January 1, 1979.

Section 36. Section **31A-17-507** is amended to read:

31A-17-507. Reserve valuation method -- Life insurance and endowment benefits.

(1) Except as otherwise provided in Sections 31A-17-508, 31A-17-511, and 31A-17-513, reserves according to the commissioner's reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such policies, over the then present value of any future modified net premiums therefor. The modified net premiums for any such policy shall be such uniform percentage of the respective contract premiums for such benefits that the present value, at the date of issue of the policy, of all such modified net premiums shall be equal to the sum of the then present value of such benefits provided for by the policy and the excess of Subsection (1)(a) over Subsection (1)(b), as follows:

(a) A net level annual premium equal to the present value, at the date of issue, of such benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per annum payable on the first and each subsequent anniversary of such policy on which a premium falls due; provided, however, that such net level annual premium shall not exceed the net level annual premium on the 19 year premium whole life plan for insurance of the same amount at an age one year higher than the age at issue of such policy.

(b) A net one year term premium for such benefits provided for in the first policy year.

(2) Provided that for any life insurance policy issued on or after January 1, 1997, for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the reserve according to the commissioner's reserve valuation method as of any policy anniversary occurring on or before the assumed ending date defined herein as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than such excess premium shall, except as otherwise provided in Section 31A-17-511, be the greater of the reserve as of such policy anniversary calculated as described in Subsection (1) and the reserve as of such policy anniversary calculated as described in that subsection, but with:

(a) the value defined in Subsection (1)(a) being reduced by 15% of the amount of such excess first year premium[~~,~~];

(b) all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date[~~,~~];

(c) the policy being assumed to mature on such date as an endowment[~~,~~]; and

(d) the cash surrender value provided on such date being considered as an endowment benefit. In making the above comparison the mortality and interest bases stated in Sections 31A-17-504 and 31A-17-506 shall be used.

(3) Reserves according to the commissioner's reserve valuation method for:

(a) life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums;

(b) group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under [~~26 U.S.C. Sec. 408, as amended~~] Section 408, Internal Revenue Code;

(c) [~~disability~~] accident and health and accidental death benefits in all policies and contracts;

and

(d) all other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts, shall be calculated by a method consistent with the principles of Subsections (1) and (2).

Section 37. Section **31A-17-508** is amended to read:

31A-17-508. Reserve valuation method -- Annuity and pure endowment benefits.

(1) This section shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under [~~26 U.S.C. Sec. 408, as amended~~] Section 408, Internal Revenue Code.

(2) Reserves according to the commissioner's annuity reserve method for benefits under annuity or pure endowment contracts, excluding any [~~disability~~] accident and health and accidental death benefits in such contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by such contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of such contract, that become payable prior to the end of such respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate, or rates, specified in such contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of such contracts to determine nonforfeiture values.

Section 38. Section **31A-17-509** is amended to read:

31A-17-509. Minimum reserves.

(1) In no event shall a company's aggregate reserves for all life insurance policies, excluding [~~disability~~] accident and health and accidental death benefits, issued on or after January 1, 1994, be less than the aggregate reserves calculated in accordance with the methods set forth in Sections

31A-17-507, 31A-17-508, 31A-17-511, and 31A-17-512 and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for such policies.

(2) In no event shall the aggregate reserves for all policies, contracts, and benefits be less than the aggregate reserves determined by the qualified actuary to be necessary to render the opinion required by Section 31A-17-503.

Section 39. Section **31A-17-513** is amended to read:

31A-17-513. Minimum standards for accident and health plans.

The commissioner shall promulgate a rule containing the minimum standards applicable to the valuation of [~~disability~~] accident and health plans.

Section 40. Section **31A-17-601** is amended to read:

31A-17-601. Definitions.

As used in this part:

(1) "Adjusted RBC report" means an RBC report that has been adjusted by the commissioner in accordance with Subsection 31A-17-602[~~(4)~~] (5).

(2) "Corrective order" means an order issued by the commissioner specifying corrective action that the commissioner determines is required.

(3) "Health organization" means:

(a) an entity that is authorized under Chapter 7 or 8; and

(b) that is:

(i) a health maintenance organization;

(ii) a limited health service organization;

(iii) a dental or vision plan;

(iv) a hospital, medical, and dental indemnity or service corporation; or

(v) other managed care organization.

[~~(3)~~] (4) "Life or [~~disability~~] accident and health insurer" means:

(a) an insurance company licensed to write life insurance, disability insurance, or both; or

(b) a licensed property casualty insurer writing only disability insurance.

[~~(4)~~] (5) "Property and casualty insurer" means any insurance company licensed to write

lines of insurance other than life but does not include a monoline mortgage guaranty insurer, financial guaranty insurer, or title insurer.

[~~(5)~~] (6) "RBC" means risk-based capital.

[~~(6)~~] (7) "RBC instructions" means the RBC report including risk-based capital instructions adopted by the department by rule.

[~~(7)~~] (8) "RBC level" means an insurer's or health organization's authorized control level RBC, company action level RBC, mandatory control level RBC, or regulatory action level RBC.

(a) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;

(b) "Company action level RBC" means the product of 2.0 and its authorized control level RBC;

(c) "Mandatory control level RBC" means the product of .70 and the authorized control level RBC; and

(d) "Regulatory action level RBC" means the product of 1.5 and its authorized control level RBC.

[~~(8)~~] (9) (a) "RBC plan" means a comprehensive financial plan containing the elements specified in Subsection 31A-17-603(2). [~~If~~]

(b) Notwithstanding Subsection (9)(a), the plan is a "revised RBC plan" if:

(i) the commissioner rejects the RBC plan[~~,~~]; and [~~it~~]

(ii) the plan is revised by the insurer or health organization, with or without the commissioner's recommendation[~~, the plan shall be called the "Revised RBC Plan."~~].

[~~(9)~~] (10) "RBC report" means the report required in Section 31A-17-602.

Section 41. Section **31A-17-602** is amended to read:

31A-17-602. RBC reports -- RBC of life and accident and health insurers -- RBC of property and casualty insurers.

(1) Every domestic life or [~~disability~~] accident and health insurer [~~and~~], every domestic property and casualty insurer, and every domestic health organization shall:

(a) on or before March 1, prepare and submit to the commissioner a report of its RBC levels

as of the end of the calendar year just ended, in a form and containing the information as is required by the RBC instructions; [~~and~~]

(b) file its RBC report with the insurance commissioner in any state in which the insurer or health organization is authorized to do business, if the insurance commissioner of that state notifies the insurer or health organization of its request in writing, in which case the insurer or health organization may file its RBC report not later than the later of:

(i) 15 days from the receipt of notice to file its RBC report with that state; or

(ii) March 1[~~.~~]; and

(c) file the documents described in Subsections (1)(a) and (b) with the National Association of Insurance Commissioners in accordance with RBC instructions.

(2) A life and [~~disability~~] accident and health insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take into account and may adjust for the covariance between:

(a) the risk with respect to the insurer's assets;

(b) the risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(c) the interest rate risk with respect to the insurer's business; and

(d) all other business risks and other relevant risks as set forth in the RBC instructions.

(3) A property and casualty insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take the following into account and may adjust for the covariance between:

(a) asset risk;

(b) credit risk;

(c) underwriting risk; and

(d) all other business risks and the other relevant risks as set forth in the RBC instructions.

(4) A health organization's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take the following into account and may adjust for the covariance between:

(a) asset risk;

(b) credit risk;

(c) underwriting risk; and

(d) all other business risks and such other relevant risks as are set forth in the RBC instructions.

[~~(4)~~] (5) (a) If a domestic insurer files an RBC report that the commissioner determines is inaccurate, the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the insurer of the adjustment.

(b) The notice under Subsection [~~(4)~~] (5)(a) shall contain a statement of the reason for the adjustment.

(6) The commissioner may make rules to assist in applying the provisions of this part to health organizations.

Section 42. Section **31A-17-603** is amended to read:

31A-17-603. Company action level event.

(1) "Company action level event" means any of the following events:

(a) the filing of an RBC report by an insurer or health organization that indicates that:

(i) the insurer's or health organization's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC; or

(ii) if a life or [~~disability~~] accident and health insurer, the insurer has:

(A) total adjusted capital that is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 2.5; and

(B) a negative trend, determined in accordance with the "trend test calculation" included in the RBC instructions;

(b) the notification by the commissioner to the insurer or health organization of an adjusted RBC report that indicates an event in Subsection (1)(a), provided the insurer or health organization does not challenge the adjusted RBC report under Section 31A-17-607; or

(c) if, pursuant to Section 31A-17-607, an insurer or health organization challenges an adjusted RBC report that indicates the event in Subsection (1)(a), the notification by the

commissioner to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge.

(2) (a) In the event of a company action level event, the insurer or health organization shall prepare and submit to the commissioner an RBC plan that shall:

(i) identify the conditions that contribute to the company action level event;

(ii) contain proposals of corrective actions that the insurer or health organization intends to take and that are expected to result in the elimination of the company action level event;

(iii) provide projections of the insurer's or health organization's financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of:

(A) statutory operating income[~~,~~];

(B) net income[~~,~~];

(C) capital[~~, and~~];

(D) surplus; and

(E) RBC levels;

(iv) identify the key assumptions impacting the insurer's or health organization's projections and the sensitivity of the projections to the assumptions; and

(v) identify the quality of, and problems associated with, the insurer's or health organization's business, including its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

(b) For purposes of Subsection (2)(a)(iii), the projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense, and benefit component.

(3) The RBC plan shall be submitted:

(a) within 45 days of the company action level event; or

(b) if the insurer or health organization challenges an adjusted RBC report pursuant to Section 31A-17-607, within 45 days after notification to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge.

(4) (a) Within 60 days after the submission by an insurer or health organization of an RBC plan to the commissioner, the commissioner shall notify the insurer or health organization whether the RBC plan:

(i) shall be implemented; or

(ii) is unsatisfactory.

(b) If the commissioner determines the RBC plan is unsatisfactory, the notification to the insurer or health organization shall set forth the reasons for the determination, and may propose revisions that will render the RBC plan satisfactory. Upon notification from the commissioner, the insurer or health organization shall:

(i) prepare a revised RBC plan that incorporates any revision proposed by the commissioner; and

(ii) submit the revised RBC plan to the commissioner:

(A) within 45 days after the notification from the commissioner; or

(B) if the insurer challenges the notification from the commissioner under Section 31A-17-607, within 45 days after a notification to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge.

(5) In the event of a notification by the commissioner to an insurer or health organization that the insurer's or health organization's RBC plan or revised RBC plan is unsatisfactory, the commissioner may specify in the notification that the notification constitutes a regulatory action level event subject to the insurer's or health organization's right to a hearing under Section 31A-17-607.

(6) Every domestic insurer or health organization that files an RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the insurer or health organization is authorized to do business if:

(a) the state has an RBC provision substantially similar to Subsection 31A-17-608(1); and

(b) the insurance commissioner of that state notifies the insurer or health organization of its request for the filing in writing, in which case the insurer or health organization shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

(i) 15 days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with that state; or

(ii) the date on which the RBC plan or revised RBC plan is filed under Subsections (3) and (4).

Section 43. Section **31A-17-604** is amended to read:

31A-17-604. Regulatory action level event.

(1) "Regulatory action level event" means with respect to any insurer or health organization, any of the following events:

(a) the filing of an RBC report by the insurer or health organization that indicates that the insurer's or health organization's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;

(b) the notification by the commissioner to an insurer or health organization of an adjusted RBC report that indicates the event in Subsection (1)(a), provided the insurer or health organization does not challenge the adjusted RBC report under Section 31A-17-607;

(c) if, pursuant to Section 31A-17-607, the insurer or health organization challenges an adjusted RBC report that indicates the event in Subsection (1)(a), the notification by the commissioner to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge;

(d) the failure of the insurer or health organization to file an RBC report by March 1, unless the insurer or health organization has:

(i) provided an explanation for the failure that is satisfactory to the commissioner; and

(ii) cured the failure within ten days after March 1;

(e) the failure of the insurer or health organization to submit an RBC plan to the commissioner within the time period set forth in Subsection 31A-17-603(3);

(f) notification by the commissioner to the insurer or health organization that:

(i) the RBC plan or revised RBC plan submitted by the insurer or health organization is unsatisfactory; and

(ii) the notification constitutes a regulatory action level event with respect to the insurer or

health organization, provided the insurer has not challenged the determination under Section 31A-17-607;

(g) if, pursuant to Section 31A-17-607, the insurer or health organization challenges a determination by the commissioner under Subsection (1)(f), the notification by the commissioner to the insurer or health organization that after a hearing the commissioner rejects the challenge; or

(h) notification by the commissioner to the insurer or health organization that the insurer or health organization has failed to adhere to its RBC plan or revised RBC plan, but only if:

(i) the failure has a substantial adverse effect on the ability of the insurer or health organization to eliminate the company action level event in accordance with its RBC plan or revised RBC plan; and

(ii) the commissioner has so stated in the notification, provided the insurer or health organization has not challenged the determination under Section 31A-17-607; or

(iii) if, pursuant to Section 31A-17-607, the insurer or health organization challenges a determination by the commissioner under Subsection (1)(h), the notification by the commissioner to the insurer or health organization that after a hearing the commissioner rejects the challenge.

(2) In the event of a regulatory action level event the commissioner shall:

(a) require the insurer or health organization to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(b) perform any examination or analysis the commissioner considers necessary of the assets, liabilities, and operations of the insurer or health organization, including a review of its RBC plan or revised RBC plan; and

(c) subsequent to the examination or analysis, issue a corrective order specifying the corrective action the commissioner determines is required.

(3) In determining a corrective action, the commissioner may take into account such factors the commissioner considers relevant with respect to the insurer or health organization based upon the commissioner's examination or analysis of the assets, liabilities, and operations of the insurer or health organization, including the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan shall be submitted:

(a) within 45 days after the occurrence of the regulatory action level event;

(b) if the insurer or health organization challenges an adjusted RBC report pursuant to Section 31A-17-607 and the commissioner determines the challenge is not frivolous, within 45 days after the notification to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge; or

(c) if the insurer or health organization challenges a revised RBC plan pursuant to Section 31A-17-607 and the commissioner determines the challenge is not frivolous, within 45 days after the notification to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge.

Section 44. Section **31A-17-605** is amended to read:

31A-17-605. Authorized control level event.

(1) "Authorized control level event" means any of the following events:

(a) the filing of an RBC report by the insurer or health organization that indicates that the insurer's or health organization's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(b) the notification by the commissioner to the insurer or health organization of an adjusted RBC report that indicates the event in Subsection (1)(a), provided the insurer or health organization does not challenge the adjusted RBC report under Section 31A-17-607;

(c) if, pursuant to Section 31A-17-607, the insurer or health organization challenges an adjusted RBC report that indicates the event in Subsection (1)(a), notification by the commissioner to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge;

(d) the failure of the insurer or health organization to respond, in a manner satisfactory to the commissioner, to a corrective order, provided the insurer or health organization has not challenged the corrective order under Section 31A-17-607; or

(e) if the insurer or health organization has challenged a corrective order under Section 31A-17-607 and the commissioner after a hearing rejects the challenge or modifies the corrective order, the failure of the insurer or health organization to respond, in a manner satisfactory to the

commissioner, to the corrective order subsequent to rejection or modification by the commissioner.

(2) (a) In the event of an authorized control level event with respect to an insurer or health organization, the commissioner shall:

(i) take any action required under Section 31A-17-604 regarding an insurer or health organization with respect to which a regulatory action level event has occurred; or

(ii) take any action as is necessary to cause the insurer or health organization to be placed under regulatory control under Section 31A-27-201 if the commissioner considers it to be in the best interests of:

(A) the policyholders [~~and~~] or members;

(B) creditors of the insurer or health organization; and

(C) the public.

(b) In the event the commissioner takes an action described in Subsection (2)(a), the authorized control level event is sufficient grounds for the commissioner to take action under Section 31A-27-201, and the commissioner shall have the rights, powers, and duties with respect to the insurer or health organization set forth in Section 31A-27-201.

(c) If the commissioner takes an action under Subsection (2)(a) pursuant to an adjusted RBC report, the insurer or health organization is entitled to the protections afforded to [~~insurers~~] an insurer or health organization under Section 31A-27-203 pertaining to summary proceedings.

Section 45. Section **31A-17-606** is amended to read:

31A-17-606. Mandatory control level event.

(1) "Mandatory control level event" means any of the following events:

(a) the filing of an RBC report that indicates that the insurer's or health organization's total adjusted capital is less than its mandatory control level RBC;

(b) notification by the commissioner to the insurer or health organization of an adjusted RBC report that indicates the event in Subsection (1)(a), provided the insurer or health organization does not challenge the adjusted RBC report under Section 31A-17-607; or

(c) if, pursuant to Section 31A-17-607, the insurer or health organization challenges an adjusted RBC report that indicates the event in Subsection (1)(a), notification by the commissioner

to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge.

(2) (a) [~~(i)~~] In the event of a mandatory control level event with respect to [~~a life~~] an insurer or health organization, the commissioner shall take any actions necessary to place the insurer under regulatory control under Section 31A-27-201.

[~~(ii)~~] (b) The mandatory control level event is sufficient grounds for the commissioner to take action under Section 31A-27-201, and the commissioner shall have the rights, powers, and duties with respect to the insurer or health organization as are set forth in Section 31A-27-201.

[~~(iii)~~] (c) If the commissioner takes an action pursuant to an adjusted RBC report, the insurer or health organization is entitled to the protections of Section 31A-27-203 pertaining to summary proceedings.

[~~(iv)~~] (d) Notwithstanding the other provisions of Subsection (2), the commissioner may forego action for up to 90 days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90-day period.

[~~(b) (i) In the event of a mandatory control level with respect to a property and casualty insurer, the commissioner shall take any action necessary to place the insurer under regulatory control under Section 31A-27-201.~~]

[~~(ii) The mandatory control level event is sufficient grounds for the commissioner to take action under Section 31A-27-201 and the commissioner shall have the rights, powers, and duties with respect to the insurer set forth in Section 31A-27-201.~~]

[~~(iii) If the commissioner takes actions pursuant to an adjusted RBC report, the insurer shall be entitled to the protections of Section 31A-27-203 pertaining to summary proceedings.~~]

[~~(iv) Notwithstanding any other provision of this section, the commissioner may forego action for up to 90 days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90-day period.~~]

Section 46. Section **31A-17-607** is amended to read:

31A-17-607. Hearings.

(1) (a) Following receipt of a notice described in Subsection (2), the insurer or health organization shall have the right to a confidential departmental hearing at which the insurer or health organization may challenge any determination or action by the commissioner.

(b) The insurer or health organization shall notify the commissioner of its request for a hearing within five days after the notification by the commissioner under Subsections 31A-17-604(1), (2), and (3).

(c) Upon receipt of the insurer's or health organization's request for a hearing, the commissioner shall set a date for the hearing, which date shall be no less than ten nor more than 30 days after the date of the insurer's or health organization's request.

(2) An insurer or health organization has the right to a hearing under Subsection (1) after:

(a) notification to an insurer or health organization by the commissioner of an adjusted RBC report;

(b) notification to an insurer or health organization by the commissioner that:

(i) the insurer's or health organization's RBC plan or revised RBC plan is unsatisfactory; and

(ii) the notification constitutes a regulatory action level event with respect to the insurer or health organization;

(c) notification to any insurer or health organization by the commissioner that the insurer or health organization has failed to adhere to its RBC plan or revised RBC plan and that the failure has substantial adverse effect on the ability of the insurer or health organization to eliminate the company
action level event with respect to the insurer or health organization in accordance with its RBC plan or revised RBC plan; or

(d) notification to an insurer or health organization by the commissioner of a corrective order with respect to the insurer or health organization.

Section 47. Section **31A-17-608** is amended to read:

31A-17-608. Confidentiality -- Prohibition on announcements -- Prohibition on use in ratemaking.

(1) (a) The commissioner shall keep confidential to the extent that information in a report

or plan is not required to be included in a publicly available annual statement schedule, any detail in an RBC report or RBC plan including the results or report of any examination or analysis of an insurer or health organization performed pursuant to this part, that is filed by a domestic or foreign insurer or health organization with the commissioner or any corrective order issued by the commissioner pursuant to examination or analysis.

(b) Information kept confidential under Subsection (1)(a) may not be made public or be subject to subpoena, other than by the commissioner and then only for the purpose of enforcement actions taken by the commissioner pursuant to this part or any other provision of the insurance laws of this state.

(2) (a) Except as otherwise required under this part, any insurer or health organization, agent, broker, or other person engaged in any manner in the insurance business may not publish, disseminate, circulate or place before the public, or cause, directly or indirectly, the publishing, disseminating, circulating or placing before the public including, in a newspaper, magazine, other publication, a notice, circular, pamphlet, letter, or poster, or over any radio or television station, an advertisement, announcement, or statement containing an assertion, representation, or statement with regard to the RBC levels of any insurer or health organization, or of any component derived in the calculation.

(b) If any materially false statement with respect to the comparison regarding an insurer's or health organization's total adjusted capital to its RBC levels, or an inappropriate comparison of any other amount to the insurer's or health organization's RBC levels is published in any written publication and the insurer or health organization is able to demonstrate to the commissioner with substantial proof the falsity of the statement or the inappropriateness, the insurer or health organization may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement or inappropriate comparison.

(3) The commissioner may not use an RBC instruction, report, plan, or revised plan:

(a) for ratemaking;

(b) as evidence in any rate proceeding; or

(c) to calculate or derive any element of an appropriate premium level or rate of return for

any line of insurance or coverage that an insurer or health organization or any affiliate is authorized to write or cover.

Section 48. Section **31A-17-609** is amended to read:

31A-17-609. Alternate adjusted capital.

(1) Except as provided in Section 31A-17-602, [~~insurers~~] an insurer or health organization licensed under Chapters 5, 7, 8, 9, and 14 shall maintain total adjusted capital as defined in Section 31A-1-301 in an amount equal to the greater of:

(a) 175% of the minimum required capital, or of the minimum permanent surplus in the case of nonassessable mutuals, required by Section 31A-5-211, 31A-7-201, 31A-8-209, 31A-9-209, or 31A-14-205; or

(b) the net total of:

(i) 10% of net insurance premiums earned during the year; plus

(ii) 5% of the admitted value of common stocks and real estate; plus

(iii) 2% of the admitted value of all other invested assets, exclusive of cash deposits, short-term investments, policy loans, and premium notes; less

(iv) the amount of any asset valuation reserve being maintained by the insurer or health organization, but not to exceed the sum of Subsections (1)(b)(ii) and (iii).

(2) As used in Subsection (1)(b), "premiums earned" means premiums and other consideration earned for insurance in the 12-month period ending on the date the calculation is made.

(3) The commissioner may consider an insurer or health organization to be financially hazardous under Subsection 31A-27-307(3), if the insurer or health organization does not have qualified assets in an aggregate value exceeding the sum of the insurer's or health organization's liabilities and the total adjusted capital required by Subsection (1).

(4) The commissioner shall consider an insurer or health organization to be financially hazardous under Subsection 31A-27-307(3) if the insurer or health organization does not have qualified assets in an aggregate value exceeding the sum of the insurer's or health organization's liabilities and 70% of the total adjusted capital required by Subsection (1).

Section 49. Section **31A-17-610** is amended to read:

31A-17-610. Foreign insurers.

(1) (a) Any foreign insurer or health organization shall, upon the written request of the commissioner, submit to the commissioner an RBC report as of the end of the most recent calendar year by the later of:

(i) the date an RBC report would be required to be filed by a domestic insurer or health organization under this part; or

(ii) 15 days after the request is received by the foreign insurer or health organization.

(b) Any foreign insurer or health organization shall, at the written request of the commissioner, promptly submit to the commissioner a copy of any RBC plan that is filed with the insurance commissioner of any other state.

(2) (a) The commissioner may require a foreign insurer or health organization to file an RBC plan with the commissioner if:

(i) there is a company action level event, regulatory action level event, or authorized control level event with respect to the foreign insurer or health organization as determined under:

(A) the RBC statute applicable in the state of domicile of the insurer or health organization; or[~~,~~]

(B) if no RBC statute is in force in that state, under [~~the provisions of~~] this part; and

(ii) the insurance commissioner of the state of domicile of the foreign insurer or health organization fails to require the foreign insurer or health organization to file an RBC plan in the manner specified under:

(A) that state's RBC statute; or[~~,~~]

(B) if no RBC statute is in force in that state, under Section 31A-17-603.

(b) If the commissioner requires a foreign insurer or health organization to file an RBC plan, the failure of the foreign insurer or health organization to file the RBC plan with the commissioner is grounds to order the insurer or health organization to cease and desist from writing new insurance business in this state.

(3) The commissioner may make application to the Third District Court for Salt Lake County permitted under Section 31A-27-401 with respect to the liquidation of property of a foreign

[~~insurers~~] insurer or health organization found in this state if:

(a) a mandatory control level event occurs with respect to any foreign insurer or health organization; and

(b) no domiciliary receiver has been appointed with respect to the foreign insurer or health organization under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign insurer or health organization.

Section 50. Section **31A-17-613** is amended to read:

31A-17-613. Effective date of notice.

A notice by the commissioner to an insurer or health organization that may result in regulatory action under this chapter is effective the sooner of:

(1) the date the insurer or health organization receives the notice; or

(2) three days after mailing the notice.

Section 51. Section **31A-18-105** is amended to read:

31A-18-105. Permitted classes of investments.

The following classes of investment may be counted for the purposes specified under Chapter 17, Part 6, Risk-Based Capital:

(1) bonds or other evidences of indebtedness of:

(a) (i) governmental units in the United States or Canada[~~, or~~];

(ii) instrumentalities of [~~those~~] the governmental units[~~,~~] described in Subsection (1)(a)(i); or [~~of~~]

(iii) private corporations domiciled in the United States[~~,~~]; and

(b) including demand deposits and certificates of deposits in solvent banks and savings and loan institutions;

(2) equipment trust obligations or certificates [~~which~~] that are adequately secured instruments evidencing an interest in transportation equipment [~~which~~] that is located wholly or in part within the United States, with a right to receive determined portions of the rental, or to purchase other fixed obligatory payments for the use or purchase of the transportation equipment;

(3) loans secured by:

(a) mortgages[~~,~~];

(b) trust deeds[~~,~~]; or

(c) other statutorily authorized types of security interests in real estate located in the United States;

(4) loans secured by pledged securities or evidences of debt eligible for investment under this section;

(5) preferred stocks of United States corporations;

(6) common stocks of United States corporations;

(7) real estate which is used as the home office or branch office of the insurer;

(8) real estate in the United States which produces substantial income;

(9) loans upon the security of the insurer's own policies in amounts that are adequately secured by the policies and that do not exceed the surrender value of the policies;

(10) financial futures contracts used for hedging and not for speculation, as approved under rules adopted by the commissioner;

(11) investments in foreign securities of the classes permitted under this section as required for compliance with Section 31A-18-103;

(12) investments permitted under Subsection 31A-18-102(2); and

(13) other investments as the commissioner authorizes by rule.

Section 52. Section **31A-19a-101** is amended to read:

31A-19a-101. Title -- Scope and purposes.

(1) This chapter is known as the "Utah Rate Regulation Act."

(2) (a) (i) Except as provided in Subsection (2)(a)(ii), this chapter applies to all kinds and lines of direct insurance written on risks or operations in this state by an insurer authorized to do business in this state.

(ii) This chapter does not apply to:

(A) life insurance other than credit life insurance;

(B) variable and fixed annuities;

(C) health and [~~disability~~] accident and health insurance other than credit [~~disability~~]

accident and health insurance; and

(D) reinsurance.

(b) This chapter applies to all insurers authorized to do any line of business, except those specified in Subsection (2)(a)(ii).

(3) It is the purpose of this chapter to:

(a) protect policyholders and the public against the adverse effects of excessive, inadequate, or unfairly discriminatory rates;

(b) encourage independent action by and reasonable price competition among insurers so that rates are responsive to competitive market conditions;

(c) provide formal regulatory controls for use if independent action and price competition fail;

(d) provide regulatory procedures for the maintenance of appropriate data reporting systems;

(e) authorize cooperative action among insurers in the rate-making process, and regulate that cooperation to prevent practices that bring about a monopoly or lessen or destroy competition;

(f) encourage the most efficient and economic marketing practices; and

(g) regulate the business of insurance in a manner that, under the McCarran-Ferguson Act, 15 U.S.C. Secs. 1011 through 1015, will preclude application of federal antitrust laws.

(4) Rate filings made prior to July 1, 1986, under former Title 31, Chapter 18, are continued. Rate filings made after July 1, 1986, are subject to the requirements of this chapter.

Section 53. Section **31A-21-103** is amended to read:

31A-21-103. Capacity to contract.

Any person 16 years of age or older who is otherwise competent to contract under Utah law, and who is not subject to any legal disability, may contract for insurance. If there is a conservator appointed under Title 75, the conservator, rather than the person whose property is subject to the conservatorship, may contract for insurance to protect the property under conservatorship. In the case of a conservatorship over the person or property of a person under 16 years of age, the conservator may invest funds of the estate in life or [~~disability~~] accident and health insurance or annuity contracts, but only with the approval of the court having jurisdiction over the

conservatorship.

Section 54. Section **31A-21-104** is amended to read:

31A-21-104. Insurable interest and consent.

(1) (a) An insurer may not knowingly provide insurance to a person who does not have or expect to have an insurable interest in the subject of the insurance.

(b) A person may not knowingly procure, directly, by assignment, or otherwise, an interest in the proceeds of an insurance policy unless he has or expects to have an insurable interest in the subject of the insurance.

(c) Except as provided in Subsections (6), (7), and (8), any insurance provided in violation of this subsection is subject to Subsection (5).

(2) As used in this chapter:

(a) "Insurable interest" in a person means, for persons closely related by blood or by law, a substantial interest engendered by love and affection, or in the case of other persons, a lawful and substantial interest in having the life, health, and bodily safety of the person insured continue. Policyholders in group insurance contracts need no insurable interest if certificate holders or persons other than group policyholders who are specified by the certificate holders are the recipients of the proceeds of the policies. Each person has an unlimited insurable interest in his own life and health. A shareholder or partner has an insurable interest in the life of other shareholders or partners for purposes of insurance contracts that are an integral part of a legitimate buy-sell agreement respecting shares or a partnership interest in the business.

(b) "Insurable interest" in property or liability means any lawful and substantial economic interest in the nonoccurrence of the event insured against.

(c) "Viatical settlement" means a written contract entered into by a person who is the policyholder of a life insurance policy insuring the life of a terminally ill person, under which the insured assigns, transfers ownership, irrevocably designates a specific person or otherwise alienates all control and right in the insurance policy to another person, when the proceeds of the contract is paid to the policyholder of the insurance policy or the policyholder's designee prior to the death of the subject.

(3) Except as provided in Subsection (4), an insurer may not knowingly issue an individual life or [~~disability~~] accident and health insurance policy to a person other than the one whose life or health is at risk unless that person, who is 18 years of age or older and not under guardianship under Title 75, Chapter 5, Protection of Persons Under Disability and Their Property, has given written consent to the issuance of the policy. The person shall express consent either by signing an application for the insurance with knowledge of the nature of the document, or in any other reasonable way. Any insurance provided in violation of this subsection is subject to Subsection (5).

(4) (a) A life or [~~disability~~] accident and health insurance policy may be taken out without consent in the following cases:

(i) A person may obtain insurance on a dependent who does not have legal capacity.

(ii) A creditor may, at the creditor's expense, obtain insurance on the debtor in an amount reasonably related to the amount of the debt.

(iii) A person may obtain life and [~~disability~~] accident and health insurance on immediate family members living with or dependent on the person.

(iv) A person may obtain [~~a disability~~] an accident and health insurance policy on others that would merely indemnify the policyholder against expenses he would be legally or morally obligated to pay.

(v) The commissioner may adopt rules permitting issuance of insurance for a limited term on the life or health of a person serving outside the continental United States who is in the public service of the United States, if the policyholder is related within the second degree by blood or by marriage to the person whose life or health is insured.

(b) Consent may be given by another in the following cases:

(i) A parent, a person having legal custody of a minor, or a guardian of the person under Title 75, Chapter 5, Protection of Persons Under Disability and Their Property, may consent to the issuance of a policy on a dependent child or on a person under guardianship under Title 75, Chapter 5, Protection of Persons Under Disability and Their Property.

(ii) A grandparent may consent to the issuance of life or [~~disability~~] accident and health insurance on a grandchild.

(iii) A court of general jurisdiction may give consent to the issuance of a life or [~~disability~~] accident and health insurance policy on an ex parte application showing facts the court considers sufficient to justify the issuance of that insurance.

(5) An insurance policy is not invalid because the policyholder lacks insurable interest or because consent has not been given, but a court with appropriate jurisdiction may order the proceeds to be paid to some person who is equitably entitled to them, other than the one to whom the policy is designated to be payable, or it may create a constructive trust in the proceeds or a part of them on behalf of such a person, subject to all the valid terms and conditions of the policy other than those relating to insurable interest or consent.

(6) This section does not prevent any organization described under 26 U.S.C. Sec. 501(c)(3), (e), or (f), as amended, and the regulations made under this section, and which is regulated under Title 13, Chapter 22, Charitable Solicitations Act, from soliciting and procuring, by assignment or designation as beneficiary, a gift or assignment of an interest in life insurance on the life of the donor or assignor or from enforcing payment of proceeds from that interest.

(7) This section does not prevent:

(a) any policyholder of life insurance, whether or not the policyholder is also the subject of the insurance, from entering into a viatical settlement;

(b) any person from soliciting a person to enter into a viatical settlement; or

(c) a person from enforcing payment of proceeds from the interest obtained under a viatical settlement.

(8) Notwithstanding Subsection (1), an insurer authorized under this title to issue a workers' compensation policy may issue a workers' compensation policy to a sole proprietorship, corporation, or partnership that elects not to include any owner, corporate officer, or partner as an employee under the policy even if at the time the policy is issued the sole proprietorship, corporation, or partnership has no employees.

Section 55. Section **31A-21-201** is amended to read:

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

(1) (a) A form subject to Subsection 31A-21-101(1), except as exempted under Subsections

31A-21-101(2) through (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 the commissioner receives:

(i) the form;

(ii) the applicable filing fee as prescribed under Section 31A-3-103; 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~~] prohibit the use of 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

(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, it fails to conspicuously, as defined by rule, provide:

(A) the exact name of the insurer [~~and~~];

(B) its state of domicile; and

(C) for life insurance and annuity policies only, the address of its administrative office.

(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.

(c) (i) Whenever the commissioner [~~disapproves~~] prohibits the use of 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~~] prohibited, it may not be used unless appropriate changes are filed with and [~~approved~~] reviewed by the commissioner.

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

(d) The commissioner's [~~disapproval~~] prohibition under this Subsection (3) shall:

(i) be in writing [~~and constitutes~~];

(ii) constitute an order[~~. The order shall~~]; and

(iii) state the reasons for [~~disapproval~~] the prohibition.

(4) (a) If, after a hearing, the commissioner determines that it is in the public interest, 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 the forms if different than stated in this section.

(c) The types of forms 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 56. Section **31A-21-301** is amended to read:

31A-21-301. Clauses required to be in a prominent position.

(1) The following portions of insurance policies shall appear conspicuously in the policy:

(a) [~~the name and state of domicile of the insurer~~] as required by Subsection 31A-21-201 (3)(a)(iii)[~~;~~]:

(i) the exact name of the insurer;

(ii) the state of domicile of the insurer; and

(iii) for life insurance and annuity policies only, the address of the administrative office of the insurer;

(b) information that two or more insurers under Subsection (1)(a) undertake only several liability, as required by Section 31A-21-306;

(c) if a policy is assessable, a statement of that;

(d) a statement that benefits are variable, as required by Subsection 31A-22-411(1); however,
the methods of calculation need not be in a prominent position;

(e) the right to return a life or [~~disability~~] accident and health insurance policy under Sections 31A-22-423 and 31A-22-606; and

(f) the beginning and ending dates of insurance protection.

(2) Each clause listed in Subsection (1) shall be displayed conspicuously and separately from any other clause.

Section 57. Section **31A-21-303** is amended to read:

31A-21-303. Termination of insurance policies by insurers.

(1) (a) Except as otherwise provided in this section, in other statutes, or by rule under Subsection (1)(c), this section applies to all policies of insurance other than life and [~~disability~~] accident and health insurance and annuities, if the policies of insurance are issued on forms that are subject to filing and approval under Subsection 31A-21-201(1).

(b) A policy may provide terms more favorable to insureds than this section requires.

(c) The commissioner may by rule totally or partially exempt from this section classes of insurance policies in which the insureds do not need protection against arbitrary or unannounced termination.

(d) The rights provided by this section are in addition to and do not prejudice any other rights the insureds may have at common law or under other statutes.

(2) (a) As used in this Subsection (2), "grounds" means:

(i) material misrepresentation;

(ii) substantial change in the risk assumed, unless the insurer should reasonably have

foreseen the change or contemplated the risk when entering into the contract;

(iii) substantial breaches of contractual duties, conditions, or warranties;

(iv) attainment of the age specified as the terminal age for coverage, in which case the insurer may cancel by notice under Subsection (2)(c), accompanied by a tender of proportional return of premium; or

(v) in the case of automobile insurance, revocation or suspension of the driver's license of the named insured or any other person who customarily drives the car.

(b) (i) Except as provided in Subsection (2)(e) or unless the conditions of Subsection (2)(b)(ii) are met, an insurance policy may not be canceled by the insurer before the earlier of:

(A) the expiration of the agreed term; or

(B) one year from the effective date of the policy or renewal.

(ii) Notwithstanding Subsection (2)(b)(i), an insurance policy may be canceled by the insurer for:

(A) nonpayment of a premium when due; or

(B) on grounds defined in Subsection (2)(a).

(c) (i) The cancellation provided by Subsection (2)(b), except cancellation for nonpayment of premium, is effective no sooner than 30 days after the delivery or first-class mailing of a written notice to the policyholder.

(ii) Cancellation for nonpayment of premium is effective no sooner than ten days after delivery or first class mailing of a written notice to the policyholder.

(d) (i) Notice of cancellation for nonpayment of premium shall include a statement of the reason for cancellation.

(ii) Subsection (6) applies to the notice required for grounds of cancellation other than nonpayment of premium.

(e) (i) Subsections (2)(a) through (d) do not apply to any insurance contract that has not been previously renewed if the contract has been in effect less than 60 days when the written notice of cancellation is mailed or delivered.

(ii) A cancellation under this Subsection (2)(e) may not be effective until at least ten days

after the delivery to the insured of a written notice of cancellation.

(iii) If the notice required by this Subsection (2)(e) is sent by first-class mail, postage prepaid, to the insured at the insured's last-known address, delivery is considered accomplished after the passing, since the mailing date, of the mailing time specified in the Utah Rules of Civil Procedure.

(iv) A policy cancellation subject to this Subsection (2)(e) is not subject to the procedures described in Subsection (6).

(3) A policy may be issued for a term longer than one year or for an indefinite term if the policy includes a clause providing for cancellation by the insurer by giving notice as provided in Subsection (4)(b)(i) 30 days prior to any anniversary date.

(4) (a) Subject to Subsections (2), (3), and (4)(b), a policyholder has a right to have the policy renewed:

(i) on the terms then being applied by the insurer to similar risks; and

(ii) (A) for an additional period of time equivalent to the expiring term if the agreed term is one year or less; or

(B) for one year if the agreed term is longer than one year.

(b) Except as provided in Subsection (4)(c), the right to renewal under Subsection (4)(a) is extinguished if:

(i) at least 30 days prior to the policy expiration or anniversary date a notice of intention not to renew the policy beyond the agreed expiration or anniversary date is delivered or sent by first-class
mail by the insurer to the policyholder at the policyholder's last-known address;

(ii) not more than 45 nor less than 14 days prior to the due date of the renewal premium, the insurer delivers or sends by first-class mail a notice to the policyholder at the policyholder's last-known address, clearly stating:

(A) the renewal premium;

(B) how it may be paid; and

(C) that failure to pay the renewal premium by the due date extinguishes the policyholder's right to renewal;

(iii) the policyholder has:

(A) accepted replacement coverage; or

(B) requested or agreed to nonrenewal; or

(iv) the policy is expressly designated as nonrenewable.

(c) Unless the conditions of Subsection (4)(b)(iii) or (iv) apply, an insurer may not fail to renew an insurance policy as a result of a telephone call or other inquiry that:

(i) references a policy coverage; and

(ii) does not result in a claim being filed or paid.

(5) (a) (i) Subject to Subsection (5)(b), if the insurer offers or purports to renew the policy, but on less favorable terms or at higher rates, the new terms or rates take effect on the renewal date if the insurer delivered or sent by first-class mail to the policyholder notice of the new terms or rates at least 30 days prior to the expiration date of the prior policy.

(ii) If the insurer did not give the prior notification described in Subsection (5)(a)(i) to the policyholder the new terms or rates do not take effect until 30 days after the notice is delivered or sent by first-class mail, in which case the policyholder may elect to cancel the renewal policy at any time during the 30-day period.

(iii) Return premiums or additional premium charges shall be calculated proportionately on the basis that the old rates apply.

(b) Subsection (5)(a) does not apply if the only change in terms that is adverse to the policyholder is:

(i) a rate increase generally applicable to the class of business to which the policy belongs;

(ii) a rate increase resulting from a classification change based on the altered nature or extent of the risk insured against; or

(iii) a policy form change made to make the form consistent with Utah law.

(6) (a) If a notice of cancellation or nonrenewal under Subsection (2)(c) does not state with reasonable precision the facts on which the insurer's decision is based, the insurer shall send by first-class mail or deliver that information within ten working days after receipt of a written request by the policyholder.

(b) A notice under Subsection (2)(c) is not effective unless it contains information about the policyholder's right to make the request.

(7) If a risk-sharing plan under Section 31A-2-214 exists for the kind of coverage provided by the insurance being cancelled or nonrenewed, a notice of cancellation or nonrenewal required under Subsection (2)(c) or (4)(b)(i) may not be effective unless it contains instructions to the policyholder for applying for insurance through the available risk-sharing plan.

(8) There is no liability on the part of, and no cause of action against, any insurer, its authorized representatives, agents, employees, or any other person furnishing to the insurer information relating to the reasons for cancellation or nonrenewal or for any statement made or information given by them in complying or enabling the insurer to comply with this section unless actual malice is proved by clear and convincing evidence.

(9) This section does not alter any common law right of contract rescission for material misrepresentation.

Section 58. Section **31A-21-307** is amended to read:

31A-21-307. Other insurance.

(1) When two or more policies promise to indemnify an insured against the same loss without intending cumulative coverage, no "other insurance" provisions of the policies may reduce the aggregate protection of the insured below the lesser of the actual insured loss suffered by the insured and the maximum indemnification promised by any policy without regard to any "other insurance" provision.

(2) Subject to Subsection (1), the policies may by their terms define the extent to which each insurance is primary and each is excess, but if the "other insurance" terms of the policies are inconsistent, there is joint and several liability to the insured on any coverage which overlaps and which has inconsistent terms. Subsequent settlement among the insurers does not alter any rights of the insured. The commissioner may adopt rules consistent with this section concerning "other insurance."

(3) This section does not apply to [~~disability~~] accident and health insurance policies. Refer to Section 31A-22-619 for the coordination of [~~disability~~] accident and health benefits.

Section 59. Section **31A-21-401** is amended to read:

31A-21-401. Scope and construction of part.

This part applies to all mass marketed life or [~~disability~~] accident and health insurance, notwithstanding Subsection 31A-1-103(3)[~~(h)~~]. This part may not be construed to limit the application of other provisions of this title to insurers effecting mass marketed life or [~~disability~~] accident and health insurance policies on persons in this state.

Section 60. Section **31A-21-402** is amended to read:

31A-21-402. Definitions.

As used in this part:

(1) "Direct response solicitation" means any offer by an insurer to persons in this state, either directly or through a third party, to effect life or [~~disability~~] accident and health insurance coverage which enables the individual to apply or enroll for the insurance on the basis of the offer. Direct response solicitation does not include solicitations for insurance through an employee benefit plan exempt from state regulation under preemptive federal law, nor does it include solicitations through the individual's creditor with respect to credit life or credit [~~disability~~] accident and health insurance.

(2) "Mass marketed life or [~~disability~~] accident and health insurance" means the insurance under any individual, franchise, group, or blanket policy of life or [~~disability~~] accident and health insurance which is offered by means of direct response solicitation through a sponsoring organization or through the mails or other mass communications media and under which the person insured pays all or substantially all of the cost of his insurance.

Section 61. Section **31A-21-403** is amended to read:

31A-21-403. Orders terminating effectiveness of policies.

Upon the commissioner's order, no mass marketed life or [~~disability~~] accident and health insurance issued by an insurer may continue to be effected on persons in this state. The commissioner may issue an order under this section only if he finds, after a hearing, that the total charges for the insurance to the persons insured are unreasonable in relation to the benefits provided. The commissioner's findings under this section must be in writing. Orders under this section may direct the insurer to cease effecting the insurance until the total charges for the insurance are found

by the commissioner to be reasonable in relation to the benefits provided.

Section 62. Section **31A-21-404** is amended to read:

31A-21-404. Out-of-state insurers.

Any insurer extending mass marketed life or [~~disability~~] accident and health insurance under a group or blanket policy issued outside of this state to residents of this state shall, with respect to the mass marketed life or [~~disability~~] accident and health insurance policy:

(1) comply with Sections 31A-23-302 and 31A-23-303 and Part III of Chapter 26; and

(2) upon the commissioner's request, deliver to the commissioner a copy of any mass marketed life or [~~disability~~] accident and health insurance policy, certificates issued under these policies, and advertising material used in this state in connection with the policy.

Section 63. Section **31A-21-501** is amended to read:

31A-21-501. Definitions.

For purposes of this part:

(1) "Applicant" means:

(a) in the case of an individual life or [~~disability~~] accident and health policy, the person who seeks to contract for insurance benefits; or

(b) in the case of a group life or [~~disability~~] accident and health policy, the proposed certificate holder.

(2) "Cohabitant" means an emancipated individual pursuant to Section 15-2-1 or an individual who is 16 years of age or older who:

(a) is or was a spouse of the other party;

(b) is or was living as if a spouse of the other party;

(c) is related by blood or marriage to the other party;

(d) has one or more children in common with the other party; or

(e) resides or has resided in the same residence as the other party.

(3) "Child abuse" means the commission or attempt to commit against a child a criminal offense described in:

(a) Title 76, Chapter 5, Part 1, Assault and Related Offenses;

(b) Title 76, Chapter 5, Part 4, Sexual Offenses;

(c) Subsections 76-9-702(1) through (4), Lewdness- Sexual battery; or

(d) Section 76-9-702.5, Lewdness Involving a Child.

(4) "Domestic violence" means any criminal offense involving violence or physical harm or threat of violence or physical harm, or any attempt, conspiracy, or solicitation to commit a criminal offense involving violence or physical harm, when committed by one cohabitant against another and includes commission or attempt to commit, any of the following offenses by one cohabitant against another:

(a) aggravated assault, as described in Section 76-5-103;

(b) assault, as described in Section 76-5-102;

(c) criminal homicide, as described in Section 76-5-201;

(d) harassment, as described in Section 76-5-106;

(e) telephone harassment, as described in Section 76-9-201;

(f) kidnaping, child kidnaping, or aggravated kidnaping, as described in Sections 76-5-301, 76-5-301.1, and 76-5-302;

(g) mayhem, as described in Section 76-5-105;

(h) sexual offenses, as described in Title 76, Chapter 5, Part 4, and Title 76, Chapter 5a;

(i) stalking, as described in Section 76-5-106.5;

(j) unlawful detention, as described in Section 76-5-304;

(k) violation of a protective order or ex parte protective order, as described in Section 76-5-108;

(l) any offense against property described in Title 76, Chapter 6, Part 1, 2, or 3;

(m) possession of a deadly weapon with intent to assault, as described in Section 76-10-507; or

(n) discharge of a firearm from a vehicle, near a highway, or in the direction of any person, building, or vehicle, as described in Section 76-10-508.

(5) "Subject of domestic abuse" means an individual who is, has been, may currently be, or may have been subject to domestic violence or child abuse.

Section 64. Section **31A-21-502** is amended to read:

31A-21-502. Scope of part.

This part applies to only life and [~~disability~~] accident and health insurance.

Section 65. Section **31A-21-503** is amended to read:

31A-21-503. Discrimination based on domestic violence or child abuse prohibited.

(1) Except as provided in Subsection (2), an insurer of life or [~~disability~~] accident and health insurance may not consider whether an insured or applicant is the subject of domestic abuse as a factor to:

(a) refuse to insure the applicant;

(b) refuse to continue to insure the insured;

(c) refuse to renew or reissue a policy to insure the insured or applicant;

(d) limit the amount, extent, or kind of coverage available to the insured or applicant;

(e) charge a different rate for coverage to the insured or applicant;

(f) exclude or limit benefits or coverage under an insurance policy or contract for losses incurred;

(g) deny a claim; or

(h) terminate coverage or fail to provide conversion privileges in violation of Sections 31A-22-612 and 31A-22-710 under a group [~~disability~~] accident and health policy for the insured because the coverage was issued in the name of the perpetrator of the domestic violence or abuse.

(2) (a) Notwithstanding Subsection (1), an insurer may underwrite based on the physical or mental condition of an insured or applicant if the underwriting is based on a determination that there is a correlation between the medical or mental condition and a material increase in insurance risk.

(b) For purposes of Subsection (2)(a), the fact that an insured or applicant is a subject of domestic abuse is not a mental or physical condition.

(c) The determination required by Subsection (2)(a) shall be made in conformance with sound actuarial principles.

(d) Within 30 days after receiving an oral or written request from an insured or applicant, an insurer shall disclose in writing:

(i) the basis of an action permitted under Subsection (2)(a); and

(ii) if the policy has been issued or modified, the extent the action taken will impact the amount, extent, or kind of coverage or benefits available to the insured.

Section 66. Section **31A-21-505** is amended to read:

31A-21-505. Limit on liability.

An insurer that issues a life or [~~disability~~] accident and health insurance policy to an individual who is the subject of domestic abuse is not liable civilly or criminally for the death of or any injuries to the insured as a result of domestic violence or child abuse beyond the obligations of the insurer under:

(1) the insurance policy; or

(2) this title.

Section 67. Section **31A-22-307** is amended to read:

31A-22-307. Personal injury protection coverages and benefits.

(1) Personal injury protection coverages and benefits include:

(a) the reasonable value of all expenses for necessary medical, surgical, X-ray, dental, rehabilitation, including prosthetic devices, ambulance, hospital, and nursing services, not to exceed a total of $3,000 per person;

(b) (i) the lesser of $250 per week or 85% of any loss of gross income and loss of earning capacity per person from inability to work, for a maximum of 52 consecutive weeks after the loss, except that this benefit need not be paid for the first three days of disability, unless the disability continues for longer than two consecutive weeks after the date of injury; and

(ii) a special damage allowance not exceeding $20 per day for a maximum of 365 days, for services actually rendered or expenses reasonably incurred for services that, but for the injury, the injured person would have performed for his household, except that this benefit need not be paid for the first three days after the date of injury unless the person's inability to perform these services continues for more than two consecutive weeks;

(c) funeral, burial, or cremation benefits not to exceed a total of $1,500 per person; and

(d) compensation on account of death of a person, payable to his heirs, in the total of $3,000.

(2) (a) To determine the reasonable value of the medical expenses provided for in Subsection (1) and under Subsection 31A-22-309 (1)(e), the commissioner shall conduct a relative value study of services and accommodations for the diagnosis, care, recovery, or rehabilitation of an injured person in the most populous county in the state to assign a unit value and determine the 75th percentile charge for each type of service and accommodation. The study shall be updated every other year. In conducting the study, the department may consult or contract with appropriate public and private medical and health agencies or other technical experts. The costs and expenses incurred in conducting, maintaining, and administering the relative value study shall be funded by the tax created under Section 59-9-105. Upon completion of the study, the department shall prepare and publish a relative value study which sets forth the unit value and the 75th percentile charge assigned to each type of service and accommodation.

(b) The reasonable value of any service or accommodation is determined by applying the unit value and the 75th percentile charge assigned to the service or accommodation under the relative value study. If a service or accommodation is not assigned a unit value or the 75th percentile charge under the relative value study, the value of the service or accommodation shall equal the reasonable cost of the same or similar service or accommodation in the most populous county of this state.

(c) This Subsection (2) does not preclude the department from adopting a schedule already established or a schedule prepared by persons outside the department, if it meets the requirements of this Subsection (2).

(d) Every insurer shall report to the Commissioner of Insurance any patterns of overcharging, excessive treatment, or other improper actions by a health provider within 30 days after such insurer has knowledge of such pattern.

(e) (i) In disputed cases, a court on its own motion or on the motion of either party may designate an impartial medical panel of not more than three licensed physicians to examine the claimant and testify on the issue of the reasonable value of the claimant's medical services or expenses.

(ii) An impartial medical panel designated under Subsection (2)(e)(i) shall consist of a majority of health care professionals within the same license classification and specialty as the

provider of the claimant's medical services or expenses.

(3) Medical expenses as provided for in Subsection (1)(a) and in Subsection 31A-22-309 (1)(e) include expenses for any nonmedical remedial care and treatment rendered in accordance with a recognized religious method of healing.

(4) The insured may waive for the named insured and the named insured's spouse only the loss of gross income benefits of Subsection (1)(b)(i) if the insured states in writing that:

(a) within 31 days of applying for coverage, neither the insured nor the insured's spouse received any earned income from regular employment; and

(b) for at least 180 days from the date of the writing and during the period of insurance, neither the insured nor the insured's spouse will receive earned income from regular employment.

(5) This section does not prohibit the issuance of policies of insurance providing coverages greater than the minimum coverage required under this chapter nor does it require the segregation of those minimum coverages from other coverages in the same policy.

(6) Deductibles are not permitted with respect to the insurance coverages required under this section.

Section 68. Section **31A-22-403** is amended to read:

31A-22-403. Incontestability.

(1) This section does not apply to group policies.

(2) Each life insurance policy is, and shall state that, after it has been in force during the lifetime of the insured for a period of two years from its date of issue, it is incontestable except for the following:

(a) The policy may be contested for nonpayment of premiums.

(b) The policy may be contested as to:

(i) provisions relating to [~~disability~~] accident and health benefits allowed under Section 31A-22-609[~~,~~]; and [~~as to~~]

(ii) additional benefits in the event of death by accident [~~or accidental means~~].

(c) If the policy allows the insured, after the policy's issuance and for an additional premium, to obtain a death benefit which is larger than when the policy was originally issued, then the payment

of the additional increment of benefit is contestable until two years after the incremental increase of benefits, but the only ground of contest that may arise is in connection with the incremental increase.

(3) A reinstated life insurance policy or annuity contract may be contested for two years following reinstatement on the same basis as at original issuance, but only as to matters arising in connection with the reinstatement. Any grounds for contest available at original issuance continue to be available for contest until the policy has been in force for a total of two years during the lifetime of the insured.

(4) The limitations on incontestability under this section preclude only a contest of the validity of the policy, and do not preclude the good faith assertion at any time of defenses based upon provisions in the policy which exclude or qualify coverage, whether or not those qualifications or exclusions are specifically excepted in the policy's incontestability clause. Provisions on which the contestable period would normally run may not be reformulated as coverage exclusions or restrictions to take advantage of this Subsection (4).

Section 69. 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~~] of issuance of the policy, whether:

(i) the suicide was voluntary or involuntary; or

(ii) the insured was sane or insane.

(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 to obtain a death benefit that is larger than when the policy was originally effective for an additional premium, the payment of the additional increment of benefit may be 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; or

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

Section 70. Section **31A-22-415** is amended to read:

31A-22-415. Simultaneous death.

Section 75-2-702 applies to all policies of life and [~~disability~~] accident and health insurance.

Section 71. Section **31A-22-423** is amended to read:

31A-22-423. Policy and annuity examination period.

(1) (a) Except as provided under Subsection (2), all life insurance policies and annuities shall contain a notice prominently printed on or attached to the cover or front page stating that the policyholder has the right to return the policy for any reason on or before:

(i) ten days after delivery; or

(ii) in case of a replacement policy, 20 days after the replacement policy is delivered.

(b) For purposes of this section, "return" means a written statement on the policy or an accompanying writing that the policy is being returned for termination of coverage that is delivered to or mailed first class to the insurer or its agent.

(c) A policy returned under this section is void from the date of [~~return~~] issuance.

(d) A policyholder returning a policy is entitled to a refund of any premium paid[~~, except that the insurer may retain an amount not exceeding that determined by rule adopted by the commissioner~~].

(2) This section does not apply to:

(a) group policies; and

(b) other classes of life insurance policies that the commissioner specifies by rule after finding that a right to return those policies would be impracticable or unnecessary to protect the policyholder's interests.

Section 72. Section **31A-22-424** is enacted to read:

31A-22-424. Documents constituting entire life insurance policy.

(1) A life insurance policy shall contain a provision that defines the documents and agreements that constitute the entire contract between the parties.

(2) Except as permitted by Section 31A-21-106, all documents and agreements defined under Subsection (1) shall be attached to the policy.

Section 73. Section **31A-22-510** is amended to read:

31A-22-510. Requirements for group life insurance delivered in another jurisdiction.

(1) [~~No~~] A Utah resident may not be enrolled in a policy of group life insurance delivered in another jurisdiction in violation of Subsection (2) or (3), notwithstanding any contrary provision in Subsection 31A-1-103(3) [~~(h)~~].

(2) Unless specifically authorized by the commissioner under Section 31A-22-509, coverage under a group life insurance policy delivered in another jurisdiction may not be initially provided to any person unless the policy conforms substantially to one of the types of groups specified under Sections 31A-22-502 through 31A-22-508.

(3) [~~No coverage~~] Coverage may not be initially provided to any person in Utah under a group life policy issued in another jurisdiction by an insurer not authorized to engage in life insurance business in Utah unless the policyholder conforms substantially to the type of group specified under Section 31A-22-502, 31A-22-503, or 31A-22-504.

Section 74. Section **31A-22-517** is amended to read:

31A-22-517. Conversion on termination of eligibility.

(1) If any portion of the insurance on a person covered under the policy ceases because of termination of employment or of membership in the classes eligible for coverage, the person is entitled to be issued by the insurer, without evidence of insurability, an individual policy of life insurance without [~~disability~~] accident and health or other supplementary benefits, if an application for the individual policy is made and the first premium paid to the insurer within 31 days after the termination.

(2) The individual policy shall, at the option of the person entitled, be on any form then customarily issued by the insurer at the age and for the amount applied for, except that the group policy may exclude the option to elect term insurance.

(3) The individual policy shall be for an amount not in excess of the life insurance which ceases because of the termination, less the amount of any life insurance for which the person is eligible because of the termination and within 30 days after it. Any amount of insurance which matures on or before the termination, as an endowment payable to the person insured, whether in one sum, in installments, or in the form of an annuity, is not included in the amount which is considered to cease because of the termination.

(4) The premium on the individual policy shall be at the insurer's customary rate at the time of termination, which is applicable to the form and amount of the individual policy, to the class of risk to which the person belonged when terminated from the group policy, and to the age attained on the effective date of the individual policy.

(5) Subject to the conditions of this section, the conversion privilege is available:

(a) to a surviving dependent, if any, at the death of the employee or member, with respect to the survivor's coverage under the group policy which terminates by reason of the death; and

(b) to the dependent of the employee or member upon termination of coverage of the dependent, while the employee or member remains insured, because the dependent ceases to be a qualified dependent under the group policy.

Section 75. Section **31A-22-518** is amended to read:

31A-22-518. Conversion on termination of policy.

[~~If~~] (1) Subject to Subsection (2), if the group policy terminates or is amended to terminate the insurance of any class of covered persons, every insured person whose insurance terminates, including the insured dependent of a covered person who has been insured for at least five years prior to the termination date, is entitled to have the insurer issue to [~~him~~] the person an individual policy of life insurance, subject to the conditions and limitations in Section 31A-22-517[~~, except that the~~].

(2) The group policy [~~may~~] described in Subsection (1) shall provide [~~either~~] that[~~: (1) The~~] the amount of the individual policy may not [~~exceed~~] be less than the smaller of:

(a) the amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which [~~he~~] the person is eligible under any group policy issued or reinstated by the same or another insurer within 30 days

after the termination[~~. (2) The amount of the individual policy may not exceed~~]; or

(b) $10,000.

Section 76. Section **31A-22-520** is amended to read:

31A-22-520. Continuation of coverage during total disability.

(1) An insured person in a group life insurance policy may continue coverage during the total disability of the insured person or dependent by timely payment to the policyholder of that portion, if any, of the premium that would have been required on behalf of the insured person in the absence of total disability.

(2) The continuation shall be on a premium paying basis until the earlier of:

(a) six months from the date of total disability;

(b) approval by the insurer of continuation of the coverage under any disability provision the group insurance policy may contain; or

(c) the discontinuance of the group insurance policy.

(3) If the group policy has a waiting period for [~~a disability~~] an accident and health benefit, the continuation extends to the end of the waiting period, even if the group policy is otherwise discontinued.

Section 77. Section **31A-22-522** is enacted to read:

31A-22-522. Required provision for notice of termination.

(1) A policy for group or blanket life insurance coverage issued or renewed after July 1, 2001, shall include a provision that obligates the policyholder to notify each employee or group member:

(a) in writing;

(b) 30 days before the date the coverage is terminated; and

(c) (i) that the group or blanket life insurance coverage is being terminated; and

(ii) the rights the employee or group member has to continue coverage upon termination.

(2) For a policy for group or blanket life insurance coverage described in Subsection (1), an insurer shall:

(a) include a statement of a policyholder's obligations under Subsection (1) in the insurer's

monthly notice to the policyholder of premium payments due; and

(b) provide a sample notice to the policyholder at least once a year.

Section 78. Section **31A-22-600** is amended to read:

31A-22-600. Scope of Part VI.

(1) [~~This~~] Except where a provision's application is otherwise specifically limited, this part applies to all [~~disability~~]:

(a) accident and health insurance contracts, including credit [~~disability,~~] accident and health;

(b) franchise[~~, and~~];

(c) group contracts[~~, except where a provision's application is otherwise specifically limited.~~]; and

(d) a life insurance and annuity policy, but only if:

(i) it includes supplemental benefits and riders including accelerated benefits; and

(ii) receipt of benefits in contingent on morbidity requirements.

(2) Nothing in this part applies to or affects:

(a) workers' compensation insurance;

(b) reinsurance; or

[~~(c) annuities or life insurance, or their supplemental contracts which contain only those provisions relating to disability insurance which provide additional benefits in case of dismemberment or loss of sight by accident, safeguard the contract against lapse, or give a special surrender value or special benefit or an annuity if the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract; (d) disability~~]

(c) accident and health insurance when it is part of or supplemental to liability, steam boiler, elevator, automobile, or other insurance covering loss of or damage to property, provided the loss, damage, or expense arises out of a hazard directly related to the other insurance.

(3) Except as provided in Subsection (1), this part does not apply to or affect a life insurance or annuity policy including a life insurance policy:

(a) with a rider or supplemental benefit that accelerates the death benefit contingent upon a mortality risk specifically for one or more of the qualifying events of:

(i) terminal illness;

(ii) medical conditions requiring extraordinary medical intervention; or

(iii) permanent institutional confinement; and

(b) that provides the option of a lump-sum payment for those benefits.

Section 79. Section **31A-22-601** is amended to read:

31A-22-601. Applicability of life insurance provisions.

Sections 31A-22-412 through 31A-22-417 apply to death benefits in [~~disability~~] accident and health insurance policies.

Section 80. Section **31A-22-602** is amended to read:

31A-22-602. Premium rates.

(1) This section does not apply to group [~~disability~~] accident and health insurance.

(2) The benefits in [~~a disability~~] an accident and health insurance policy shall be reasonable in relation to the premiums charged.

(3) The commissioner shall disapprove [~~a disability~~] an accident and health insurance policy form if it does not satisfy Subsection (2).

Section 81. Section **31A-22-603** is amended to read:

31A-22-603. Persons insured under an individual accident and health policy.

A policy of individual [~~disability~~] accident and health insurance may insure only one person, except that originally or by subsequent amendment, upon the application of an adult policyholder, a policy may insure any two or more eligible members of the policyholder's family, including husband, wife, dependent children, and any other person dependent upon the policyholder.

Section 82. Section **31A-22-604** is amended to read:

31A-22-604. Reimbursement by insurers of Medicaid benefits.

(1) As used in this section, "Medicaid" means the program under Title XIX of the federal Social Security Act.

(2) Any [~~disability~~] accident and health insurer, including a group [~~disability~~] accident and health insurance plan, as defined in Section 607(1), Federal Employee Retirement Income Security Act of 1974, or health maintenance organization as defined in Section 31A-8-101, is prohibited from

considering the availability or eligibility for medical assistance in this or any other state under Medicaid, when considering eligibility for coverage or making payments under its plan for eligible enrollees, subscribers, policyholders, or certificate holders.

(3) To the extent that payment for covered expenses has been made under the state Medicaid program for health care items or services furnished to an individual in any case when a third party has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by any other party for those health care items or services.

(4) Title 26, Chapter 19, Medical Benefits Recovery Act, applies to reimbursement of insurers of Medicaid benefits.

Section 83. Section **31A-22-605** is amended to read:

31A-22-605. Accident and health insurance standards.

(1) The purposes of this section include:

(a) reasonable standardization and simplification of terms and coverages of individual and franchise [~~disability~~] accident and health insurance policies, including [~~disability~~] accident and health
insurance contracts of insurers licensed under Chapters 7 and 8, to facilitate public understanding and comparison in purchasing;

(b) elimination of provisions contained in individual and franchise [~~disability~~] accident and health insurance contracts [~~which~~] that may be misleading or confusing in connection with either the purchase of those types of coverages or the settlement of claims; and

(c) full disclosure in the sale of individual and franchise [~~disability~~] accident and health insurance contracts.

(2) As used in this section:

(a) "Direct response insurance policy" means an individual insurance policy solicited and sold without the policyholder having direct contact with a natural person intermediary.

(b) "Medicare" is defined in Subsection 31A-22-620(1)(e).

(c) "Medicare supplement policy" is defined in Subsection 31A-22-620(1)(f).

(3) This section applies to all individual and franchise [~~disability~~] accident and health policies.

(4) The commissioner shall adopt rules relating to the following matters:

(a) standards for the manner and content of policy provisions, and disclosures to be made in connection with the sale of policies covered by this section, dealing with at least the following matters:

(i) terms of renewability;

(ii) initial and subsequent conditions of eligibility;

(iii) nonduplication of coverage provisions;

(iv) coverage of dependents;

(v) preexisting conditions;

(vi) termination of insurance;

(vii) probationary periods;

(viii) limitations;

(ix) exceptions;

(x) reductions;

(xi) elimination periods;

(xii) requirements for replacement;

(xiii) recurrent conditions;

(xiv) coverage of persons eligible for Medicare; and

(xv) definition of terms;

(b) minimum standards for benefits under each of the following categories of coverage in policies covered in this section:

(i) basic hospital expense coverage;

(ii) basic medical-surgical expense coverage;

(iii) hospital confinement indemnity coverage;

(iv) major medical expense coverage;

(v) [~~disability~~] income [~~protection~~] <u>replacement</u> coverage;

(vi) accident only coverage;

(vii) specified disease or specified accident coverage;

(viii) limited benefit health coverage; and

(ix) nursing home and long-term care coverage;

(c) the content and format of the outline of coverage, in addition to that required under Subsection (6); [~~and~~]

(d) the method of identification of policies and contracts based upon coverages provided[~~.~~]; and

(e) rating practices.

(5) Nothing in Subsection (4)(b) precludes the issuance of policies that combine categories of coverage in that subsection provided that any combination of categories meets the standards of a component category of coverage.

(6) The commissioner may adopt rules relating to the following matters:

(a) establishing disclosure requirements for insurance policies covered in this section, designed to adequately inform the prospective insured of the need for and extent of the coverage offered, and requiring that this disclosure be furnished to the prospective insured with the application form, unless it is a direct response insurance policy;

(b) (i) prescribing caption or notice requirements designed to inform prospective insureds that particular insurance coverages are not Medicare Supplement coverages;

(ii) the requirements of Subsection (6)(b)(i) apply to all [~~disability~~] insurance policies and certificates sold to persons eligible for Medicare; and

(c) requiring the disclosures or information brochures to be furnished to the prospective insured on direct response insurance policies, upon his request or, in any event, no later than the time of the policy delivery.

(7) A policy covered by this section may be issued only if it meets the minimum standards established by the commissioner under Subsection (4), an outline of coverage accompanies the policy or is delivered to the applicant at the time of the application, and, except with respect to direct response insurance policies, an acknowledged receipt is provided to the insurer. The outline of coverage shall include:

(a) a statement identifying the applicable categories of coverage provided by the policy as

prescribed under Subsection (4);

(b) a description of the principal benefits and coverage;

(c) a statement of the exceptions, reductions, and limitations contained in the policy;

(d) a statement of the renewal provisions, including any reservation by the insurer of a right to change premiums;

(e) a statement that the outline is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions; and

(f) any other contents the commissioner prescribes.

(8) If a policy is issued on a basis other than that applied for, the outline of coverage shall accompany the policy when it is delivered and it shall clearly state that it is not the policy for which application was made.

(9) (a) Notwithstanding Subsection 31A-22-609(2), and except as provided under Subsection (9)(b), an insurer that elects to use an application form without questions concerning the insured's health history or medical treatment history, shall provide coverage under the policy for any loss which occurs more than 12 months after the effective date of the policy due to a preexisting condition which is not specifically excluded from coverage.

(b) (i) An insurer that issues a specified disease policy, regardless of whether the basis of issuance is a detailed application form, a simplified application form, or an enrollment form, may not deny a claim for loss due to a preexisting condition which occurs more than six months after the effective date of coverage.

(ii) A specified disease policy may not define a preexisting condition more restrictively than a condition which first manifested itself within six months prior to the effective date of coverage or which was diagnosed by a physician at any time prior to the effective date of coverage.

(iii) A specified disease policy may not include wording that provides a defense based upon a preexisting condition except as allowed under this Subsection (9).

(10) Notwithstanding Subsection 31A-22-606(1), limited accident and health policies or certificates issued to persons eligible for Medicare shall contain a notice prominently printed on or attached to the cover or front page which states that the policyholder or certificate holder has the

right to return the policy for any reason within 30 days after its delivery and to have the premium refunded.

Section 84. Section **31A-22-606** is amended to read:

31A-22-606. Policy examination period.

(1) (a) Except as provided in Subsection (2), all [~~disability~~] accident and health policies shall contain a notice prominently printed on or attached to the cover or front page stating that the policyholder has the right to return the policy for any reason within ten days after its delivery.

(b) "Return" means delivery to the insurer or its agent or mailing of the policy to either, properly addressed and stamped for first class handling, with a written statement on the policy or an accompanying communication that it is being returned for termination of coverage. A policy returned under Subsection (1) is void from the beginning and a policyholder returning his policy is entitled to a refund of any premium paid.

(2) This section does not apply to:

(a) group policies;

(b) policies issued to persons entitled to a 30-day examination period under Subsection 31A-22-605(10);

(c) single premium nonrenewable policies issued for terms not longer than 60 days;

(d) policies covering accidents only or accidental bodily injury only; and

(e) other classes of policies which the commissioner by rule specifies after a finding that a right to return those policies would be impracticable or unnecessary to protect the policyholder's interests.

Section 85. Section **31A-22-607** is amended to read:

31A-22-607. Grace period.

(1) Every individual or franchise [~~disability~~] accident and health insurance policy shall contain clauses providing for a grace period of at least seven days for weekly premium policies, ten days for monthly premium policies and 30 days for all other policies, for each premium after the first. During the grace period, the policy continues in force.

(2) Every group or blanket [~~disability~~] accident and health policy shall provide for a grace

period of at least 30 days, unless the policyholder gives written notice of discontinuance prior to the date of discontinuance, in accordance with the policy terms. In group or blanket policies, the policy may provide for payment of a pro rata premium for the period the policy is in effect during the grace period under this [~~subsection~~] Subsection (2).

(3) If the insurer has not guaranteed the insured a right to renew [~~a disability~~] an accident and health policy, any grace period beyond the expiration or anniversary date may, if provided in the policy, be cut off by compliance with the notice provision under Subsection 31A-21-303(4)(b).

Section 86. Section **31A-22-608** is amended to read:

31A-22-608. Reinstatement of individual or franchise accident and health insurance policies.

(1) Every individual or franchise [~~disability~~] accident and health insurance policy shall contain a provision which reads as follows:

"REINSTATEMENT: If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept the premium, without also requiring an application for reinstatement, shall reinstate the policy. However, if the insurer or agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy shall be reinstated upon approval of this application from the insurer or, lacking this approval, upon the 45th day following the date of the conditional receipt, unless the insurer has previously notified the insured in writing of its disapproval of the application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after that date. In all other respects the insured and insurer have the same rights under the reinstated policy as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to this policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement."

(2) The last sentence of the provision set forth in Subsection (1) may be omitted from any

policy [~~which~~] that the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age 50, or in the case of a policy issued after age ~~44~~, for at least five years from its date of issue.

Section 87. Section **31A-22-609** is amended to read:

31A-22-609. Incontestability for accident and health insurance.

(1) [~~No~~] (a) A statement made by an applicant in the application for individual or franchise [~~disability~~] accident and health insurance coverage [~~and no~~] or statement made relating to the person's insurability by a person insured under a group policy, except fraudulent misrepresentation, [~~is~~] may not be a basis for avoidance of the policy or denial of a claim for loss incurred or disability commencing after the coverage has been in effect for two years.

(b) The insurer has the burden of proving fraud by clear and convincing evidence.

(c) The policy may provide for incontestability even for fraudulent misstatements.

(2) Except as otherwise provided under Subsection 31A-22-605(9), [~~no~~] a claim for loss incurred or disability commencing after two years from the date of issue of the policy may not be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage, unless the condition was excluded from coverage by name or specific description in a provision [~~which~~] that was in effect on the date of loss.

Section 88. Section **31A-22-610** is amended to read:

31A-22-610. Dependent coverage from moment of birth or adoption.

(1) As used in this section:

(a) "Child" means, in connection with any adoption, or placement for adoption of the child, an individual who is younger than 18 years of age as of the date of the adoption or placement for adoption.

(b) "Placement for adoption" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child.

(2) (a) If any [~~disability~~] accident and health insurance policy provides coverage for any members of the policyholder's or certificate holder's family, the policy shall also provide that any health insurance benefits applicable to dependents of the insured are applicable on the same basis

to a newly born child from the moment of birth, and to an adopted child:

(i) beginning from the moment of birth if placement for adoption occurs within 30 days of the child's birth; or

(ii) beginning from the date of placement if placement for adoption occurs 30 days or more after the child's birth.

(b) This coverage is not subject to any preexisting conditions, and includes any injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities or prematurity.

(c) If the payment of a specific premium is required to provide coverage for a child of the policyholder or certificate holder, the policy may require that the insurer be notified of the birth or placement for the purpose of adoption, and that the required premium be paid within 30 days after the date of birth or placement for the purpose of adoption, in order to have the coverage extend beyond that 30-day period.

(3) The coverage required by Subsection (2) as to children placed for the purpose of adoption with a policyholder or certificate holder continues in the same manner as it would with respect to a child of the policyholder or certificate holder unless the placement is disrupted prior to legal adoption and the child is removed from placement. The coverage requirement ends if the child is removed from placement prior to being legally adopted.

(4) The provisions of this section apply to employee welfare benefit plans as defined in Section 26-19-2.

Section 89. Section **31A-22-610.2** is amended 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~~] an accident and health insurer who offers maternity coverage.

Section 90. Section **31A-22-610.5** is amended to read:

31A-22-610.5. Dependent coverage.

(1) As used in this section, "child" has the same meaning as defined in Section 78-45-2.

(2) (a) Any individual or group health insurance policy or health maintenance organization contract that provides coverage for a policyholder's or certificate holder's dependent shall not terminate coverage of an unmarried dependent by reason of the dependent's age before the dependent's 26th birthday and shall, upon application, provide coverage for all unmarried dependents up to age 26.

(b) The cost of coverage for unmarried dependents 19 to 26 years of age shall be included in the premium on the same basis as other dependent coverage.

(c) This section does not prohibit the employer from requiring the employee to pay all or part of the cost of coverage for unmarried dependents.

(3) An individual or group health insurance policy or health maintenance organization contract shall reinstate dependent coverage, and for purposes of all exclusions and limitations, shall treat the dependent as if the coverage had been in force since it was terminated; if:

(a) the dependent has not reached the age of 26 by July 1, 1995;

(b) the dependent had coverage prior to July 1, 1994;

(c) prior to July 1, 1994, the dependent's coverage was terminated solely due to the age of the dependent; and

(d) the policy has not been terminated since the dependent's coverage was terminated.

(4) (a) When a parent is required by a court or administrative order to provide health insurance coverage for a child, [~~a disability~~] an accident and health insurer may not deny enrollment of a child under the [~~disability~~] accident and health insurance plan of the child's parent on the grounds the child:

(i) was born out of wedlock and is entitled to coverage under Subsection (6);

(ii) was born out of wedlock and the custodial parent seeks enrollment for the child under the custodial parent's policy;

(iii) is not claimed as a dependent on the parent's federal tax return; or

(iv) does not reside with the parent or in the insurer's service area.

(b) [~~A disability~~] An accident and health insurer providing enrollment under Subsection (4)(a)(iv) is subject to the requirements of Subsection (5).

(5) A health maintenance organization or a preferred provider organization may use alternative delivery systems or indemnity insurers to provide coverage under Subsection (4)(a)(iv) outside its service area. [~~The provisions of~~] Section 31A-8-408 [~~do~~] does not apply to this Subsection (5).

(6) When a child has [~~disability~~] accident and health coverage through an insurer of a noncustodial parent the insurer shall:

(a) provide information to the custodial parent as necessary for the child to obtain benefits through that coverage, but the insurer or employer, or the agents or employees of either of them, are not civilly or criminally liable for providing information in compliance with this Subsection (6)(a), whether the information is provided pursuant to a verbal or written request;

(b) permit the custodial parent or the service provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and

(c) make payments on claims submitted in accordance with Subsection (6)(b) directly to the custodial parent, the provider, or the state Medicaid agency.

(7) When a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family health coverage, the insurer shall:

(a) permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to an enrollment season restrictions;

(b) if the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under family coverage upon application of the child's other parent, the state agency administering the Medicaid program, or the state agency administering 42 U.S.C. 651 through 669, the child support enforcement program; and

(c) not disenroll or eliminate coverage of the child unless the insurer is provided satisfactory written evidence that:

(i) the court or administrative order is no longer in effect; or

(ii) the child is or will be enrolled in comparable [~~disability~~] accident and health coverage through another insurer which will take effect not later than the effective date of disenrollment.

(8) An insurer may not impose requirements on a state agency [~~which~~] that has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered for [~~disability~~] accident and health benefits from the insurer that are different from requirements applicable to an agent or assignee of any other individual so covered.

(9) Insurers may not reduce their coverage of pediatric vaccines below the benefit level in effect on May 1, 1993.

(10) When a parent is required by a court or administrative order to provide health coverage, which is available through an employer doing business in this state, the employer shall:

(a) permit the parent to enroll under family coverage any child who is otherwise eligible for coverage without regard to any enrollment season restrictions;

(b) if the parent is enrolled but fails to make application to obtain coverage of the child, enroll the child under family coverage upon application by the child's other parent, by the state agency administering the Medicaid program, or the state agency administering 42 U.S.C. 651 through 669, the child support enforcement program;

(c) not disenroll or eliminate coverage of the child unless the employer is provided satisfactory written evidence that:

(i) the court order is no longer in effect;

(ii) the child is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment; or

(iii) the employer has eliminated family health coverage for all of its employees; and

(d) withhold from the employee's compensation the employee's share, if any, of premiums for health coverage and to pay this amount to the insurer.

(11) An order issued under Section 62A-11-326.1 may be considered a "qualified medical support order" for the purpose of enrolling a dependent child in a group [~~disability~~] accident and health insurance plan as defined in Section 609(a), Federal Employee Retirement Income Security Act of 1974.

(12) This section does not affect any insurer's ability to require as a precondition of any child being covered under any policy of insurance that:

(a) the parent continues to be eligible for coverage;

(b) the child shall be identified to the insurer; and

(c) the premium shall be paid when due.

(13) The provisions of this section apply to employee welfare benefit plans as defined in Section 26-19-2.

Section 91. Section **31A-22-611** is amended to read:

31A-22-611. Policy extension for handicapped children.

(1) Every [~~disability~~] accident and health insurance policy or contract that provides that coverage of a dependent child of a person insured under the policy shall terminate upon reaching a limiting age as specified in the policy, shall also provide that the age limitation does not terminate the coverage of a dependent child while the child is and continues to be both:

(a) incapable of self-sustaining employment because of mental retardation or physical handicap; and

(b) chiefly dependent upon the person insured under the policy for support and maintenance.

(2) The insurer may require proof of the incapacity and dependency be furnished by the person insured under the policy within 30 days of the date the child attains the limiting age, and at any time thereafter, except that the insurer may not require proof more often than annually after the two-year period immediately following attainment of the limiting age by the child.

Section 92. Section **31A-22-612** is amended to read:

31A-22-612. Conversion privileges for insured former spouse.

(1) [~~No disability~~] An accident and health insurance policy, which in addition to covering the insured also provides coverage to the spouse of the insured, may not contain a provision for termination of coverage of a spouse covered under the policy, except by entry of a valid decree of divorce or annulment between the parties.

(2) Every policy which contains this type of provision shall provide that upon the entry of the divorce decree the spouse is entitled to have issued an individual policy of [~~disability~~] accident

and health insurance without evidence of insurability, upon application to the company and payment of the appropriate premium. The policy shall provide the coverage being issued which is most nearly similar to the terminated coverage. Probationary or waiting periods in the policy are considered satisfied to the extent the coverage was in force under the prior policy.

(3) When the insurer receives actual notice that the coverage of a spouse is to be terminated because of a divorce or annulment, the insurer shall promptly provide the spouse written notification of the right to obtain individual coverage as provided in Subsection (2), the premium amounts required, and the manner, place, and time in which premiums may be paid. The premium is determined in accordance with the insurer's table of premium rates applicable to the age and class of risk of the persons to be covered and to the type and amount of coverage provided. If the spouse applies and tenders the first monthly premium to the insurer within 30 days after receiving the notice provided by this subsection, the spouse shall receive individual coverage that commences immediately upon termination of coverage under the insured's policy.

(4) This section does not apply to [~~disability~~] accident and health insurance policies offered on a group blanket basis.

Section 93. Section **31A-22-613** is amended to read:

31A-22-613. Permitted provisions for accident and health insurance policies.

The following provisions may be contained in [~~a disability~~] an accident and health insurance policy, but if they are in that policy, they shall conform to at least the [~~following~~] minimum requirements for the policyholder [~~:~~] in this section.

(1) Any provision respecting change of occupation may provide only for a lower maximum benefit payment and for reduction of loss payments proportionate to the change in appropriate premium rates, if the change is to a higher rated occupation, and this provision shall provide for retroactive reduction of premium rates from the date of change of occupation or the last policy anniversary date, whichever is the more recent, if the change is to a lower rated occupation.

(2) Section 31A-22-405 applies to misstatement of age in [~~disability~~] accident and health policies, with the appropriate modifications of terminology.

(3) Any policy which contains a provision establishing, as an age limit or otherwise, a date

after which the coverage provided by the policy is not effective, and if that date falls within a period for which a premium is accepted by the insurer or if the insurer accepts a premium after that date, the coverage provided by the policy continues in force, subject to any right of cancellation, until the end of the period for which the premium was accepted. This Subsection (3) does not apply if the acceptance of premium would not have occurred but for a misstatement of age by the insured.

(4) Any provision dealing with preexisting conditions shall be consistent with Subsections 31A-22-605(9)(a) and 31A-22-609(2), and any applicable rule adopted by the commissioner.

(5) (a) If an insured is otherwise eligible for maternity benefits, a policy may not contain language which requires an insured to obtain any additional preauthorization or preapproval for customary and reasonable maternity care expenses or for the delivery of the child after an initial preauthorization or preapproval has been obtained from the insurer for prenatal care. A requirement for notice of admission for delivery is not a requirement for preauthorization or preapproval, however, the maternity benefit may not be denied or diminished for failure to provide admission notice. The policy may not require the provision of admission notice by only the insured patient.

(b) This Subsection (5) does not prohibit an insurer from:

(i) requiring a referral before maternity care can be obtained;

(ii) specifying a group of providers or a particular location from which an insured is required to obtain maternity care; or

(iii) limiting reimbursement for maternity expenses and benefits in accordance with the terms and conditions of the insurance contract so long as such terms do not conflict with Subsection (5)(a).

(6) An insurer may only represent that a policy:

(a) offers a vision benefit if the policy:

(i) charges a premium for the benefit; and

(ii) provides reimbursement for materials or services provided under the policy; and

(b) covers laser vision correction, whether photorefractive keratectomy, laser assisted in-situ keratomelusis, or related procedure, if the policy:

(i) charges a premium for the benefit; and

(ii) the procedure is at least a partially covered benefit.

Section 94. 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 term.

(d) Notwithstanding the requirements of Subsection (2)(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~~].

[~~(ii) recommend 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.~~]

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

[~~(c) The plans recommended by the committee 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.~~]

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

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

[~~(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.~~]

[~~(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 that can be used to pay:~~]

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

[~~(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.~~]

[~~(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 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)~~] (6) (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)~~](6)(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)~~] (7) (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; and

(ii) coverage limits under the plan.

(b) In addition to the requirements of Subsections [~~(9)~~] (7)(a) and (d), an insurer described in Subsection [~~(9)~~] (7)(a) shall submit the written disclosure required by this Subsection [~~(9)~~] (7) to the commissioner:

(i) [~~annually~~] upon commencement of operations in the state; and

(ii) anytime the insurer amends any of the following described in Subsection [~~(9)~~] (7)(a):

(A) treatment policies;

(B) practice standards;

(C) restrictions; 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)~~] (7), 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)~~] (7)(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 95. Section **31A-22-614** is amended to read:

31A-22-614. Claims under accident and health policies.

(1) Section 31A-21-312 applies generally to claims under [~~disability~~] accident and health policies.

(2) (a) Subject to Subsection (1), [~~no disability~~] an accident and health insurance policy may not contain a claim notice requirement less favorable to the insured than one which requires written notice of the claim within 20 days after the occurrence or commencement of any loss covered by the policy. The policy shall specify to whom claim notices may be given.

(b) If a loss of time benefit under a policy may be paid for a period of at least two years, an insurer may require periodic notices that the insured continues to be disabled, unless the insured is legally incapacitated. The insured's delay in giving that notice does not impair the insured's or beneficiary's right to any indemnity which would otherwise have accrued during the six months preceding the date on which that notice is actually given.

(3) [~~No disability~~] An accident and health insurance policy may not contain a time limit on proof of loss which is more restrictive to the insured than a provision requiring written proof of loss, delivered to the insurer, within the following time:

(a) for a claim where periodic payments are contingent upon continuing loss, within 90 days after the termination of the period for which the insurer is liable;

(b) for any other claim, within 90 days after the date of the loss.

(4) (a) (i) Section 31A-26-301 applies generally to the payment of claims.

(ii) Indemnity for loss of life is paid in accordance with the beneficiary designation effective at the time of payment. If no valid beneficiary designation exists, the indemnity is paid to the insured's estate. Any other accrued indemnities unpaid at the insured's death are paid to the insured's estate.

(b) Reasonable facility of payment clauses, specified by the commissioner by rule or in approving the policy form, are permitted. Payment made in good faith and in accordance with those clauses discharges the insurer's obligation to pay those claims.

(c) All or a portion of any indemnities provided under [~~a disability~~] an accident and health policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering the services.

Section 96. Section **31A-22-617** is amended to read:

31A-22-617. Preferred provider contract provisions.

Health insurance policies may provide for insureds to receive services or reimbursement under the policies in accordance with preferred health care provider contracts as follows:

(1) Subject to restrictions under this section, any insurer or third party administrator may enter into contracts with health care providers as defined in Section 78-14-3 under which the health care providers agree to supply services, at prices specified in the contracts, to persons insured by an insurer. [~~The~~]

(a) A health care provider contract may require the health care provider to accept the specified payment as payment in full, relinquishing the right to collect additional amounts from the insured person.

(b) The insurance contract may reward the insured for selection of preferred health care providers by:

(i) reducing premium rates[~~,~~];

(ii) reducing deductibles[~~,~~];

(iii) coinsurance[~~, or~~];

(iv) other copayments[~~,~~]; or

(v) in any other reasonable manner.

(c) If the insurer is a managed care organization, as defined in Subsection 31A-27-311.5(1)(f):

(i) the insurance contract and the health care provider contract shall provide that in the event the managed care organization becomes insolvent, the rehabilitator or liquidator may:

(A) require the health care provider to continue to provide health care services under the contract until the later of:

(I) 90 days from the date of the filing of a petition for rehabilitation or the petition for liquidation; or

(II) the date the term of the contract ends; and

(B) subject to Subsection (1)(c)(v), reduce the fees the provider is otherwise entitled to receive from the managed care organization during the time period described in Subsection (1)(c)(i)(A);

(ii) the provider is required to:

(A) accept the reduced payment under Subsection (1)(c)(i)(B) as payment in full; and

(B) relinquish the right to collect additional amounts from the insolvent managed care organization's enrollee, as defined in Section 31A-27-311.5(1)(b);

(iii) if the contract between the health care provider and the managed care organization has not been reduced to writing, or the contract fails to contain the language required by Subsection (1)(c)(i), the provider may not collect or attempt to collect from the enrollee:

(A) sums owed by the insolvent managed care organization; or

(B) the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B);

(iv) the following may not bill or maintain any action at law against an enrollee to collect sums owed by the insolvent managed care organization or the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B):

(A) a provider;

(B) an agent;

(C) a trustee; or

(D) an assignee of a person described in Subsections (1)(c)(iv)(A) through (C); and

(v) notwithstanding Subsection (1)(c)(i):

(A) a rehabilitator or liquidator may not reduce a fee by less than 75% of the provider's regular fee set forth in the contract; and

(B) the enrollee shall continue to pay the copayments, deductibles, and other payments for services received from the provider that the enrollee was required to pay before the filing of:

(I) a petition for rehabilitation; or

(II) a petition for liquidation.

(2) (a) Subject to Subsections (2)(b) through (2)(f), an insurer using preferred health care provider contracts shall pay for the services of health care providers not under the contract, unless the illnesses or injuries treated by the health care provider are not within the scope of the insurance contract. As used in this section, "class of health care providers" means all health care providers licensed or licensed and certified by the state within the same professional, trade, occupational, or facility licensure or licensure and certification category established pursuant to Titles 26 and 58.

(b) When the insured receives services from a health care provider not under contract, the insurer shall reimburse the insured for at least 75% of the average amount paid by the insurer for comparable services of preferred health care providers who are members of the same class of health care providers. The commissioner may adopt a rule dealing with the determination of what constitutes 75% of the average amount paid by the insurer for comparable services of preferred health care providers who are members of the same class of health care providers.

(c) When reimbursing for services of health care providers not under contract, the insurer may make direct payment to the insured.

(d) Notwithstanding Subsection (2)(b), an insurer using preferred health care provider contracts may impose a deductible on coverage of health care providers not under contract.

(e) When selecting health care providers with whom to contract under Subsection (1), an insurer may not unfairly discriminate between classes of health care providers, but may discriminate within a class of health care providers, subject to Subsection (7).

(f) For purposes of this section, unfair discrimination between classes of health care providers shall include:

(i) refusal to contract with class members in reasonable proportion to the number of insureds covered by the insurer and the expected demand for services from class members; and

(ii) refusal to cover procedures for one class of providers that are:

(A) commonly utilized by members of the class of health care providers for the treatment of illnesses, injuries, or conditions;

(B) otherwise covered by the insurer; and

(C) within the scope of practice of the class of health care providers.

(3) Before the insured consents to the insurance contract, the insurer shall fully disclose to the insured that it has entered into preferred health care provider contracts. The insurer shall provide sufficient detail on the preferred health care provider contracts to permit the insured to agree to the terms of the insurance contract. The insurer shall provide at least the following information:

(a) a list of the health care providers under contract and if requested their business locations and specialties;

(b) a description of the insured benefits, including any deductibles, coinsurance, or other copayments;

(c) a description of the quality assurance program required under Subsection (4); and

(d) a description of the grievance procedures required under Subsection (5).

(4) (a) An insurer using preferred health care provider contracts shall maintain a quality assurance program for assuring that the care provided by the health care providers under contract meets prevailing standards in the state.

(b) The commissioner in consultation with the executive director of the Department of

Health may designate qualified persons to perform an audit of the quality assurance program. The auditors shall have full access to all records of the organization and its health care providers, including medical records of individual patients.

(c) The information contained in the medical records of individual patients shall remain confidential. All information, interviews, reports, statements, memoranda, or other data furnished for purposes of the audit and any findings or conclusions of the auditors are privileged. The information is not subject to discovery, use, or receipt in evidence in any legal proceeding except hearings before the commissioner concerning alleged violations of this section.

(5) An insurer using preferred health care provider contracts shall provide a reasonable procedure for resolving complaints and grievances initiated by the insureds and health care providers.

(6) An insurer may not contract with a health care provider for treatment of illness or injury unless the health care provider is licensed to perform that treatment.

(7) (a) [~~No~~] A health care provider or insurer may not discriminate against a preferred health care provider for agreeing to a contract under Subsection (1).

(b) Any health care provider licensed to treat any illness or injury within the scope of the health care provider's practice, who is willing and able to meet the terms and conditions established by the insurer for designation as a preferred health care provider, shall be able to apply for and receive the designation as a preferred health care provider. Contract terms and conditions may include reasonable limitations on the number of designated preferred health care providers based upon substantial objective and economic grounds, or expected use of particular services based upon prior provider-patient profiles.

(8) Upon the written request of a provider excluded from a provider contract, the commissioner may hold a hearing to determine if the insurer's exclusion of the provider is based on the criteria set forth in Subsection (7)(b).

(9) Insurers are subject to the provisions of Sections 31A-22-613.5, 31A-22-614.5, and 31A-22-618.

(10) Nothing in this section is to be construed as to require an insurer to offer a certain

benefit or service as part of a health benefit plan.

(11) This section does not apply to catastrophic mental health coverage provided in accordance with Section 31A-22-625.

Section 97. Section **31A-22-619** is amended to read:

31A-22-619. Coordination of benefits.

(1) The commissioner shall adopt rules concerning the coordination of benefits between [~~disability~~] accident and health insurance policies.

(2) Rules adopted by the commissioner under Subsection (1):

(a) may not prohibit coordination of benefits with individual [~~disability~~] accident and health insurance policies; and

(b) shall apply equally to all [~~disability~~] accident and health insurance policies without regard to whether the policies are group or individual policies.

Section 98. Section **31A-22-620** is amended to read:

31A-22-620. Medicare Supplement Insurance Minimum Standards Act.

(1) As used in this section:

(a) "Applicant" means:

(i) in the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and

(ii) in the case of a group Medicare supplement policy, the proposed certificate holder.

(b) "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

(c) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(d) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering, or issuing for delivery in this state, Medicare supplement policies or certificates.

(e) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

(f) "Medicare Supplement Policy" means a group or individual policy of disability insurance, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act, 42 U.S.C. Section 1395 et seq., or an issued policy under a demonstration project specified in 41 U.S.C. Section 1395ss(g)(1), that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare.

(g) "Policy Form" means the form on which the policy is delivered or issued for delivery by the issuer.

(2) (a) Except as otherwise specifically provided, this section applies to:

(i) all Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this section;

(ii) all certificates issued under group Medicare supplement policies, that have been delivered or issued for delivery in this state on or after the effective date of this section; and

(iii) policies or certificates that were in force prior to the effective date of this section, with respect to requirements for benefits, claims payment, and policy reporting practice under Subsection (3)(d), and loss ratios under Subsection (4).

(b) This section does not apply to a policy of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or a combination of employers and labor unions, for employees or former employees or a combination of employees and former employees, or for members or former members of the labor organizations, or a combination of members and former members of labor organizations.

(c) This section does not prohibit, nor does it apply to insurance policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons that are not marketed or held out to be Medicare supplement policies or benefit plans.

(3) (a) A Medicare supplement policy or certificate in force in the state may not contain benefits that duplicate benefits provided by Medicare.

(b) Notwithstanding any other provision of law of this state, a Medicare supplement policy or certificate may not exclude or limit benefits for loss incurred more than six months from the

effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than: "A condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage."

(c) The commissioner shall adopt rules to establish specific standards for policy provisions of Medicare supplement policies and certificates. The standards adopted shall be in addition to and in accordance with applicable laws of this state. A requirement of this title relating to minimum required policy benefits, other than the minimum standards contained in this section, may not apply to Medicare supplement policies and certificates. The standards may include:

(i) terms of renewability;

(ii) initial and subsequent conditions of eligibility;

(iii) nonduplication of coverage;

(iv) probationary periods;

(v) benefit limitations, exceptions, and reductions;

(vi) elimination periods;

(vii) requirements for replacement;

(viii) recurrent conditions; and

(ix) definitions of terms.

(d) The commissioner shall adopt rules establishing minimum standards for benefits, claims payment, marketing practices, compensation arrangements, and reporting practices for Medicare supplement policies and certificates.

(e) The commissioner may adopt such rules as are necessary to conform Medicare supplement policies and certificates to the requirements of federal law and regulations promulgated thereunder, including:

(i) requiring refunds or credits if the policies do not meet loss ratio requirements;

(ii) establishing a uniform methodology for calculating and reporting loss ratios;

(iii) assuring public access to policies, premiums, and loss ratio information of issuers of Medicare supplement insurance;

(iv) establishing a process for approving or disapproving policy forms and certificate forms and proposed premium increases;

(v) establishing a policy for holding public hearings prior to approval of premium increases; and

(vi) establishing standards for Medicare select policies and certificates.

(f) The commissioner may adopt rules that prohibit policy provisions not otherwise specifically authorized by statute that, in the opinion of the commissioner, are unjust, unfair, or unfairly discriminatory to any person insured or proposed to be insured under a Medicare supplement policy or certificate.

(4) Medicare supplement policies shall return to policyholders benefits that are reasonable in relation to the premium charged. The commissioner shall make rules to establish minimum standards for loss ratios of Medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health maintenance organization on a service basis rather than on a reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.

(5) (a) To provide for full and fair disclosure in the sale of Medicare supplement policies, a Medicare supplement policy or certificate may not be delivered in this state unless an outline of coverage is delivered to the applicant at the time application is made.

(b) The commissioner shall prescribe the format and content of the outline of coverage required by Subsection (5)(a).

(c) For purposes of this section, "format" means style arrangements and overall appearance, including such items as the size, color, and prominence of type and arrangement of text and captions. The outline of coverage shall include:

(i) a description of the principal benefits and coverage provided in the policy;

(ii) a statement of the renewal provisions, including any reservation by the issuer of a right to change premiums; and disclosure of the existence of any automatic renewal premium increases based on the policyholder's age; and

(iii) a statement that the outline of coverage is a summary of the policy issued or applied for

and that the policy should be consulted to determine governing contractual provisions.

(d) The commissioner may make rules for captions or notice if the commissioner finds that the rules are:

(i) in the public interest; and

(ii) designed to inform prospective insureds that particular insurance coverages are not Medicare supplement coverages, for all accident and health insurance policies sold to persons eligible for Medicare, other than:

(A) a medicare supplement policy; or

(B) a disability income policy.

[~~(d)~~] (e) The commissioner may prescribe by rule a standard form and the contents of an informational brochure for persons eligible for Medicare, that is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of Medicare. Except in the case of direct response insurance policies, the commissioner may require by rule that the informational brochure be provided concurrently with delivery of the outline of coverage to any prospective insureds eligible for Medicare. With respect to direct response insurance policies, the commissioner may require by rule that the prescribed brochure be provided upon request to any prospective insureds eligible for Medicare, but in no event later than the time of policy delivery.

[~~(e)~~] (f) The commissioner may adopt reasonable rules to govern the full and fair disclosure of the information in connection with the replacement of [~~disability~~] accident and health policies, subscriber contracts, or certificates by persons eligible for Medicare.

(6) Notwithstanding Subsection (1), Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate, or attached to the front page, stating in substance that the applicant has the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this section shall be paid directly to the applicant by the issuer in a timely manner.

(7) Every issuer of Medicare supplement insurance policies or certificates in this state shall provide a copy of any Medicare supplement advertisement intended for use in this state, whether

through written or broadcast medium, to the commissioner for review.

Section 99. Section **31A-22-623** is amended to read:

31A-22-623. Coverage of inborn metabolic errors.

(1) As used in this section:

(a) "Dietary products" means medical food or a low protein modified food product that:

(i) is specifically formulated to treat inborn errors of amino acid or urea cycle metabolism;

(ii) is not a natural food that is naturally low in protein; and

(iii) is used under the direction of a physician.

(b) "Inborn errors of amino acid or urea cycle metabolism" means a disease caused by an inherited abnormality of body chemistry which is treatable by the dietary restriction of one or more amino acid.

(2) The commissioner shall establish, by rule, minimum standards of coverage for dietary products used for the treatment of inborn errors of amino acid or urea cycle metabolism at levels consistent with the major medical benefit provided under [~~a disability~~] an accident and health insurance policy.

Section 100. Section **31A-22-624** is amended to read:

31A-22-624. Primary care physician.

[~~A disability~~] An accident and health insurance policy that requires an insured to select a primary care physician to receive optimum coverage:

(1) shall permit an insured to select a participating provider who is an obstetrician/gynecologist and is qualified and willing to provide primary care services, as defined by the health care plan, as the insured's provider from whom primary care services are received;

(2) shall clearly state in literature explaining the policy the option available to female insureds under Subsection (1); and

(3) may not impose a higher premium, higher copayment requirement, or any other additional expense on an insured by virtue of the insured selecting a primary care physician in accordance with Subsection (1).

Section 101. Section **31A-22-626** is amended to read:

31A-22-626. Coverage of diabetes.

(1) As used in this section, "diabetes" includes individuals with:

(a) complete insulin deficiency or type 1 diabetes;

(b) insulin resistant with partial insulin deficiency or type 2 diabetes; and

(c) elevated blood glucose levels induced by pregnancy or gestational diabetes.

(2) The commissioner shall establish, by rule, minimum standards of coverage for diabetes for [~~disability~~] accident and health insurance policies that provide a health insurance benefit before July 1, 2000.

(3) In making rules under Subsection (2), the commissioner shall require rules:

(a) with durational limits, amount limits, deductibles, and coinsurance for the treatment of diabetes equitable or identical to coverage provided for the treatment of other illnesses or diseases; and

(b) that provide coverage for:

(i) diabetes self-management training and patient management, including medical nutrition therapy as defined by rule, provided by an accredited or certified program and referred by an attending physician within the plan and consistent with the health plan provisions for self-management education:

(A) recognized by the federal Health Care Financing [~~Agency~~] Administration; or

(B) certified by the Department of Health; and

(ii) the following equipment, supplies, and appliances to treat diabetes when medically necessary:

(A) blood glucose monitors, including those for the legally blind;

(B) test strips for blood glucose monitors;

(C) visual reading urine and ketone strips;

(D) lancets and lancet devices;

(E) insulin;

(F) injection aides, including those adaptable to meet the needs of the legally blind, and infusion delivery systems;

(G) syringes;

(H) prescriptive oral agents for controlling blood glucose levels; and

(I) glucagon kits.

(4) (a) Before October 1, 2003, the commissioner shall report to the Health and Human Services Interim Committee on the effects of Section 31A-22-626. The report shall be based on three years of data and shall include, to the extent possible:

(i) a review of the rules established under Subsection (3);

(ii) the change in availability of coverage resulting from this section;

(iii) the extent to which persons have been benefitted by the provisions of this section; and

(iv) the impact of this section on premiums.

(b) The Legislature shall consider the results of the report under Subsection (4)(a) when determining whether to reauthorize the provisions of this section.

Section 102. Section **31A-22-630** is amended to read:

31A-22-630. 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~~] an accident and health 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 103. Section **31A-22-631** is enacted to read:

31A-22-631. Policy summary or illustration.

(1) (a) Except as provided in Subsection (1)(b), at the time a life insurance policy is delivered, a policy summary or illustration shall be delivered for the life insurance policy if:

(i) the life insurance policy includes riders or supplemental benefits, including accelerated benefits; and

(ii) receipt of benefits under the life insurance policy is contingent upon morbidity requirements.

(b) In the case of a direct response solicitation, the insurer shall deliver the policy summary or illustration at the sooner of:

(i) the applicant's request; or

(ii) at the time of policy delivery regardless of whether the applicant requests a policy summary or illustration.

(2) In addition to complying with all applicable requirements, the policy summary or illustration shall include:

(a) a clear and prominent disclosure of how the rider or supplemental benefit interacts with other components of the policy, including deductions from death benefits and policy values;

(b) an illustration for each covered person of:

(i) the amount of benefits;

(ii) the length of benefits; and

(iii) the guaranteed lifetime benefits, if any;

(c) a disclosure of the maximum premiums for the rider or supplemental benefit;

(d) any exclusions, reductions, or limitations on the benefits of the rider or supplemental benefit; and

(e) if applicable to the policy type:

(i) a disclosure of the effects of exercising other rights under the policy; and

(ii) guaranteed maximum lifetime benefits.

Section 104. Section **31A-22-632** is enacted to read:

31A-22-632. Report to policy holder.

(1) An insurer shall provide the policyholder a monthly report if an accident and health rider or supplemental benefit is:

(a) funded through a life insurance vehicle by acceleration of the death benefit; and

(b) in benefit payment status.

(2) The report required by Subsection (1) shall include:

(a) any rider or supplemental benefits paid out during the month;

(b) an explanation of any changes in the policy due to rider or supplemental benefits being paid out such as:

(i) death benefits; or

(ii) cash values; and

(c) the amount of the rider or supplemental benefits existing or remaining.

Section 105. Section **31A-22-701** is amended to read:

Part VII. Group Accident and Health Insurance

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

(1) A group or blanket [~~disability~~] accident and health insurance policy may be issued to:

(a) any group to which a group life insurance policy may be issued under Sections 31A-22-502 through 31A-22-507;

(b) a policy issued pursuant to a conversion privilege under Part VII; or

(c) a group specifically authorized by the commissioner upon a finding that:

(i) authorization is not contrary to the public interest;

(ii) the proposed group is actuarially sound;

(iii) formation of the proposed group may result in economies of scale in administrative, marketing, and brokerage costs; and

(iv) the health insurance policy, certificate, or other indicia of coverage that will be offered

to the proposed group is substantially equivalent to policies that are otherwise available to similar groups.

(2) Blanket policies may also be issued to:

(a) any common carrier or any operator, owner, or lessee of a means of transportation, as policyholder, covering persons who may become passengers as defined by reference to their travel status;

(b) an employer, as policyholder, covering any group of employees, dependents, or guests, as defined by reference to specified hazards incident to any activities of the policyholder;

(c) an institution of learning, including a school district, school jurisdictional units, or the head, principal, or governing board of any of those units, as policyholder, covering students, teachers, or employees;

(d) any religious, charitable, recreational, educational, or civic organization, or branch of those organizations, as policyholder, covering any group of members or participants as defined by reference to specified hazards incident to the activities sponsored or supervised by the policyholder;

(e) a sports team, camp, or sponsor of the team or camp, as policyholder, covering members, campers, employees, officials, or supervisors;

(f) any volunteer fire department, first aid, civil defense, or other similar volunteer organization, as policyholder, covering any group of members or participants as defined by reference to specified hazards incident to activities sponsored, supervised, or participated in by the policyholder;

(g) a newspaper or other publisher, as policyholder, covering its carriers;

(h) an association, including a labor union, which has a constitution and bylaws and which has been organized in good faith for purposes other than that of obtaining insurance, as policyholder, covering any group of members or participants as defined by reference to specified hazards incident to the activities or operations sponsored or supervised by the policyholder;

(i) a health insurance purchasing association organized and controlled solely by participating employers as defined in Section 31A-34-103; and

(j) any other class of risks which, in the judgment of the commissioner, may be properly

eligible for blanket [~~disability~~] accident and health insurance.

(3) The judgment of the commissioner may be exercised on the basis of:

(a) individual risks [~~or~~];

(b) class of risks; or

(c) both Subsections (3)(a) and (b).

Section 106. Section **31A-22-702** is amended to read:

31A-22-702. Adjustment of premium rate and application of dividends or rate reductions.

Any group [~~disability~~] accident and health insurance policy may provide for the adjustment of the rate of premium based upon the experience under the contract. If a policy dividend is declared or a reduction in rate is made or continued for the first or any subsequent year of insurance under any policy of group [~~disability~~] accident and health insurance, the excess, if any, of the aggregate dividends or rate reductions under the policy and all other group insurance policies of the policyholder over the aggregate expenditure for insurance under those policies made from funds contributed by the policyholder, including expenditures made in connection with the administration of the policies, shall be applied by the policyholder for the sole benefit of insured employees or members unless the insured employee or member explicitly elects otherwise.

Section 107. Section **31A-22-703** is amended to read:

31A-22-703. Conversion rights on termination of group accident and health insurance coverage.

(1) Except as provided in Subsections (2) through (5), all policies of [~~disability~~] accident and health insurance offered on a group basis under this title or Title 49, Chapter 8, Group Insurance Program Act, shall provide that a person whose insurance under the group policy has been terminated for any reason, and who has been continuously insured under the group policy or its predecessor for at least six months immediately prior to termination, is entitled to choose [~~either~~] a converted individual [~~or group~~] policy of [~~disability~~] accident and health insurance from the insurer which conforms to Section 31A-22-708 or an extension of benefits under the group policy as provided in Section 31A-22-714.

(2) Subsection (1) does not apply if the policy:

(a) provides catastrophic, aggregate stop loss, or specific stop loss benefits;

(b) provides benefits for specific diseases or for accidental injuries only, or for dental service; or

(c) is [~~a disability~~] an income replacement policy.

(3) An employee or group member does not have conversion rights under Subsection (1) if:

(a) termination of the group coverage occurred because of failure of the group member to pay any required individual contribution;

(b) the individual group member acquires other group coverage covering all preexisting conditions including maternity, if the coverage existed under the replaced group coverage; or

(c) the person [~~who would be covered is or could be covered by Medicare~~] has:

(i) performed an act or practice that constitutes fraud; or

(ii) made an intentional misrepresentation of material fact under the terms of the coverage.

(4) Notwithstanding Subsections (1), (2), and (3), an employee or group member does not have conversion rights under Subsection (1) if the individual or group member qualifies to continue coverage under his existing group policy in accordance with the terms of his policy.

(5) (a) Notwithstanding Subsection 31A-22-613(1), an insurer may reduce benefits under a converted [~~disability~~] policy covering any person to the extent the benefits provided or available to that person under one or more of the sources listed under Subsection (5)(b), together with the benefits provided by the converted policy, would result in [~~overinsurance according to the insurer's standards. The insurer's standards shall bear a reasonable relationship to actual health care costs in the area in which the insured lives at the time of conversion and shall be filed with the commissioner prior to their use in denying~~] coverage that would result in payment of more than 100% of the amount of the claim.

(b) The benefits sources referred to under Subsection (5)(a) include:

(i) benefits under another insurance policy; and

(ii) benefits under any arrangement of coverage for individuals in a group, whether on an insured or an uninsured basis[~~; and~~].

[~~(iii) benefits provided for or available to that person, in accordance with the requirements of any state or federal law.~~]

(6) (a) The conversion policy shall provide maternity benefits equal to the lesser of the maternity benefits of the group policy or the conversion policy until termination of pregnancy that exists on the date of conversion if:

(i) one of the following is pregnant on the date of the conversion:

(A) the insured;

(B) a spouse of the insured; or

(C) a dependent of the insured; and

(ii) the accident and health policy had maternity benefits.

(b) The requirements of this Subsection (6) do not apply to a pregnancy that occurs after the date of conversion.

Section 108. Section **31A-22-704** is amended to read:

31A-22-704. Conversion rules and procedures.

(1) Written application for the converted policy shall be made and the first premium paid to the insurer no later than 60 days after termination of the group [~~disability~~] accident and health insurance.

(2) The converted policy shall be issued without evidence of insurability.

(3) (a) The initial premium for the converted policy for the first 12 months and subsequent renewal premiums shall be determined in accordance with premium rates applicable to age, class of risk of the person, and the type and amount of insurance provided[~~.~~]; and

(b) the initial premium for the first 12 months may not be raised based on pregnancy of a covered insured.

(4) Conditions pertaining to health are not an acceptable basis for classification under this section.

(5) The premium for converted [~~disability~~] policies shall be payable monthly or quarterly as required by the insurer for the policy form and plan selected, unless another mode of premium payment is mutually agreed upon.

(6) The converted policy becomes effective at the time the insurance under the group policy terminates.

(7) The converted policy covers the employee or member and the dependents who were covered by the group policy on the date of termination of insurance. At the option of the insurer, a separate converted policy may be issued to cover any dependent.

Section 109. Section **31A-22-705** is amended to read:

31A-22-705. Provisions in conversion policies.

(1) A converted policy may include a provision under which the insurer may request from the person covered, information in advance of any premium due date as to whether there is other coverage as specified under Subsection 31A-22-703(4).

(2) The converted policy may provide that the insurer may refuse to renew the policy or the coverage of any person insured:

[~~(a) if the insured could be covered by Medicare;~~]

[~~(b) the converted policy creates an unreasonable over-insurance position;~~]

[~~(c)~~] (a) for fraud or [~~material~~] intentional misrepresentation of a material fact in applying for any benefits under the converted policy; or

[~~(d)~~] (b) for any other reason approved by the commissioner by rule or order.

(3) [~~No~~] An insurer may not be required to issue a converted policy which provides benefits in excess of those provided under the group policy from which conversion is made.

(4) [~~No~~] A converted policy may not exclude a preexisting condition not excluded under the group policy.

(5) During the first policy year, the converted policy may provide that the benefits payable under the converted policy, together with the benefits paid for the individual under the group policy, do not exceed those that would have been payable had the individual's insurance under the group policy remained in force and effect.

Section 110. Section **31A-22-715** is amended to read:

31A-22-715. Optional rider for alcohol and drug dependency treatment.

Each group [~~disability~~] accident and health insurance policy shall contain an optional rider

allowing certificate holders to obtain coverage for alcohol or drug dependency treatment in programs licensed by the Department of Human Services, under Title 62A, Chapter 2, inpatient hospitals accredited by the joint commission on the accreditation of hospitals, or facilities licensed by the Department of Health.

Section 111. Section **31A-22-716** is amended to read:

31A-22-716. Required provision for notice of termination.

(1) Every policy for group or blanket [~~disability~~] accident and health coverage issued or renewed after July 1, 1990, shall include a provision that obligates the policyholder to give 30 days prior written notice of termination to each employee or group member and to notify each employee or group member of his rights to continue coverage upon termination.

(2) An insurer's monthly notice to the policyholder of premium payments due shall include a statement of the policyholder's obligations as set forth in Subsection (1). Insurers shall provide a sample notice to the policyholder at least once a year.

Section 112. Section **31A-22-717** is amended to read:

31A-22-717. Provisions pertaining to service members and their families affected by Operation Desert Shield and Operation Desert Storm.

For any group or blanket [~~disability~~] accident and health coverage, an insurer:

(1) may not refuse to reinstate an insured or his family whose coverage lapsed due to the insured's participation in Operation Desert Shield or Operation Desert Storm provided application is made within 180 days of release from active duty;

(2) shall reinstate an insured in full upon payment of the first premium without the requirement of a waiting period or exclusion for preexisting conditions or any other underwriting requirements that were covered previously; and

(3) may not increase the insured's premium in excess of what it would have been increased in the normal course of time had the insured not participated in Operation Desert Shield or Operation Desert Storm.

Section 113. Section **31A-22-720** is amended to read:

31A-22-720. Mental health parity.

(1) (a) A group [~~disability~~] accident and health 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~~] accident and health plan; and

(ii) provides a mental health benefit.

(b) A group [~~disability~~] accident and health plan described in Subsection (1)(a) shall:

(i) include in the aggregate lifetime limit for medical or surgical services covered by the group [~~disability~~] accident and health 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~~] accident and health 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~~] accident and health plan offered by an insurer shall comply with Subsection (2)(b) if the group [~~disability~~] accident and health plan:

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

(ii) provides a mental health benefit.

(b) A group [~~disability~~] accident and health plan described in Subsection (2)(a) shall:

(i) include in the annual limit for medical or surgical services covered by the group [~~disability~~] accident and health 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~~] accident and health 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~~] accident and health 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~~] accident and health 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 114. Section **31A-22-801** is amended to read:

31A-22-801. Scope of part.

(1) Except as provided under Subsection (2), all life insurance and [~~disability~~] accident and health insurance in connection with loans or other credit transactions are subject to this part.

(2) (a) Insurance in connection with a loan or other credit transaction of more than ten years duration is not subject to this part, but is subject to other provisions of this title.

(b) Isolated transactions on the part of an insurer [~~which~~] that are not related to an agreement or plan for insuring debtors of the creditor are not subject to this part.

Section 115. Section **31A-22-802** is amended to read:

31A-22-802. Definitions.

As used in Part VIII:

(1) "Credit [~~disability~~] accident and health insurance" means [~~disability~~] insurance on a

debtor to provide indemnity for payments coming due on a specific loan or other credit transaction while the debtor is disabled.

(2) "Credit life insurance" means life insurance on the life of a debtor in connection with a specific loan or credit transaction.

(3) "Credit transaction" means any transaction under which the payment for money loaned or for goods, services, or properties sold or leased is to be made on future dates.

(4) "Creditor" means the lender of money or the vendor or lessor of goods, services, or property, for which payment is arranged through a credit transaction, or any successor to the right, title, or interest of any lender or vendor.

(5) "Debtor" means a borrower of money or a purchaser, including a lessee under a lease intended as security, of goods, services, or property, for which payment is arranged through a credit transaction.

(6) "Indebtedness" means the total amount payable by a debtor to a creditor in connection with a credit transaction, including principal finance charges and interest.

(7) "Net indebtedness" means the total amount required to liquidate the indebtedness, exclusive of any unearned interest, any insurance on the monthly outstanding balance coverage, or any finance charge.

(8) "Net written premiums" means gross written premiums minus refunds on termination.

Section 116. Section **31A-22-803** is amended to read:

31A-22-803. Forms of insurance permitted.

Credit life insurance and credit [~~disability~~] accident and health insurance may be issued only in the following forms:

(1) individual policies of term life insurance issued to debtors;

(2) individual policies of term [~~disability~~] accident and health insurance issued to debtors, or [~~disability~~] accident and health benefit provisions in individual policies of credit life insurance;

(3) group policies of term life insurance issued to creditors, providing insurance upon the lives of debtors;

(4) group policies of term [~~disability~~] accident and health insurance issued to creditors

insuring debtors, or [~~disability~~] accident and health benefit provisions in group credit life insurance policies.

Section 117. Section **31A-22-804** is amended to read:

31A-22-804. Limitations on amounts of insurance.

(1) Except as provided under Subsection (2), the initial amount of credit life insurance on the life of any one debtor may not exceed the total amount repayable under the contract of indebtedness. Where an indebtedness is repayable in substantially equal periodic installments, the amount of insurance may not exceed the scheduled or actual amount of unpaid indebtedness, whichever is greater.

(2) Subsection (1) does not apply to:

(a) insurance on agricultural credit transaction commitments not exceeding the commitment period, which may be written for the amount of the commitment on a nondecreasing or level term plan;

(b) insurance on educational credit transaction commitments, which may be written to include the portion of the commitment that has not been advanced by the creditor;

(c) insurance on preauthorized lines of credit not exceeding the commitment period which may be written for the preauthorized amount on a nondecreasing or level term plan, whether secured or unsecured[~~.~~]; and

(d) insurance on any other class of lawful credit transaction or commitment, which in the commissioner's opinion does not require the application of the restrictions under Subsection (1), in which case the commissioner may authorize by rule a class exception to Subsection (1).

(3) The total amount of indemnity payable by credit [~~disability~~] accident and health insurance in the event of disability, as defined in the policy, may not exceed the aggregate of the periodic scheduled unpaid installments of the indebtedness. The amount of each periodic indemnity payment may not exceed the total amount repayable under the contract of indebtedness divided by the number of periodic installments.

Section 118. Section **31A-22-805** is amended to read:

31A-22-805. Beginning date of insurance.

(1) Except as provided under Subsection (2), any credit life insurance or credit [~~disability~~] accident and health insurance, subject to acceptance by the insurer, commences on the date when the debtor becomes obligated to the creditor.

(2) (a) Where a group policy provides coverage for existing obligations, the insurance on a debtor with respect to that indebtedness commences on the effective date of the policy.

(b) Where evidence of insurability is required and the evidence is furnished more than 30 days after the debtor becomes obligated to the creditor, the insurance may commence when the insurance company determines the evidence of insurability to be satisfactory. In this event, the insurer shall make an appropriate refund or adjustment of any charge to the debtor for insurance.

(3) The insurance may not extend more than 15 days beyond the scheduled maturity date of the indebtedness, unless it does so at no additional cost to the debtor.

(4) If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall terminate before any new insurance may be issued in connection with the renewed or refinanced indebtedness. In all cases of termination prior to scheduled maturity, a refund shall be paid or credited as provided in Section 31A-22-808.

Section 119. Section **31A-22-806** is amended to read:

31A-22-806. Provisions of policies and certificates.

(1) All credit life insurance and credit [~~disability~~] accident and health insurance shall be evidenced by an individual policy, or, in the case of group insurance, by a certificate of insurance delivered to the debtor.

(2) Each of these types of policies or certificates shall, in addition to satisfying the requirements of Chapter 21, set forth:

(a) the name and home office address of the insurer;

(b) the identity, by name or otherwise, of the persons insured;

(c) the rate, premium, or amount of payment by the debtor, if any, given separately for credit life insurance and credit [~~disability~~] accident and health insurance;

(d) a description of the amount, term, and coverage, including any exceptions, limitations, and restrictions;

(e) that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness; and

(f) that whenever the amount of insurance exceeds the unpaid indebtedness, that excess is payable to a beneficiary, other than the creditor, named by the debtor or to the debtor's estate.

(3) Except as provided in Subsection (4), the policy or certificate shall be delivered to the debtor within 30 days after the date when the indebtedness is incurred.

(4) (a) If the policy or certificate is not delivered to the debtor within 30 days after the date the indebtedness is incurred, a copy of the application for the policy or a notice of proposed insurance shall be delivered to the debtor.

(b) The application or the notice shall be signed by the debtor and shall set forth:

(i) the name and home office address of the insurer;

(ii) the name of the debtor;

(iii) the premium or amount of payment by the debtor, if any, separately for credit life insurance and credit [~~disability~~] accident and health insurance; and

(iv) the amount, term, and a brief description of the coverage provided.

(c) The copy of the application for or notice of proposed insurance, shall also refer exclusively to insurance coverage, and shall be separate from the loan, sale, or other credit statement of account or instrument, unless the information required by this Subsection (4)(c) is prominently set forth therein.

(d) Upon acceptance of the insurance by the insurer and within 60 days after the later of the date on which the indebtedness is incurred or the date on which the credit life or credit [~~disability~~] accident and health policy was purchased, the insurer shall deliver the individual policy or group certificate of insurance to the debtor.

(e) The application or notice shall state that upon acceptance by the insurer, the insurance is effective as provided in Section 31A-22-805.

(5) If the named insurer does not accept the risk, the debtor shall receive a policy or certificate of insurance setting forth the name and home office address of the substituted insurer and the amount of the premium to be charged. If the premium is less than that set forth in the notice of

proposed insurance, an appropriate refund shall be made.

(6) If a creditor makes available to the debtors more than one plan of credit life or credit [~~disability~~] accident and health insurance, all debtors must be informed of the plans applicable to the specific type of loan transaction for which the debtor is applying.

Section 120. Section **31A-22-807** is amended to read:

31A-22-807. Filing and approval of forms -- Loss ratio standards.

(1) All forms of policies, certificates of insurance, statements of insurance, endorsements, and riders intended for use in Utah are subject to Section 31A-21-201.

(2) In addition to the grounds for disapproval under Subsection 31A-21-201(3), it is a ground for disapproval that the benefits provided in the form are not reasonable in relation to the premium charge.

(3) In ascertaining whether the benefits are reasonable in relation to the premium charged, the commissioner shall consider the mortality cost of the life insurance and the morbidity cost of the [~~disability~~] accident and health insurance, and the reserves set up for the payment of claims unreported or in the process of settlement. The benefits are considered reasonable in relation to the premium charged if the premium rate charged develops or may reasonably be expected to develop a loss ratio of not less than 50% for credit life insurance and not less than 55% for credit [~~disability~~] accident and health insurance given the above costs.

(4) Benefits are considered reasonable in relation to premium charged if the ratio of claims incurred to premium earned during the most recent four-year period at the rates in use produces a loss ratio that is equal to or exceeds the minimum loss ratio standard specified in Subsection (3).

(5) If the minimum loss ratio test produces a loss ratio that exceeds Subsection (4)'s minimum loss ratio standard by five percentage points or more, the insurer may file for approval and use rates that are higher than prima facie rates, if it can be expected that the use of those higher rates will continue to produce a loss ratio for the accounts to which they are applied that will satisfy the minimum loss ratio test.

(6) If the minimum loss ratio test produces a loss ratio that is lower than Subsection (4)'s minimum loss standard by five percentage points or more, the commissioner may require that the

insurer file adjusted rates that can be expected to produce a loss ratio that will satisfy the minimum loss ratio test, or to submit reasons acceptable to the commissioner why the insurer should not be required to file these adjusted rates.

Section 121. Section **31A-22-808** is amended to read:

31A-22-808. Premiums and refunds.

(1) Each policy, certificate, or statement of insurance shall provide that in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund of an amount paid by the debtor for insurance shall be paid or credited promptly to the person entitled to it. The formula used in computing the refund shall be filed with and approved by the commissioner under Chapter 21, Part II. No refund is required if it would be less than $5.

(2) If a creditor requires a debtor to make any payment for credit life or credit [~~disability~~] accident and health insurance and an individual policy, certificate, or statement of insurance is not issued, the creditor shall immediately give written notice to the debtor and credit the account.

(3) The amount charged the debtor for credit life or [~~disability~~] accident and health insurance may not exceed the premiums charged by the insurer as computed at the time the charge to the debtor is determined.

Section 122. Section **31A-22-809** is amended to read:

31A-22-809. Right of debtor to choose insurer.

When credit life insurance or credit [~~disability~~] accident and health insurance is required as security for any indebtedness, the creditor shall inform the debtor of the debtor's option to furnish the required insurance through existing policies of insurance owned or controlled by the debtor or to procure and furnish the required coverage through any insurer authorized to transact life or [~~disability~~] accident and health insurance in Utah.

Section 123. Section **31A-22-1002** is amended to read:

31A-22-1002. Duration of coverage.

(1) Any insurer assuming a workers' compensation risk shall carry it until the policy is canceled, either:

(a) by agreement between the Division of Industrial Accidents in the Labor Commission,

the insurer, and the employer; or

(b) after:

(i) [~~30 days~~] notice by the insurer to the employer as provided in Section 31A-21-303; and

(ii) notice to the Division of Industrial Accidents in the Labor Commission as provided in Section 34A-2-205.

(2) Subsection (1) does not affect the requirements of Section 31A-22-1001.

Section 124. Section **31A-22-1101** is amended to read:

31A-22-1101. Combination of lines.

(1) Legal expense insurance may be transacted alone or together with life insurance, [~~disability~~] accident and health insurance, or casualty insurance.

(2) [~~No~~] An insurer may not transact liability insurance and also issue legal expense insurance policies providing coverage for the expense of enforcing claims against third persons, unless the requirements of Subsection (3) are met and the commissioner is satisfied that the interests of policyholders of legal expense insurance policies are not endangered by potential conflicts of interest within the insurer.

(3) Adequate precautions shall be taken to make sure that the handling of an insured's claim for legal assistance in enforcing a claim against a third person is not affected by the insurer's actual or potential obligation as a liability insurer to pay the claim for the third person. These precautions may include:

(a) a provision in the policy that claims against third persons shall be handled exclusively by attorneys selected by the insureds themselves rather than by the insurer, that no information about the case other than the name of the defendant and the nature of the claim may be made available to the insurer, and that the insurer may not interfere with the handling of the case; or

(b) organizational separation between the legal expense and the liability insurance departments with respect to management, accounting, record keeping, and claims handling, with appropriate rules and procedures, satisfactory to the commissioner, to prevent the exchange of information between the two departments about details of cases.

Section 125. Section **31A-22-1401** is amended to read:

31A-22-1401. Application.

(1) The requirements of this part apply to individual policies and to group policies and certificates marketed in this state on or after July 1, [~~1991~~] 2001, other than employee and labor union group policies and certificates.

(2) Entities subject to this part shall comply with other applicable insurance laws and rules unless they are in conflict with this part.

(3) The laws, regulations, and rules designed and intended to apply to Medicare supplement insurance policies may not be applied to long-term care insurance.

(4) Any policy or rider advertised, marketed, or offered as long-term care or nursing home insurance shall comply with the provisions of this part.

Section 126. Section **31A-22-1402** is amended to read:

31A-22-1402. Definitions.

Unless the context requires otherwise, the following definitions apply in this part:

(1) "Applicant" means:

(a) in the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; and

(b) in the case of a group long-term care insurance policy, the proposed certificate holder.

[~~(2) (a) "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage:~~]

[~~(i) for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis;~~]

[~~(ii) for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care service, provided in a setting other than an acute care unit of a hospital.~~]

[~~(b) The term includes group and individual annuities and life insurance policies or riders which provide directly or supplement long-term care insurance. The term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity.~~]

[~~(c) Long-term care insurance does not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.~~]

(2) Notwithstanding Section 31A-1-301,"certificate" means a certificate issued under a group long-term care insurance policy if the group long-term care insurance policy is delivered or issued for delivery in this state.

(3) Notwithstanding Section 31A-1-301, "policy" means a policy, contract subscriber agreement, rider, or endorsement, if the policy, contract subscriber agreement, rider, or endorsement is delivered or issued:

(a) in this state; and

(b) by:

(i) an insurer;

(ii) a fraternal benefit society;

(iii) a nonprofit health, hospital, or medical service corporation;

(iv) a prepaid health plan;

(v) a health maintenance organization; or

(vi) an entity similar to an entity described in Subsections (3)(b)(i) through (v).

Section 127. Section **31A-22-1407** is amended to read:

31A-22-1407. Restricted conditional terms.

(1) A long-term care insurance policy may not contain a provision that conditions eligibility:

(a) [~~conditions eligibility~~] for any benefits on a prior hospitalization requirement; [~~or~~]

(b) [~~conditions eligibility~~] for benefits provided in an institutional care setting on the receipt of a higher level of institutional care[~~.~~]; or

(c) for any benefits on a prior institutionalization requirement except for eligibility for:

(i) waiver of premium;

(ii) post confinement;

(iii) post-acute care; or

(iv) recuperative benefits.

(2) A long-term care insurance policy containing [~~any limitations or conditions for eligibility other than those prohibited in Subsection (1)~~] post confinement, post-acute care, or recuperative benefits shall clearly label the limitations or conditions, including any required number of days of confinement in a separate paragraph of the policy or certificate that is entitled "Limitations or Conditions on Eligibility for Benefits."

[~~(3) A long-term care insurance policy containing a benefit advertised, marketed, or offered as a home health care benefit may not condition receipt of benefits on a prior institutionalization.~~]

[~~(4) A long-term care insurance policy or rider that provides benefits only following institutionalization may not condition the benefits upon admission to a facility for the same or related conditions within a period of less than 30 days after discharge from the institution.~~]

(3) A long-term care insurance policy or rider that conditions eligibility of noninstitutional benefits on the prior receipt of institutional care may not require a prior institutional stay of more than 30 days.

Section 128. Section **31A-22-1409** is amended to read:

31A-22-1409. Statements of coverage.

(1) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the applicant to the document and its purpose.

(2) The commissioner may prescribe a standard format of an outline of coverage, including style, arrangement, and overall appearance, and the content.

(3) In the case of agent solicitations an agent must deliver the outline of coverage prior to the presentation of any application or enrollment form.

(4) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

(5) An outline of coverage under this section shall include:

(a) a description of the principal benefits and coverage provided in the policy;

(b) a statement of the principal exclusions, reductions, and limitations contained in the policy;

(c) a statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium;

(d) a specific description of continuation or conversion provisions of group coverage;

(e) a statement that the outline of coverage is not a contract of insurance but a summary only and that the policy or group master policy contains governing contractual provisions;

(f) a description of the terms under which the policy or certificate may be returned and premium refunded; [~~and~~]

(g) a brief description of the relationship of cost of care and benefits[~~.~~]; and

(h) a statement that discloses to the policyholder or certificate holder whether the policy is intended to be a federally tax-qualified, long-term care insurance contract under Section 7702B(b), Internal Revenue Code.

(6) A certificate issued pursuant to a group long-term care insurance policy, which policy is delivered or issued for delivery in this state, shall include:

(a) a description of the principal benefits and coverage provided in the policy;

(b) a statement of the principal exclusions, reductions, and limitations contained in the policy; [~~and~~]

(c) a statement that the group master policy determines governing contractual provisions[~~.~~]; and

(d) a statement that any long-term care inflation protection option required by rule is not available under the policy.

(7) If an application for a long-term care contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than 30 days after the date of approval.

[~~(7)~~] (8) At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's

request. However, the insurer shall deliver the summary to the applicant no later than at the time of policy delivery regardless of request. In addition to complying with all applicable requirements, the summary shall also include:

(a) an explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

(b) an illustration for each covered person of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any;

(c) any exclusions, reductions, and limitations on benefits of long-term care; and

(d) if applicable to the policy type, the summary shall also include:

(i) a disclosure of the effects of exercising other rights under the policy;

(ii) a disclosure of guarantees related to long-term care costs of insurance charges; and

(iii) current and projected maximum lifetime benefits.

(9) The provisions of the policy summary required under Subsection (8) may be incorporated into:

(a) a basic illustration; or

(b) the life insurance policy summary required to be delivered in accordance with rule.

Section 129. Section **31A-22-1412** is amended to read:

31A-22-1412. Nonforfeiture benefits.

(1) (a) A long-term care insurance policy or certificate may not be delivered or issued for delivery in this state unless the [~~issuer of the policy or certificate offers nonforfeiture benefits to the defaulting or surrendering policyholder or certificate holder~~] policyholder or certificate holder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit.

(b) The offer of a nonforfeiture benefit under Subsection (1)(a) may be in the form of a rider that is attached to the policy.

(c) If the policyholder or certificate holder declines the nonforfeiture benefit offered under this Subsection (1), the insurer shall provide a contingent benefit upon lapse of the policy or certificate that is available for a specified period of time following a substantial increase in premium rates.

(d) (i) Except as provided in Subsection (1)(d)(ii), if a group long-term care insurance policy is issued, the offer required in this Subsection (1) shall be made to the group policyholder.

(ii) If the policy is issued to a group authorized under Section 31A-22-509, the offer required under this Subsection (1) shall be made to each proposed certificate holder.

(2) The commissioner shall make rules:

(a) specifying the types of nonforfeiture benefits [~~and~~] to be offered as part of a long-term care insurance policy or certificate;

(b) specifying the standards for [~~the~~] nonforfeiture benefits [~~to be included in the policies and certificates.~~]; and

(c) regarding contingent benefits upon lapse, including a determination of:

(i) the specified period of time during which a contingent benefit upon lapse will be available as provided in Subsection (1); and

(ii) the substantial premium rate increase that triggers a contingent benefit upon lapse as provided in Subsection (1).

Section 130. Section **31A-22-1413** is enacted to read:

31A-22-1413. Claim information.

If a claim under a long-term care insurance contract is denied, within 60 days of the date a written request by the policyholder or a representative of a policyholder is filed with the insurer, the insurer shall:

(1) provide a written explanation of the reason for the denial; and

(2) make available all information directly related to the denial.

Section 131. Section **31A-22-1414** is enacted to read:

31A-22-1414. Marketing.

A policy or rider shall comply with this part if it is advertised, marketed, or offered as:

(1) long-term care insurance; or

(2) nursing home insurance.

Section 132. Section **31A-23-101** is amended to read:

31A-23-101. Purposes.

The purposes of this chapter include:

(1) promoting the professional competence of insurance agents, brokers, and consultants;

(2) providing maximum freedom of marketing methods for insurance, consistent with the interests of the Utah public;

(3) preserving and encouraging competition at the consumer level; [~~and~~]

(4) regulating insurance marketing practices in conformity with the general purposes of [~~the Insurance Code.~~] this title; and

(5) governing the qualifications and procedures for the licensing of insurance producers.

Section 133. Section **31A-23-102** is amended to read:

31A-23-102. Definitions.

As used in this chapter:

[~~(1) Except as provided in Subsection (2):~~]

[~~(a) "Escrow" is a license category that allows a person to conduct escrows, settlements, or closings on behalf of a title insurance agency or a title insurer.~~]

[~~(b) "Limited license" means a license that is issued for a specific product of insurance and limits an individual or agency to transact only for those products.~~]

[~~(c) "Search" is a license category that allows a person to issue title insurance commitments or policies on behalf of a title insurer.~~]

[~~(d) "Title marketing representative" means a person who:~~]

[~~(i) represents a title insurer in soliciting, requesting, or negotiating the placing of:~~]

[~~(A) title insurance; or~~]

[~~(B) escrow, settlement, or closing services; and~~]

[~~(ii) does not have a search or escrow license.~~]

[~~(2) The following persons are not acting as agents, brokers, title marketing representatives, or consultants when acting in the following capacities:~~]

[~~(a) any regular salaried officer, employee, or other representative of an insurer or licensee under this chapter who devotes substantially all of the officer's, employee's, or representative's working time to activities other than those described in Subsection (1) and Subsections~~

~~31A-1-301(51), (52), and (54) including the clerical employees of persons required to be licensed under this chapter;~~]

[~~(b) a regular salaried officer or employee of a person seeking to purchase insurance, who receives no compensation that is directly dependent upon the amount of insurance coverage purchased;~~]

[~~(c) a person who gives incidental advice in the normal course of a business or professional activity, other than insurance consulting, if neither that person nor that person's employer receives direct or indirect compensation on account of any insurance transaction that results from that advice;~~]

[~~(d) a person who, without special compensation, performs incidental services for another at the other's request, without providing advice or technical or professional services of a kind normally provided by an agent, broker, or consultant;~~]

[~~(e) a holder of a group insurance policy, or any other person involved in mass marketing, but only:~~]

[~~(i) with respect to administrative activities in connection with that type of policy, including the collection of premiums; and~~]

[~~(ii) if the person receives no compensation for the activities described in Subsection (2)(e)(i) beyond reasonable expenses including a fair payment for the use of capital; and~~]

[~~(f) a person who gives advice or assistance without direct or indirect compensation or any expectation of direct or indirect compensation.~~]

[~~(3)~~] (1) "Actuary" means a person who is a member in good standing of the American Academy of Actuaries.

[~~(4)~~] (2) "Agency" means a person other than an individual, and includes a sole proprietorship by which a natural person does business under an assumed name.

[~~(5)~~] (3) "Broker" means an insurance broker or any other person, firm, association, or corporation that for any compensation, commission, or other thing of value acts or aids in any manner in soliciting, negotiating, or procuring the making of any insurance contract on behalf of an insured other than itself.

[~~(6)~~] (4) "Bail bond agent" means [~~any~~] an individual:

(a) appointed by an authorized bail bond surety insurer or appointed by a licensed bail bond surety company to execute or countersign undertakings of bail in connection with judicial proceedings; and

(b) who receives or is promised money or other things of value for this service.

[~~(7)~~] (5) "Captive insurer" means:

(a) an insurance company owned by another organization whose exclusive purpose is to insure risks of the parent organization and affiliated companies; or

(b) in the case of groups and associations, an insurance organization owned by the insureds whose exclusive purpose is to insure risks of member organizations, group members, and their affiliates.

[~~(8)~~] (6) "Controlled insurer" means a licensed insurer that is either directly or indirectly controlled by a broker.

[~~(9)~~] (7) "Controlling broker" means a broker who either directly or indirectly controls an insurer.

[~~(10)~~] (8) "Controlling person" means any person, firm, association, or corporation that directly or indirectly has the power to direct or cause to be directed, the management, control, or activities of a reinsurance intermediary.

(9) "Escrow" means a license category that allows a person to conduct escrows, settlements, or closings on behalf of:

(a) a title insurance agency; or

(b) a title insurer.

(10) "Home state" means any state or territory of the United States or the District of Columbia in which an insurance producer:

(a) maintains the insurance producer's principal:

(i) place of residence; or

(ii) place of business; and

(b) is licensed to act as an insurance producer.

(11) "Insurer" is as defined in Section 31A-1-301, except the following persons or similar

persons are not insurers for purposes of Part 6, Broker Controlled Insurers:

(a) all risk retention groups as defined in:

(i) the Superfund Amendments and Reauthorization Act of 1986, Pub. L. No. 99-499;

(ii) the Risk Retention Act, 15 U.S.C. Sec. 3901 et seq.; and

(iii) [~~Title 31A,~~] Chapter 15, Part II, Risk Retention Groups Act;

(b) all residual market pools and joint underwriting authorities or associations; and

(c) all captive insurers.

(12) "License" is defined in Section 31A-1-301.

(13) "Limited license" means a license that:

(a) is issued for a specific product of insurance; and

(b) limits an individual or agency to transact only for that product or insurance.

(14) "Limited line insurance" includes:

(a) bail bond;

(b) credit life;

(c) credit disability;

(d) credit property;

(e) credit unemployment;

(f) involuntary unemployment;

(g) legal expense;

(h) mortgage life;

(i) mortgage guaranty;

(j) mortgage disability;

(k) motor club;

(l) rental car-related;

(m) travel insurance; and

(n) any other form of limited insurance or insurance offered in connection with an extension of credit that:

(i) is limited to partially or wholly extinguishing that credit obligation; and

(ii) the commissioner determines should be designated a form of limited line insurance.

[~~(12)~~] (15) (a) "Managing general agent" means any person, firm, association, or corporation that:

(i) manages all or part of the insurance business of an insurer, including the management of a separate division, department, or underwriting office;

(ii) acts as an agent for the insurer whether it is known as a managing general agent, manager, or other similar term;

(iii) with or without the authority, either separately or together with affiliates, directly or indirectly produces and underwrites an amount of gross direct written premium equal to, or more than 5% of, the policyholder surplus as reported in the last annual statement of the insurer in any one quarter or year; and

(iv) [~~either~~] (A) adjusts or pays claims in excess of an amount determined by the commissioner[~~,~~]; or [~~that~~]

(B) negotiates reinsurance on behalf of the insurer.

(b) Notwithstanding Subsection [~~(12)~~] (15)(a), the following persons may not be considered as managing general agent for the purposes of this chapter:

(i) an employee of the insurer;

(ii) a [~~U.S.~~] United States manager of the United States branch of an alien insurer;

(iii) an underwriting manager that, pursuant to contract:

(A) manages all the insurance operations of the insurer;

(B) is under common control with the insurer;

(C) is subject to [~~Title 31A,~~] Chapter 16, Insurance Holding Companies; and

(D) is not compensated based on the volume of premiums written; and

(iv) the attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or inter-insurance exchange under powers of attorney.

(16) "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract if the person engaged in that act:

(a) sells insurance; or

(b) obtains insurance from insurers for purchasers.

[~~(13)~~] (17) "Producer" [~~is~~] means a person [~~who arranges for insurance coverages between insureds and insurers~~] required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

[~~(14)~~] (18) "Qualified [~~U.S.~~] United States financial institution" means an institution that:

(a) is organized or, in the case of a [~~U.S.~~] United States office of a foreign banking organization licensed, under the laws of the United States or any state;

(b) is regulated, supervised, and examined by [~~U.S.~~] United States federal or state authorities having regulatory authority over banks and trust companies; and

(c) [~~has been determined by either the commissioner, or the Securities Valuation Office of the National Association of Insurance Commissioners, to meet~~] meets the standards of financial condition and standing that are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner[~~.~~] as determined by:

(i) the commissioner; or

(ii) the Securities Valuation Office of the National Association of Insurance Commissioners.

[~~(15)~~] (19) "Reinsurance intermediary" means a reinsurance intermediary-broker or a reinsurance intermediary-manager as these terms are defined in Subsections [~~(16)~~] (20) and [~~(17)~~] (21).

[~~(16)~~] (20) "Reinsurance intermediary-broker" means a person other than an officer or employee of the ceding insurer, firm, association, or corporation who solicits, negotiates, or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of the insurer.

[~~(17)~~] (21) (a) "Reinsurance intermediary-manager" means a person, firm, association, or corporation who:

(i) has authority to bind or who manages all or part of the assumed reinsurance business of a reinsurer, including the management of a separate division, department, or underwriting office; and

(ii) acts as an agent for the reinsurer whether the person, firm, association, or corporation is known as a reinsurance intermediary-manager, manager, or other similar term.

(b) Notwithstanding Subsection [~~(17)~~] (21)(a), the following persons may not be considered reinsurance intermediary-managers for the purpose of this chapter with respect to the reinsurer:

(i) an employee of the reinsurer;

(ii) a [~~U.S.~~] United States manager of the United States branch of an alien reinsurer;

(iii) an underwriting manager that, pursuant to contract:

(A) manages all the reinsurance operations of the reinsurer;

(B) is under common control with the reinsurer;

(C) is subject to [~~Title 31A,~~] Chapter 16, Insurance Holding Companies; and

(D) is not compensated based on the volume of premiums written; and

(iv) the manager of a group, association, pool, or organization of insurers that:

(A) engage in joint underwriting or joint reinsurance; and

(B) are subject to examination by the insurance commissioner of the state in which the manager's principal business office is located.

[~~(18)~~] (22) "Reinsurer" means any person, firm, association, or corporation duly licensed in this state as an insurer with the authority to assume reinsurance.

(23) "Search" means a license category that allows a person to issue title insurance commitments or policies on behalf of a title insurer.

(24) "Sell" means to exchange a contract of insurance:

(a) by any means;

(b) for money or its equivalent; and

(c) on behalf of an insurance company.

(25) "Solicit" means:

(a) attempting to sell insurance; or

(b) asking or urging a person to apply:

(i) for a particular kind of insurance; and

(ii) from a particular insurance company.

[~~(19)~~] (26) "Surplus lines broker" means a person licensed under Subsection 31A-23-204(5) to place insurance with unauthorized insurers in accordance with Section 31A-15-103.

(27) "Terminate" means:

(a) the cancellation of the relationship between:

(i) an insurance producer; and

(ii) a particular insurer; or

(b) the termination of the producer's authority to transact insurance on behalf of a particular insurance company.

(28) "Title marketing representative" means a person who:

(a) represents a title insurer in soliciting, requesting, or negotiating the placing of:

(i) title insurance; or

(ii) escrow, settlement, or closing services; and

(b) does not have a search or escrow license.

[~~(20)~~] (29) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

(30) "Uniform application" means the version of the National Association of Insurance Commissioner's uniform application for resident and nonresident producer licensing at the time the application is filed.

(31) "Uniform business entity application" means the version of the National Association of Insurance Commissioner's uniform business entity application for resident and nonresident business entities at the time the application is filed.

Section 134. Section **31A-23-201** is amended to read:

31A-23-201. Requirement of license.

(1) (a) Unless exempted from the licensing requirement under [~~Subsection (2) or~~] Section 31A-23-201.5 or 31A-23-214, a person may not perform, offer to perform, or advertise any service as an agent, broker, or consultant in Utah, without a valid license under Section 31A-23-203.

(b) A person may not utilize the services of another as an agent, broker, or consultant if [~~he~~] that person knows or should know that the other does not have a license as required by law.

[~~(2) The commissioner may by rule exempt certain classes of persons from the license~~

~~requirement of Subsection (1) if either of these circumstances exist:~~]

[~~(a) the functions they perform do not require special competence, trustworthiness, or the regulatory surveillance made possible by licensing; or~~]

[~~(b) other existing safeguards make regulation unnecessary.~~]

(2) This part may not be construed to require an insurer to obtain an insurance producer license.

(3) [~~No~~] An insurance contract is not invalid as a result of a violation of this section.

Section 135. Section **31A-23-201.5** is enacted to read:

31A-23-201.5. Exceptions to licensing.

(1) The commissioner may not require a license as an insurance producer of:

(a) an officer, director, or employee of an insurer or of an insurance producer if:

(i) the officer, director, or employee does not receive any commission on a policy written or sold to insure risks residing, located, or to be performed in this state; and

(ii) (A) the officer's, director's, or employee's activities are:

(I) executive, administrative, managerial, clerical, or a combination of these activities; and

(II) only indirectly related to the sale, solicitation, or negotiation of insurance;

(B) the officer's, director's, or employee's function relates to:

(I) underwriting;

(II) loss control;

(III) inspection; or

(IV) the processing, adjusting, investigating or settling of a claim on a contract of insurance; or

(C) (I) the officer, director, or employee is acting in the capacity of a special agent or agency supervisor assisting an insurance producer;

(II) the officer's, director's, or employee's activities are limited to providing technical advice and assistance to a licensed insurance producer; and

(III) the officer's, director's, or employee's activities do not include the sale, solicitation, or negotiation of insurance;

(b) a person who:

(i) is paid no commission for the services described in Subsection (1)(b)(ii); and

(ii) secures and furnishes information for the purpose of:

(A) group life insurance;

(B) group property and casualty insurance;

(C) group annuities;

(D) group or blanket accident and health insurance;

(E) enrolling individuals under plans;

(F) issuing certificates under plans; or

(G) otherwise assisting in administering plans;

(c) a person who:

(i) is paid no commission for the services described in Subsection (1)(c)(ii); and

(ii) performs administrative services related to mass marketed property and casualty insurance;

(d) (i) any of the following if the conditions of Subsection (1)(d)(ii) are met:

(A) an employer or association; or

(B) an officer, director, employee, or trustee of an employee trust plan;

(ii) a person listed in Subsection (1)(d)(i):

(A) to the extent that the employer, officer, employee, director, or trustee is engaged in the administration or operation of a program of employee benefits for:

(I) the employer's or association's own employees; or

(II) the employees of a subsidiary or affiliate of an employer or association;

(B) the program involves the use of insurance issued by an insurer; and

(C) the employer, association, officer, director, employee, or trustee is not in any manner compensated, directly or indirectly, by the company issuing the contract;

(e) an employee of an insurer or organization employed by an insurer who:

(i) is engaging in:

(A) the inspection, rating, or classification of risks; or

(B) the supervision of the training of insurance producers; and

(ii) is not individually engaged in the sale, solicitation, or negotiation of insurance;

(f) a person whose activities in this state are limited to advertising:

(i) without the intent to solicit insurance in this state;

(ii) through communications in mass media including:

(A) a printed publication; or

(B) a form of electronic mass media;

(iii) that is distributed to residents outside of the state; and

(iv) if the person does not sell, solicit, or negotiate insurance that would insure risks residing, located, or to be performed in this state;

(g) a person who:

(i) is not a resident of this state;

(ii) sells, solicits, or negotiates a contract of insurance:

(A) for commercial property and casualty risks to an insured with risks located in more than one state insured under that contract; and

(B) insures risks located in a state in which the person is licensed as provided in Subsection (1)(g)(iii); and

(iii) is licensed as an insurance producer to sell, solicit, or negotiate that insurance in the state where the insured maintains its principal place of business;

(h) if the employee does not sell, solicit, or receive a commission for a contract of insurance, a salaried full-time employee who counsels or advises the employee's employer relating to the insurance interests of:

(i) the employer; or

(ii) a subsidiary or business affiliate of the employer.

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

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

(i) special competence;

(ii) special trustworthiness; or

(iii) regulatory surveillance made possible by licensing; or

(b) other existing safeguards make regulation unnecessary.

Section 136. Section **31A-23-202** is amended to read:

31A-23-202. Application for license.

(1) [~~The~~] (a) Subject to Subsection (2) the application for a resident license as an agent, a broker, or a consultant shall be:

(i) made to the commissioner on forms and in a manner [~~he~~] the commissioner prescribes[~~.~~ ~~The~~]; and

(ii) accompanied by an applicable fee that is not refunded if the application is denied; and

(b) the application for a nonresident license as an agent, a broker, or a consultant shall be:

(i) made on the uniform application; and

(ii) accompanied by an applicable fee that is not refunded if the application is denied.

(2) An application described in Subsection (1) shall provide:

(a) information about the applicant's identity[~~;~~];

(b) the applicant's:

(i) social security number[~~;~~]; or

(ii) federal employer identification number;

(c) the applicant's personal history, experience, education, and business record[~~, and~~];

(d) if the applicant is a natural person, whether the applicant is 18 years of age or older;

(e) whether the applicant has committed an act that is a ground for denial, suspension, or revocation as set forth in Section 31A-23-216; and

(f) any other information the commissioner reasonably requires.

(3) The commissioner may require any documents reasonably necessary to verify the information contained in an application.

[~~(2)~~] (4) [~~An applicant's social security number is a~~] The following are private [~~record~~] records under Subsection 63-2-302(1)(g)[~~:~~] an applicant's:

(a) social security number; or

(b) federal employer identification number.

Section 137. Section **31A-23-203** is amended to read:

31A-23-203. General requirements for license issuance and renewal.

(1) The commissioner shall issue or renew a license to act as an agent, broker, or consultant to any person who, as to the license classification applied for under Section 31A-23-204:

(a) has satisfied the character requirements under Section 31A-23-205;

(b) has satisfied any applicable continuing education requirements under Section 31A-23-206;

(c) has satisfied any applicable examination requirements under Section 31A-23-207;

(d) has satisfied any applicable training period requirements under Section 31A-23-208;

(e) if a nonresident:

(i) has complied with Section 31A-23-209; and

(ii) holds an active similar license in that person's state of residence;

(f) as to applicants for licenses to act as title insurance agents, has satisfied the requirements of Section 31A-23-211; and

(g) has paid the applicable fees under Section 31A-3-103.

(2) (a) This Subsection (2) applies to the following persons:

(i) an applicant for a pending producer's license; or

(ii) a licensed producer.

(b) A person described in Subsection (2)(a) shall report to the commissioner:

(i) any administrative action taken against the person:

(A) in another jurisdiction; or

(B) by another regulatory agency in this state; and

(ii) any criminal prosecution taken against the person in any jurisdiction.

(c) The report required by Subsection (2)(b) shall:

(i) be filed:

(A) at the time the person files the application for a producer's license; or

(B) within 30 days of the initiation of an action or prosecution described in Subsection

(2)(b); and

(ii) include a copy of the complaint or other relevant legal documents related to the action or prosecution described in Subsection (2)(b).

[~~(2)~~] (3) (a) The department may request:

(i) criminal background information maintained pursuant to Title 53, Chapter 10, Part 2, from the Bureau of Criminal Identification; and

(ii) complete Federal Bureau of Investigation criminal background checks through the national criminal history system.

(b) Information obtained by the department from the review of criminal history records received under Subsection [~~(2)~~] (3)(a) shall be used by the department for the purposes of:

(i) determining if a person satisfies the character requirements under Section 31A-23-205 for issuance or renewal of a license;

(ii) determining if a person has failed to maintain the character requirements under Section 31A-23-205; and

(iii) preventing persons who violate the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Secs. 1033 and 1034, from engaging in the business of insurance in the state.

(c) If the department requests the criminal background information, the department shall:

(i) pay to the Department of Public Safety the costs incurred by the Department of Public Safety in providing the department criminal background information under Subsection [~~(2)~~] (3)(a)(i);

(ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau of Investigation in providing the department criminal background information under Subsection[~~(2)~~] (3)(a)(ii); and

(iii) charge the person applying for a license or for renewal of a license a fee equal to the aggregate of Subsections [~~(2)~~] (3)(c)(i) and (ii).

Section 138. Section **31A-23-204** is amended to read:

31A-23-204. License classifications.

[~~Licenses~~] A resident or nonresident license issued under this chapter shall be issued under the classifications described under Subsections (1) through (6). These classifications are intended

to describe the matters to be considered under any education, examination, and training required of license applicants under Sections 31A-23-206 through 31A-23-208.

(1) [~~Agent~~] An agent and broker license [~~classifications include~~] classification includes:

(a) life insurance, including nonvariable [~~annuities~~] contracts;

(b) variable [~~annuities~~] contracts;

(c) [~~disability~~] accident and health insurance, including contracts issued to policyholders under Chapter 7 or 8;

(d) property/liability insurance, which includes:

(i) property insurance;

(ii) liability insurance;

(iii) surety and other bonds; and

(iv) policies containing any combination of these coverages;

(e) title insurance under one of the following categories:

(i) search, including authority to act as a title marketing representative;

(ii) escrow, including authority to act as a title marketing representative;

(iii) search and escrow, including authority to act as a title marketing representative; and

(iv) title marketing representative only; and

(f) workers' compensation insurance.

(2) [~~Limited~~] A limited license [~~product~~] classification includes:

(a) credit life and credit [~~disability~~] accident and health insurance;

(b) travel insurance;

(c) motor club insurance;

(d) car rental related insurance;

(e) credit involuntary unemployment insurance [~~and~~];

(f) credit property insurance;

[~~(f)~~] (g) bail bond agent; and

[~~(g)~~] (h) customer service representative.

(3) [~~Consultant~~] A consultant license classification includes:

(a) life insurance, including nonvariable [~~annuities~~] contracts;

(b) variable [~~annuities~~] contracts;

(c) [~~disability~~] accident and health insurance, including contracts issued to policyholders under Chapter 7 or 8;

(d) property/liability insurance, which includes:

(i) property insurance;

(ii) liability insurance;

(iii) surety and other bonds; and

(iv) policies containing any combination of these coverages; and

(e) workers' compensation insurance.

(4) A holder of licenses under Subsections (1)(a) and (1)(c) has all qualifications necessary to act as a holder of a license under Subsection (2)(a).

(5) (a) Upon satisfying the additional applicable requirements, a holder of a brokers license may obtain a license to act as a surplus lines broker.

(b) A license to act as a surplus lines broker gives the holder the authority to arrange insurance contracts with unauthorized insurers under Section 31A-15-103, but only as to the types of insurance under Subsection (1) for which the broker holds a brokers license.

(6) The commissioner may by rule recognize other agent, broker, limited license, or consultant license classifications as to kinds of insurance not listed under Subsections (1), (2), and (3).

Section 139. Section **31A-23-206** is amended to read:

31A-23-206. Continuing education requirements -- Regulatory authority.

(1) The commissioner shall by rule prescribe the continuing education requirements for each class of agent's license under Subsection 31A-23-204(1), except that the commissioner may not impose a continuing education requirement on a holder of a license under:

(a) Subsection 31A-23-204(2); or

(b) a license classification other than under Subsection 31A-23-204(2) that is recognized by the commissioner by rule as provided in Subsection 31A-23-204(6).

(2) (a) The commissioner may not state a continuing education requirement in terms of formal education.

(b) The commissioner may state a continuing education requirement in terms of classroom hours, or their equivalent, of insurance-related instruction received.

(c) Insurance-related formal education may be a substitute, in whole or in part, for classroom hours, or their equivalent, required under Subsection (2)(b).

(3) (a) The commissioner shall impose continuing education requirements in accordance with a two-year licensing period in which the licensee meets the requirements of this Subsection (3).

(b) Except as provided in Subsection (3)(c), for a two-year licensing period described in Subsection (3)(a) the commissioner shall require that the licensee for each line of authority held by the licensee:

(i) receive six hours of continuing education; or

(ii) pass a line of authority continuing education examination.

(c) Notwithstanding Subsection (3)(b):

(i) the commissioner may not require continuing education for more than four lines of authority held by the licensee;

(ii) the commissioner shall require:

(A) a minimum of:

(I) 12 hours of continuing education;

(II) passage of two line of authority continuing education examinations; or

(III) a combination of Subsections (3)(c)(ii)(A)(I) and (II);

(B) that the minimum continuing education requirement of Subsection (3)(c)(ii)(A) include:

(I) at least six hours or one line of authority continuing education examination for each line of authority held by the licensee not to exceed four lines of authority held by the licensee; and

(II) three hours of ethics training, which may be taken in place of three hours of the hours required for a line of authority.

(d) (i) If a licensee completes the licensee's continuing education requirement without taking a line of authority continuing education examination, the licensee shall complete at least 1/2 of the

required hours through classroom hours of insurance-related instruction.

(ii) The hours not completed through classroom hours in accordance with Subsection (3)(d)(i) may be obtained through:

(A) home study;

(B) video tape;

(C) experience credit; or

(D) other method provided by rule.

(e) (i) A licensee may obtain continuing education hours at any time during the two-year licensing period.

(ii) The licensee may not take a line of authority continuing education examination more than 90 calendar days before the date on which the licensee's license is renewed.

(f) The commissioner shall make rules for the content and procedures for line of authority continuing education examinations.

(g) (i) Beginning May 3, 1999, a licensee is exempt from continuing education requirements under this section if:

(A) as of April 1, 1990, the licensee has completed 20 years of licensure in good standing;

(B) the licensee requests an exemption from the department; and

(C) the department approves the exemption.

(ii) If the department approves the exemption under Subsection (3)(g)(i), the licensee is not required to apply again for the exemption.

(h) A licensee with a variable [~~annuity~~] contract line of authority is exempt from the requirement for continuing education for that line of authority so long as the:

(i) National Association of Securities Dealers requires continuing education for licensees having a securities license; and

(ii) licensee complies with the National Association of Securities Dealers' continuing education requirements for securities licensees.

(i) The commissioner shall, by rule:

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

requirements can be used to meet the requirements for continuing education under Subsection (3)(c); and

(ii) authorize professional agent associations to:

(A) offer qualified programs for all classes of licenses on a geographically accessible basis; and

(B) collect reasonable fees for funding and administration of the continuing education program, subject to the review and approval of the commissioner.

(j) (i) The fees permitted under Subsection (3)(i)(ii) that are charged to fund and administer the program shall reasonably relate to the costs of administering the program.

(ii) Nothing in this section prohibits a provider of continuing education programs or courses from charging fees for attendance at courses offered for continuing education credit.

(iii) The fees permitted under Subsection (3)(i)(ii) that are charged for attendance at a professional agent association program may be less for an association member, based on the member's affiliation expense, but shall preserve the right of a nonmember to attend without affiliation.

(4) The commissioner shall designate courses, including those presented by insurers, which satisfy the requirements of this section.

(5) The requirements of this section apply only to applicants who are natural persons.

[~~(6) The commissioner may waive the requirements of this section as to any person who has been an active insurance agent or broker in another state for two years immediately prior to applying for a license in this state, but only if the applicant's state of residence has imposed upon the applicant education requirements which are substantially as rigorous as those of this state.~~]

(6) A nonresident producer is considered to have satisfied this state's continuing education requirements if:

(a) the nonresident producer satisfies the nonresident producer's home state's continuing education requirements for a licensed insurance producer; and

(b) on the same basis as under this Subsection (6) the nonresident producer's home state considers satisfaction of Utah's continuing education requirements for a producer as satisfying the

continuing education requirements of the home state.

Section 140. Section **31A-23-207** is amended to read:

31A-23-207. Examination requirements.

(1) (a) The commissioner may require applicants for any particular class of license under Section 31A-23-204 to pass an examination as a requirement for a license, except that [~~no~~] an examination may not be required of applicants for:

(i) licenses under Subsection 31A-23-204(2); or

(ii) other license classifications recognized by the commissioner by rule as provided in Subsection 31A-23-204(6).

(b) The examination described in Subsection (1)(a):

(i) shall reasonably relate to the specific classes for which it is prescribed[~~. The examination~~]; and

(ii) may be administered by the commissioner or as otherwise specified by rule.

(2) The commissioner [~~may~~] shall waive the requirement of an examination for a nonresident applicant who [~~has held a similar license in his home state for the two years immediately preceding application in this state, but only if the applicant's state of residence has imposed upon the applicant examination requirements which are substantially as rigorous as those of this state.~~]:

(a) applies for an insurance producer license in this state;

(b) has been licensed for the same line of authority in another state; and

(c) (i) is licensed in the state described in Subsection (2)(b) at the time the applicant applies for an insurance producer license in this state; or

(ii) if the application is received within 90 days of the cancellation of the applicant's previous license:

(A) the prior state certifies that at the time of cancellation, the applicant was in good standing in that state; or

(B) the state's producer database records maintained by the National Association of Insurance Commissioners or the National Association of Insurance Commissioner's affiliates or subsidiaries, indicates that the producer is or was licensed in good standing for the line of authority

requested.

(3) (a) To become a resident licensee in accordance with Sections 31A-23-202 and 31A-23-203, a person licensed as an insurance producer in another state who moves to this state shall make application within 90 days of establishing legal residence in this state.

(b) A person who becomes a resident licensee under Subsection (3)(a) may not be required to meet prelicensing education or examination requirements to obtain any line of authority previously held in the prior state unless:

(i) the prior state would require a prior resident of this state to meet the prior state's prelicensing education or examination requirements to become a resident licensee; or

(ii) the commissioner imposes the requirements by rule.

[~~(3)~~] (4) This section's requirement may only be applied to applicants who are natural persons.

Section 141. Section **31A-23-209** is amended to read:

31A-23-209. Nonresident jurisdictional agreement.

(1) (a) [~~Nonresident applicants for licenses under this chapter shall~~] If a nonresident license applicant has a valid license from the nonresident license applicant's home state and the conditions of Subsection (1)(b) are met, the commissioner shall:

(i) waive any license requirement for a license under this chapter; and

(ii) issue the nonresident license applicant a nonresident producer license.

(b) Subsection (1)(a) applies if:

(i) the nonresident license applicant:

(A) is licensed as a resident in the nonresident license applicant's home state at the time the nonresident license applicant applies for a nonresident producer license;

(B) has submitted the proper request for licensure;

(C) has submitted to the commissioner:

(I) the application for licensure that the nonresident license applicant submitted to the applicant's home state; or

(II) a completed uniform application; and

(D) has paid the applicable fees under Section 31A-3-103;

(ii) the nonresident license applicant's license in the applicant's home state is in good standing; and

(iii) the nonresident license applicant's home state awards nonresident producer licenses to residents of this state on the same basis as this state awards licenses to residents of that home state.

(2) A nonresident applicant shall execute, in a form acceptable to the commissioner, an agreement to be subject to the jurisdiction of the Utah commissioner and courts on any matter related to the applicant's insurance activities in this state, on the basis of:

(a) service of process under Sections 31A-2-309 and 31A-2-310; or [~~other~~]

(b) service authorized:

(i) in the Utah Rules of Civil Procedure; or

(ii) under Section 78-27-25.

(3) The commissioner may verify the producer's licensing status through the producer database maintained by:

(a) the National Association of Insurance Commissioners; or

(b) an affiliate or subsidiary of the National Association of Insurance Commissioners.

(4) The commissioner may not assess a greater fee for an insurance license or related service to a person not residing in this state solely on the fact that the person does not reside in this state.

Section 142. Section **31A-23-211.7** is amended to read:

31A-23-211.7. Special requirements for variable annuity line of authority.

(1) Before applying for a variable [~~annuity~~] contracts line of authority, an agent, broker, or consultant shall be licensed under Section 61-1-3 as a:

(a) broker-dealer; or

(b) agent.

(2) An agent's, broker's, or consultant's variable [~~annuity~~] contracts line of authority is revoked on the day on which an agent's, broker's, or consultant's license under Section 61-1-3 is no longer valid.

Section 143. Section **31A-23-212** is amended to read:

31A-23-212. Form and contents of license.

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

(a) the name, address, and telephone number of the licensee;

(b) the license classifications under Section 31A-23-204;

(c) the date of license issuance; and

(d) any other information the commissioner considers necessary.

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

[~~(2)~~] (3) (a) An agency shall be licensed as an agency if the agency acts as:

(i) an agent;

(ii) a broker;

(iii) a surplus lines broker;

(iv) a managing general agent; or

(v) a consultant.

(b) The agency license [~~required~~] issued under [~~Subsections (2)~~] Subsection (3)(a) shall set forth the names of all natural persons licensed under this chapter who are authorized to act in those capacities for the agency in this state.

[~~(3)~~] (4) (a) So far as is practicable, the commissioner shall issue a single license to each agent, broker, or consultant for a single fee.

(b) For purposes of the fee described in Subsection (4)(a), the less expensive license is included within the most expensive license.

Section 144. Section **31A-23-216** is amended to read:

31A-23-216. Termination of license.

(1) A license issued under this chapter remains in force until:

(a) revoked, suspended, or limited under Subsection (2);

(b) lapsed under Subsection (3);

(c) surrendered to and accepted by the commissioner; or

(d) the licensee dies or is adjudicated incompetent as defined under Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons or Part 4, Protection of Property of Persons Under Disability and Minors.

[~~(2) (a) After an adjudicative proceeding under Title 63, Chapter 46b, Administrative Procedures Act, the commissioner may revoke, suspend, or limit in whole or in part the license of any agent, broker, surplus lines broker, or consultant who is found:~~]

[~~(i) to be unqualified;~~]

[~~(ii) to have violated an insurance statute, valid rule under Subsection 31A-2-201(3), or a valid order under Subsection 31A-2-201(4); or~~]

[~~(iii) if the licensee's methods and practices in the conduct of business endanger the legitimate interests of customers and the public.~~]

[~~(b) Every order suspending a license issued under this chapter shall specify the period for which the suspension is effective, but in no event may the period exceed 12 months.~~]

(2) (a) If the commissioner makes a finding under Subsection (2)(b), after an adjudicative proceeding under Title 63, Chapter 46b, Administrative Procedures Act, the commissioner may:

(i) revoke a license of an agent, broker, surplus lines broker, or consultant;

(ii) suspend for a specified period of 12 months or less a license of an agent, broker, surplus lines broker, or consultant; or

(iii) limit in whole or in part the license of any agent, broker, surplus lines broker, or consultant.

(b) The commissioner may take an action described in Subsection (2)(a) if the commissioner finds that the licensee:

(i) is unqualified for a license under Section 31A-23-203;

(ii) has violated:

(A) an insurance statute;

(B) a rule that is valid under Subsection 31A-2-201(3); or

(C) an order that is valid under Subsection 31A-2-201(4);

(iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other

delinquency proceedings in any state;

(iv) fails to pay any final judgment rendered against the person in this state within 60 days after the day the judgment became final;

(v) fails to meet the same good faith obligations in claims settlement that is required of admitted insurers;

(vi) is affiliated with and under the same general management or interlocking directorate or ownership as another insurance producer that transacts business in this state without a license;

(vii) refuses to be examined or to produce its accounts, records, and files for examination;

(viii) has an officer who refuses to:

(A) give information with respect to the administrator's affairs; or

(B) perform any other legal obligation as to an examination;

(ix) provided information in the license application that is:

(A) incorrect;

(B) misleading;

(C) incomplete; or

(D) materially untrue;

(x) has violated any insurance law, valid rule, or valid order of another state's insurance department;

(xi) has obtained or attempted to obtain a license through misrepresentation or fraud;

(xii) has improperly withheld, misappropriated, or converted any monies or properties received in the course of doing insurance business;

(xiii) has intentionally misrepresented the terms of an actual or proposed:

(A) insurance contract; or

(B) application for insurance;

(xiv) has been convicted of a felony;

(xv) has admitted or been found to have committed any insurance unfair trade practice or fraud;

(xvi) in the conduct of business in this state or elsewhere has:

(A) used fraudulent, coercive, or dishonest practices; or

(B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;

(xvii) has had an insurance license, or its equivalent, denied, suspended, or revoked in any other state, province, district, or territory;

(xviii) has forged another's name to:

(A) an application for insurance; or

(B) any document related to an insurance transaction;

(xix) has improperly used notes or any other reference material to complete an examination for an insurance license;

(xx) has knowingly accepted insurance business from an individual who is not licensed;

(xxi) has failed to comply with an administrative or court order imposing a child support obligation;

(xxii) has failed to:

(A) pay state income tax; or

(B) comply with any administrative or court order directing payment of state income tax;

(xxiii) has violated or permitted others to violate the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Secs. 1033 and 1034; or

(xxiv) has engaged in methods and practices in the conduct of business that endanger the legitimate interests of customers and the public.

(3) (a) Any license issued under this chapter shall lapse if the licensee fails to pay when due a fee under Section 31A-3-103.

(b) A licensee whose license lapses due to military service or some other extenuating circumstances such as long-term medical disability may request:

(i) reinstatement of the license; and

(ii) waiver of any of the following imposed for failure to comply with renewal procedures:

(A) an examination requirement;

(B) a fine; or

(C) other sanction imposed for failure to comply with renewal procedures.

(c) The commissioner shall by rule prescribe the license renewal and reinstatement procedures, in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act.

(4) A licensee under this chapter whose license is suspended, revoked, or lapsed, but who continues to act as a licensee, is subject to the penalties for acting as a licensee without a license.

(5) Any person licensed in this state shall immediately report to the commissioner:

(a) a suspension or revocation of that person's license in any other state, District of Columbia, or territory of the United States;

(b) the imposition of a disciplinary sanction imposed on that person by any other state, District of Columbia, or territory of the United States; and

(c) a judgment or injunction entered against that person on the basis of conduct involving fraud, deceit, misrepresentation, or violation of an insurance law or rule.

(6) An order revoking a license under Subsection (2) may specify a time, not to exceed five years, within which the former licensee may not apply for a new license. If no time is specified, the former licensee may not apply for a new license for five years without express approval by the commissioner.

(7) Any person whose license is suspended or revoked under Subsection (2) shall, when the suspension ends or a new license is issued, pay all fees that would have been payable if the license had not been suspended or revoked, unless the commissioner by order waives the payment of the interim fees. If a new license is issued more than three years after the revocation of a similar license, this subsection applies only to the fees that would have accrued during the three years immediately following the revocation.

(8) The division shall promptly withhold, suspend, restrict, or reinstate the use of a license issued under this part if so ordered by a court.

Section 145. Section **31A-23-218** is amended to read:

31A-23-218. Temporary insurance producer license -- Trustee for terminated licensee's business.

(1) (a) [~~Upon the request of the spouse, guardian, conservator, or personal representative of a deceased or disabled agent or broker, or upon the request of a person whose license has been~~

~~terminated under Section 31A-23-216, the commissioner may appoint a trustee to provide continuing service to the insureds who procured insurance through the deceased, disabled, or unlicensed person.~~] The commissioner may issue a temporary insurance producer license:

(i) to a person listed in Subsection (1)(b):

(A) if the commissioner considers that the temporary license is necessary:

(I) for the servicing of an insurance business in the public interest; and

(II) to provide continued service to the insureds who procured insurance in a circumstance described in Subsection (1)(b);

(B) for a period not to exceed 180 days; and

(C) without requiring an examination; or

(ii) in any other circumstance:

(A) if the commissioner considers the public interest will best be served by issuing the temporary license;

(B) for a period not to exceed 180 days; and

(C) without requiring an examination.

(b) The commissioner may issue a temporary insurance producer license in accordance with Subsection (1)(a) to:

(i) the surviving spouse or court-appointed personal representative of a licensed insurance producer who dies or becomes mentally or physically disabled to allow adequate time for:

(A) the sale of the insurance business owned by the producer;

(B) recovery or return of the producer to the business; or

(C) the training and licensing of new personnel to operate the producer's business;

(ii) to a member or employee of a business entity licensed as an insurance producer upon the death or disability of an individual designated in:

(A) the business entity application; or

(B) the license; or

(iii) the designee of a licensed insurance producer entering active service in the armed forces of the United States of America.

(2) If a person's license is terminated under Section 31A-23-216, the commissioner may appoint a trustee to provide in the public interest continuing service to the insureds who procured insurance through the person whose license is terminated:

(a) at the request of the person whose license is terminated; or

(b) upon the commissioner's own initiative.

(3) This section does not apply if the deceased or disabled agent or broker [~~owned or owns no~~] does not or did not own any ownership interest in the accounts and associated expiration lists [~~which~~] that were previously serviced by the agent or broker. [~~Any~~]

(4) (a) A person issued a temporary license under Subsection (1) receives the license and shall perform the duties under the license subject to the commissioner's authority to:

(i) require a temporary licensee to have a suitable sponsor who:

(A) is a licensed producer; and

(B) assumes responsibility for all acts of the temporary licensee; or

(ii) impose other requirements that are:

(A) designed to protect the insureds and the public; and

(B) similar to the condition described in Subsection (4)(a)(i).

(b) A trustee appointed under [~~this section~~] Subsection (2) shall [~~receive his appointment~~] be appointed and perform [~~his~~] the trustee's duties subject to the [~~following~~] terms and conditions[~~:~~] described in Subsections (4)(b)(i) through (vi).

[~~(1) Trustees~~] (i) (A) A trustee appointed under [~~this section~~] Subsection (2) shall be licensed
under this chapter to perform the services required by the trustor's clients.

(B) When possible, the commissioner shall appoint a trustee who is no longer actively engaged on [~~his~~] the trustee's own behalf in business as an agent or broker.

(C) The commissioner shall only select [~~persons~~] a person to act as trustee who [~~are~~] is trustworthy and competent to perform the necessary services.

[~~(2)~~] (ii) (A) If the deceased, disabled, or unlicensed person for whom the trustee is acting was an agent, the insurers through which the former agent's business was written shall cooperate with the trustee in allowing [~~him~~] the trustee to service the policies written through the insurer.

(B) The trustee shall abide by the terms of the agency agreement between the former agent and the issuing insurer, except that terms in those agreements terminating the agreement upon the death, disability, or license termination of the former agent do not bar the trustee from continuing to act under the agreement.

[~~(3)~~] (iii) (A) The commissioner shall set the trustee's compensation, which:

(I) may be stated in terms of a percentage of commissions[~~, but which is required to~~]; and

(II) shall be equitable.

(B) The compensation shall be paid exclusively from:

(I) the commissions generated by the former agent or broker's insurance accounts serviced by the trustee; and [~~from~~]

(II) other funds the former agent or broker or [~~his~~] the agent's or broker's successor in interest agree to pay.

(C) The trustee has no special priority to commissions over the former agent or broker's creditors.

[~~(4) Neither the~~] (iv) (A) The commissioner [~~nor~~] or the state [~~of Utah~~] may not be held liable for errors or omissions of:

(I) the former agent or broker; or

(II) the trustee.

(B) The trustee may not be held liable for errors and omissions [~~which~~] that were caused in any material way by the negligence of the former agent or broker.

(C) The trustee may be held liable for errors and omissions which arise solely from the trustee's negligence.

(D) The trustee's compensation level shall be sufficient to allow the trustee to purchase errors and omissions coverage, if that coverage is not provided the trustee by:

(I) the former agent or broker; or [~~his~~]

(II) the agent's or broker's successor in interest.

[~~(5)~~] (v) (A) It is a breach of the trustee's fiduciary duty to capture the accounts of trustor's clients, either directly or indirectly.

(B) The trustee may not purchase the accounts or expiration lists of the former agent or broker, unless the commissioner expressly ratifies the terms of the sale.

(C) The commissioner may adopt rules [~~which~~] that:

(I) further define the trustee's fiduciary duties; and

(II) explain how the trustee is to carry out [~~his~~] the trustee's responsibilities.

[~~(6)~~] (vi) (A) The trust may be terminated by:

(I) the commissioner; or [~~by~~]

(II) the person that requested the trust be established.

(B) The trust is terminated by written notice being delivered to:

(I) the trustee; and

(II) the commissioner.

(5) (a) The commissioner may by order:

(i) limit the authority of any temporary licensee or trustee in any way the commissioner considers necessary to protect insureds and the public; and

(ii) revoke a temporary license or trustee's appointment if the commissioner finds that the insureds or the public are endangered.

(b) A temporary license or trustee's appointment may not continue after the owner or personal representative disposes of the business.

Section 146. Section **31A-23-302** is amended to read:

31A-23-302. Unfair marketing practices.

(1) (a) (i) [~~A person who is or should be licensed under this title, an employee or agent of that licensee or person who should be licensed, a person whose primary interest is as a competitor of a person licensed under this title, and a person on behalf of any of these persons~~] Any of the following may not make or cause to be made any communication that contains false or misleading information, relating to an insurance contract, any insurer, or other licensee under this title, including information that is false or misleading because it is incomplete[~~.~~]:

(A) a person who is or should be licensed under this title;

(B) an employee or agent of a person described in Subsection (1)(a)(i)(A);

(C) a person whose primary interest is as a competitor of a person licensed under this title; and

(D) a person on behalf of any of the persons listed in this Subsection (1)(a)(i).

(ii) As used in this Subsection (1), "false or misleading information" includes:

(A) assuring the nonobligatory payment of future dividends or refunds of unused premiums in any specific or approximate amounts, but reporting fully and accurately past experience is not false or misleading information; and

(B) with intent to deceive a person examining it, filing a report, making a false entry in a record, or wilfully refraining from making a proper entry in a record.

(iii) An insurer or other licensee under this title may not:

(A) use any business name, slogan, emblem, or related device that is misleading or likely to cause the insurer or other licensee to be mistaken for another insurer or other licensee already in business[.]; or

(B) use any advertisement or other insurance promotional material that would cause a reasonable person to mistakenly believe that a state or federal government agency:

(I) is responsible for the insurance sales activities of the person;

(II) stands behind the credit of the person;

(III) guarantees any returns on insurance products of or sold by the person; or

(IV) is a source of payment of any insurance obligation of or sold by the person.

(iv) A person who is not an insurer may not assume or use any name that deceptively implies or suggests that it is an insurer.

(v) A person other than persons licensed as health maintenance organizations under Chapter 8 may not use the term "Health Maintenance Organization" or "HMO" in referring to itself.

(b) If an insurance agent or third party administrator distributes cards or documents, exhibits a sign, or publishes an advertisement that violates Subsection (1) (a), with reference to a particular insurer that the agent represents, or for whom the third party administrator processes claims, and if the cards, documents, signs, or advertisements are supplied or approved by that insurer, the agent's or the third party administrator's violation creates a rebuttable presumption that the violation was

also committed by the insurer.

(2) (a) (i) An [~~insurer or~~] insurer or licensee under this chapter, or an officer or employee of either may not induce any person to enter into or continue an insurance contract or to terminate an existing insurance contract by offering benefits not specified in the policy to be issued or continued, including premium or commission rebates.

(ii) An insurer may not make or knowingly allow any agreement of insurance that is not clearly expressed in the policy to be issued or renewed.

(iii) Subsection (2)(a) does not preclude:

(A) insurers from reducing premiums because of expense savings;

(B) the usual kinds of social courtesies not related to particular transactions; or

(C) an insurer from receiving premiums under an installment payment plan.

(b) An agent, broker, or insurer may not absorb the tax under Section 31A-3-301.

(c) (i) A title insurer or agent or any officer or employee of either may not pay, allow, give, or offer to pay, allow, or give, directly or indirectly, as an inducement to obtaining any title insurance business, any rebate, reduction, or abatement of any rate or charge made incident to the issuance of the insurance, any special favor or advantage not generally available to others, or any money or other consideration or material inducement.

(ii) "Charge made incident to the issuance of the insurance" includes escrow, settlement, and closing charges, and any other services that are prescribed by the commissioner.

(iii) An insured or any other person connected, directly or indirectly, with the transaction, including a mortgage lender, real estate broker, builder, attorney, or any officer, employee, or agent of any of them, may not knowingly receive or accept, directly or indirectly, any benefit referred to in Subsection (2)(c)(i).

(3) (a) An insurer may not unfairly discriminate among policyholders by charging different premiums or by offering different terms of coverage, except on the basis of classifications related to the nature and the degree of the risk covered or the expenses involved.

(b) Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, blanket, or franchise policy, and the terms of those policies are not unfairly

discriminatory merely because they are more favorable than in similar individual policies.

(4) A person who is or should be licensed under this title, an employee or agent of that licensee or person who should be licensed, a person whose primary interest is as a competitor of a person licensed under this title, and one acting on behalf of any of these persons, may not commit or enter into any agreement to participate in any act of boycott, coercion, or intimidation that tends to produce an unreasonable restraint of the business of insurance or a monopoly in that business.

(5) (a) A person may not restrict in the choice of an insurer or insurance agent or broker, another person who is required to pay for insurance as a condition for the conclusion of a contract or other transaction or for the exercise of any right under a contract. The person requiring the coverage may, however, reserve the right to disapprove the insurer or the coverage selected on reasonable grounds.

(b) The form of corporate organization of an insurer authorized to do business in this state is not a reasonable ground for disapproval, and the commissioner may by rule specify additional grounds that are not reasonable. This Subsection (5) does not bar an insurer from declining an application for insurance.

(6) A person may not make any charge other than insurance premiums and premium financing charges for the protection of property or of a security interest in property, as a condition for obtaining, renewing, or continuing the financing of a purchase of the property or the lending of money on the security of an interest in the property.

(7) (a) An agent may not refuse or fail to return promptly all indicia of agency to the principal on demand.

(b) A licensee whose license is suspended, limited, or revoked under Section 31A-2-308, 31A-23-216, or 31A-23-217 may not refuse or fail to return the license to the commissioner on demand.

(8) A person may not engage in any other unfair method of competition or any other unfair or deceptive act or practice in the business of insurance, as defined by the commissioner by rule, after a finding that they are misleading, deceptive, unfairly discriminatory, provide an unfair inducement, or unreasonably restrain competition.

Section 147. Section **31A-23-303** is amended to read:

31A-23-303. Inherent unsuitability.

[~~In the event~~] (1) If the commissioner finds after a hearing that a certain type of [~~disability~~] accident and health insurance, life insurance, or annuity product is inherently unsuitable for persons of certain ages or in certain conditions of health, the commissioner shall [~~promulgate~~] make a rule declaring [~~this disability~~] the accident and health insurance, life insurance, or annuity product as inherently unsuitable for persons of certain ages or in certain conditions of health. [~~No disability~~]

(2) An accident and health insurance, life insurance, or annuity product that is subject to the rule may not be sold to a person for whom the product has been determined as inherently unsuitable unless that person purchasing the product signs a receipt acknowledging having received a statement [~~which~~] that expresses that the product has been determined by the commissioner to be inherently unsuitable for persons of certain ages or in certain conditions of health.

(3) Unless the insurer or its agent establishes that its sale of coverage [~~which~~] is inconsistent with the rule made under Subsection (1) is due to excusable neglect, the purchaser may treat the sale as voidable, if acted upon by the insured within a two-year period from the date of sale.

Section 148. Section **31A-23-307** is amended to read:

31A-23-307. Title insurance agents' business.

A title insurance agent may engage in the escrow, settlement, or closing business, or any combination of such businesses, and operate as escrow, settlement, or closing agent provided that all the following exist:

(1) The title insurance agent is properly licensed under this chapter.

(2) (a) (i) All funds deposited with the agent in connection with any escrow, settlement, or closing are deposited in a federally insured financial institution in separate trust accounts, with the funds being the property of the persons entitled to them under the provisions of the escrow, settlement, or closing.

(ii) The funds shall be segregated escrow by escrow, settlement by settlement, or closing by closing in the records of the agent. [~~These funds~~]

(iii) Earnings on funds held in escrow may be paid out of the escrow account to any person

in accordance with the provisions of the escrow agreement if the agreement does not otherwise provide for payment of the earnings or any portion of the earnings on the escrow funds.

(iv) Funds held in escrow:

(A) are not subject to any debts of the agent; and

(B) may only be used to fulfill the terms of the individual escrow, settlement, or closing under which the funds were accepted. [~~None of the funds~~]

(v) Funds held in escrow may not be used until all conditions of the escrow, settlement, or closing have been met.

[~~(b) Any interest received on funds deposited with the agent in connection with any escrow, settlement, or closing shall be paid over to the depositing party to the escrow, settlement, or closing and may not be transferred to the account of the agent.~~]

(b) Assets or property other than escrow funds received by an agent in accordance with an escrow agreement shall be maintained in a manner that will:

(i) reasonably preserve and protect the asset or property from loss, theft, or damages; and

(ii) otherwise comply with all general duties and responsibilities of a fiduciary or bailee.

(c) [~~No~~] A check may not be drawn, executed or dated, or funds otherwise disbursed unless the segregated escrow account from which funds are to be disbursed contains a sufficient credit balance consisting of collected or cleared funds at the time the check is drawn, executed or dated, or funds are otherwise disbursed.

(d) As used in this Subsection (2), funds are considered to be "collected or cleared," and may be disbursed as follows:

(i) cash may be disbursed on the same day it is deposited;

(ii) wire transfers may be disbursed on the same day they are deposited;

(iii) cashier's checks, certified checks, teller's checks, U.S. Postal Service money orders, and checks drawn on a Federal Reserve Bank or Federal Home Loan Bank may be disbursed on the day following the date of deposit; and

(iv) other checks or deposits may be disbursed within the time limits provided under the Expedited Funds Availability Act, 12 U.S.C. Section 4001 et seq., as amended, and related

regulations of the Federal Reserve System or upon written notification from the financial institution to which the funds have been deposited, that final settlement has occurred on the deposited item.

(3) The title insurance agent shall maintain records of all receipts and disbursements of escrow, settlement, and closing funds.

(4) The title insurance agent shall comply with any rules adopted by the commissioner governing escrows, settlements, or closings.

Section 149. Section **31A-23-310** is amended to read:

31A-23-310. Trust obligation for funds collected.

(1) Every agent or broker is a trustee for all funds received or collected as an agent or broker for forwarding to insurers or to insureds. Except for amounts necessary to pay bank charges, and except for funds paid by insureds and belonging in part to the agent or broker as fees or commissions, an agent or broker may not commingle trust funds with the agent or broker's own funds or with funds held in any other capacity. Except as provided under Subsection (4), every agent or broker owes to insureds and insurers the fiduciary duties of a trustee with respect to money to be forwarded to insurers or insureds through the agent or broker. Unless the funds are sent to the appropriate payee by the close of the next business day after their receipt, the licensee shall deposit them in an account authorized under Subsection (2). Funds so deposited shall remain in an account authorized under Subsection (2) until sent to the appropriate payee.

(2) Funds required to be deposited under Subsection (1) shall be deposited:

(a) in a federally insured trust account with a financial institution located in this state; or

(b) in some other account, approved by the commissioner by rule or order, providing safety comparable to federally insured trust accounts.

(3) It is not a violation of Subsection (2)(a) if the amounts in the accounts exceed the amount of the federal insurance on the accounts.

(4) A trust account into which funds are deposited may be interest bearing. [~~Except as provided under Subsection 31A-23-307(2)(b), the~~] The interest accrued on the account may be paid to the agent or broker, so long as the agent or broker otherwise complies with this section and with the contract with the insurer.

(5) A financial institution or other organization holding trust funds under this section may not offset or impound trust account funds against debts and obligations incurred by the agent or broker.

(6) Any licensee who, not being lawfully entitled thereto, diverts or appropriates any portion of the funds held under Subsection (1) to the licensee's own use, is guilty of theft under Title 76, Chapter 6, Part 4. Section 76-6-412 applies in determining the classification of the offense. Sanctions under Section 31A-2-308 also apply.

Section 150. Section **31A-23-312** is amended to read:

31A-23-312. Place of business and residence address -- Records.

(1) (a) All licensees under this chapter shall register with the commissioner the address and telephone numbers of their principal place of business.

(b) If the licensee is an individual, [~~he~~] in addition to complying with Subsection (1)(a) the individual shall [~~also~~] provide [~~his~~] to the commissioner the individual's residence address and telephone number. [~~Licensees~~]

(c) A licensee shall notify the commissioner, in writing, within 30 days of any change of address or telephone number.

(2) (a) Except as provided under Subsection (3), every licensee under this chapter shall keep at the principal place of business address registered under Subsection (1), [~~a record~~] separate and distinct books and records of all transactions consummated under the Utah license. [~~The record~~]

(b) The books and records described in Subsection (2)(a) shall:

(i) be in an organized form;

(ii) be available to the commissioner for inspection upon reasonable notice; and [~~shall~~]

(iii) include all of the following:

[~~(a)~~] (A) if the licensee is an agent or broker:

[~~(i)~~] (I) a record of each insurance contract procured by or issued through the licensee, with the names of insurers and insureds, the amount of premium and commissions or other compensation, and the subject of the insurance;

[~~(ii)~~] (II) the names of any other agents or brokers from whom business is accepted, and of

persons to whom commissions or allowances of any kind are promised or paid; and

(III) a record of all consumer complaints forwarded to the licensee by an insurance regulator;

[~~(b)~~] (B) if the licensee is a consultant, a record of each agreement outlining the work performed and the fee for the work; and

[~~(c)~~] (C) any additional information which:

(I) is customary for a similar business[~~,~~]; or [~~which~~]

(II) may reasonably be required by the commissioner by rule.

(3) Subsection (2) is satisfied if the books and records specified in [~~that~~] Subsection (2) can be obtained immediately from a central storage place or elsewhere by on-line computer terminals located at the registered address.

(4) An agent who represents only a single insurer satisfies Subsection (2) if the insurer maintains the books and records pursuant to Subsection (2) at a place satisfying Subsections (1) and (5).

(5) (a) The books and records maintained [~~as to a transaction~~] under Subsection (2) or Section 31A-23-313 shall be available for the inspection of the commissioner during all business hours for a period of time after the date of the transaction as specified by the commissioner by rule, but in no case for less than three years.

(b) Discarding books and records after the applicable record retention period has expired does not place the licensee in violation of a later-adopted longer record retention period.

Section 151. Section **31A-23-317** is enacted to read:

31A-23-317. Financial services insurance activities regulation.

(1) It is the intent of the Legislature that the regulation of insurance activities of any person in this state be based on functional regulation principles established in the Gramm-Leach-Bliley Act of 1999, Pub. L. No. 106-102.

(2) The insurance activities of any person in this state shall be functionally regulated by the commissioner subject to Sections 104, 301-308, 501-507, and 509 of the Gramm-Leach-Bliley Act of 1999, Pub. L. No. 106-102.

(3) Under Title 63, Chapter 46a, Utah Administrative Rulemaking Act, the commissioner

may adopt rules consistent with Section 104(d) of the Gramm-Leach-Bliley Act of 1999, Pub. L. No. 106-102, and the functional regulation of insurance activities of any person otherwise subject to the jurisdiction of the commissioner in this state described in Subsection (2).

(4) The commissioner shall consult and coordinate with the commissioner of the Department of Financial Institutions and the director of the Division of Securities for the purpose of assuring, to the extent possible, that the rules prescribed by the department are consistent and comparable with federal regulations governing the insurance, banking, and securities industries.

Section 152. Section **31A-23-404** is amended to read:

31A-23-404. Sharing commissions.

(1) (a) Except as provided in Subsection 31A-15-103(3), a licensee under this chapter or an insurer may only pay consideration or reimburse out-of-pocket expenses to a person if the licensee knows that the person is licensed under this chapter to act as an agent or broker in Utah as to the particular type of insurance.

(b) A person may only accept commission compensation or other compensation as an agent, broker, or consultant that is directly or indirectly the result of any insurance transaction if that person is licensed under this chapter to act as an agent or broker as to the particular type of insurance.

(2) (a) Except as provided in Section 31A-23-301, a consultant may not pay or receive any commission or other compensation that is directly or indirectly the result of any insurance transaction.

(b) A consultant may share a consultant fee or other compensation received for consulting services performed within Utah only with another consultant licensed under this chapter, and only to the extent that the other consultant contributed to the services performed.

(3) This section does not prohibit the payment of renewal commissions to former licensees under this chapter, former Title 31, Chapter 17, or their successors in interest under a deferred compensation or agency sales agreement.

(4) This section does not prohibit compensation paid to or received by an individual for referral of a potential customer that seeks to purchase or obtain an opinion or advice on an insurance product if:

(a) the person is not licensed to sell insurance;

(b) the person sells or provides opinions or advice on the product; and

(c) the compensation does not depend on whether the referral results in a purchase or sale.

[~~(4)~~] (5) In selling any policy of title insurance, no sharing of commissions under Subsection (1) may occur if it will result in an unlawful rebate, or in compensation in connection with controlled business, or in payment of a forwarding fee or finder's fee. A person may share compensation for the issuance of a title insurance policy only to the extent that he contributed to the search and examination of the title or other services connected with it.

[~~(5)~~] (6) This section does not apply to bail bond agents or bail enforcement agents as defined in Section 31A-35-102.

Section 153. Section **31A-23-503** is amended to read:

31A-23-503. Duties of insurers.

(1) The insurer shall have on file an independent financial examination, in a form acceptable to the commissioner, of each managing general agent with which it has done business.

(2) If a managing general agent establishes loss reserves, the insurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the managing general agent. This is in addition to any other required loss reserve certification.

(3) The insurer shall at least semiannually conduct an on-site review of the underwriting and claims processing operations of the managing general agent.

(4) Binding authority for all reinsurance contracts or participation in insurance or reinsurance syndicates shall rest with an officer of the insurer, who may not be affiliated with the managing general agent.

(5) Within 30 days after entering into or terminating a contract with a managing general agent, the insurer shall provide written notification of the appointment or termination to the commissioner. A notice of appointment of a managing general agent shall include:

(a) a statement of duties that the applicant is expected to perform on behalf of the insurer;

(b) the lines of insurance for which the applicant is to be authorized to act; and

(c) any other information the commissioner may request.

(6) An insurer shall review its books and records each quarter to determine if any producer, as defined by Subsection 31A-23-102[~~(13)~~](17), has become a managing general agent as defined in Subsection 31A-23-102[~~(12)~~](15). If the insurer determines that a producer has become a managing general agent, the insurer shall promptly notify the producer and the commissioner of the determination. The insurer and producer shall fully comply with the provisions of this chapter within
30 days.

(7) An insurer may not appoint officers, directors, employees, subproducers, or controlling shareholders of its managing general agents to its board of directors. This Subsection (7) does not apply to relationships governed by Title 31A, Chapter 16, Insurance Holding Companies, or Chapter 23, Part 6, Broker Controlled Insurers, if it applies.

Section 154. Section **31A-23-601** is amended to read:

31A-23-601. Applicability.

This part applies to licensed insurers, as defined in Subsection 31A-23-102(11), which are either domiciled in this state or domiciled in a state that does not have a substantially similar law. All provisions of Title 31A, Chapter 16, Insurance Holding Companies, to the extent they are not superseded by this part, continue to apply to all parties within holding company systems subject to this part.

Section 155. Section **31A-23-702** is amended to read:

31A-23-702. Required contract provisions -- Reinsurance intermediary-broker.

Transactions between a reinsurance intermediary-broker and the insurer it represents in that capacity may only be entered into pursuant to a written authorization, which specifies the responsibilities of each party. The authorization shall, at a minimum, provide that the reinsurance intermediary-broker:

(1) may have his authority terminated by the insurer at any time;

(2) will render accounts to the insurer accurately detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing to the reinsurance intermediary-broker, and that he will remit all funds due to the insurer within 30 days

of receipt;

(3) shall hold, in a fiduciary capacity, all funds collected for the insurer's account in a bank, which is a qualified [~~U.S.~~] United States financial institution;

(4) will comply with Section 31A-23-703;

(5) will comply with the written standards established by the insurer for the cession or retrocession of all risks; and

(6) will disclose to the insurer any relationship with any reinsurer to which business will be ceded or retroceded.

Section 156. Section **31A-23-705** is amended to read:

31A-23-705. Required contract provisions -- Reinsurance intermediary-manager.

Transactions between a reinsurance intermediary-manager and the reinsurer it represents in that capacity may only be entered into pursuant to a written contract, which specifies the responsibilities of each party, and which shall be approved by the reinsurer's board of directors. At least 30 days before the reinsurer assumes or cedes business through the producer, a true copy of the approved contract shall be filed with the commissioner for approval. The contract shall, at a minimum, provide or require the following:

(1) The reinsurer may terminate the contract for cause upon written notice to the reinsurance intermediary-manager. The reinsurer may immediately suspend the authority of the reinsurance intermediary-manager to assume or cede business during the pendency of any dispute regarding the cause for termination.

(2) The reinsurance intermediary-manager will render accounts to the reinsurer accurately detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by, or owing to the reinsurance intermediary-manager, and he shall remit all funds due under the contract to the reinsurer at least monthly.

(3) All funds collected for the reinsurer's account will be held by the reinsurance intermediary-manager in a fiduciary capacity in a bank which is a qualified [~~U.S.~~] United States financial institution. The reinsurance intermediary-manager may retain no more than three months estimated claims payments and allocated loss adjustment expenses. The reinsurance

intermediary-manager shall maintain a separate bank account for each reinsurer that it represents.

(4) For at least ten years after expiration of each contract of reinsurance transacted by the reinsurance intermediary-manager, he shall keep a complete record for each transactions showing:

(a) the type of contract, limits, underwriting restrictions, classes of risks, and territory;

(b) period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation, and disposition of outstanding reserves on covered risks;

(c) reporting and settlement requirements of balances;

(d) rates used to compute the reinsurance premium;

(e) names and addresses of reinsurers;

(f) rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance intermediary-manager;

(g) related correspondence and memoranda;

(h) proof of placement;

(i) details regarding retrocessions handled by the reinsurance intermediary-manager, as permitted by Subsection 31A-23-707 (4), including the identity of retrocessionaires and percentage of each contract assumed or ceded;

(j) financial records, including premium and loss accounts; and

(k) when the reinsurance intermediary-manager places a reinsurance contract on behalf of a ceding insurer:

(i) directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(ii) if placed through a representative of the assuming reinsurer, other than an employee, written evidence that the reinsurer has delegated binding authority to the representative.

(5) The reinsurer will have access and the right to copy all accounts and records maintained by the reinsurance intermediary-manager which are related to its business, in a form usable by the reinsurer.

(6) The contract cannot be assigned in whole or in part by the reinsurance intermediary-manager.

(7) The reinsurance intermediary-manager will comply with the written underwriting and rating standards established by the insurer for the acceptance, rejection, or cession of all risks.

(8) The contract shall set forth the rates, terms, and purposes of commissions, charges, and other fees which the reinsurance intermediary-manager may levy against the reinsurer.

(9) If the contract permits the reinsurance intermediary-manager to settle claims on behalf of the reinsurer:

(a) All claims will be reported to the reinsurer in a timely manner.

(b) A copy of the claim file will be sent to the reinsurer at its request or as soon as it becomes
known that the claim:

(i) has the potential to exceed the lesser of an amount determined by the commissioner or the limit set by the reinsurer;

(ii) involves a coverage dispute;

(iii) may exceed the reinsurance intermediary-manager claims settlement authority;

(iv) is open for more than six months; or

(v) is closed by payment of the lesser of an amount set by the commissioner or an amount set by the reinsurer.

(c) All claim files will be the joint property of the reinsurer and reinsurance intermediary-manager. However, upon an order of liquidation of the reinsurer the files shall become the sole property of the reinsurer or its estate. The reinsurance intermediary-manager shall have reasonable access to and the right to copy the files on a timely basis.

(d) Any settlement authority granted to the reinsurance intermediary-manager may be terminated for cause upon the reinsurer's written notice to the reinsurance intermediary-manager, or upon the termination of the contract. The reinsurer may suspend the settlement authority during the pendency of the dispute regarding the cause of termination.

(10) If the contract provides for a sharing of interim profits by the reinsurance intermediary-manager, that the contract shall provide interim profits will not be paid until one year after the end of each underwriting period for property business and five years after the end of each underwriting period for casualty business, or a later time period set by the commissioner for

specified lines of insurance, and not until the adequacy of reserves on remaining claims has been verified pursuant to Subsection 31A-23-707 (3).

(11) The reinsurance intermediary-manager will annually provide the reinsurer with a statement of its financial condition prepared by an independent certified public accountant.

(12) The reinsurer shall at least semi-annually conduct an on-site review of the underwriting and claims processing operations of the reinsurance intermediary-manager.

(13) The reinsurance intermediary-manager will disclose to the reinsurer any relationship it has with any insurer prior to ceding or assuming any business with the insurer pursuant to this contract.

(14) Within the scope of its actual or apparent authority the acts of the reinsurance intermediary-manager shall be considered to be the acts of the reinsurer on whose behalf it is acting.

Section 157. Section **31A-25-102** is amended to read:

31A-25-102. Scope and purposes.

(1) This chapter applies to all third party administrators.

(2) The purposes of this chapter include:

(a) encouraging disclosure of contracts between insurers and third party administrators, both to potential insureds and to the commissioner;

(b) promoting the financial responsibility of [~~insurance~~] third party administrators;

(c) subjecting persons administering insurance in Utah to the jurisdiction of the Utah commissioner and courts; [~~and~~]

(d) regulating [~~insurance~~] third party administrators' practices in conformity with the general purposes of [~~the Insurance Code.~~] this title; and

(e) governing the qualifications and procedures for the licensing of third party administrators.

Section 158. Section **31A-25-202** is amended to read:

31A-25-202. Application for license.

(1) (a) An application for a license as a third party administrator shall be:

(i) made to the commissioner on forms and in a manner [~~he~~] the commissioner prescribes[~~;~~];

and [~~be~~]

(ii) accompanied by the applicable fee, which is not refundable if the application is denied.

(b) The application for a license as a third party administrator shall:

(i) state the applicant's:

(A) social security number; or

(B) federal employer identification number;

(ii) provide information about:

(A) the applicant's identity[~~,~~];

(B) the applicant's personal history, experience, education, and business record[~~,~~];

(C) if the applicant is a natural person, whether the applicant is 18 years of age or older; and

(D) whether the applicant has committed an act that is a ground for denial, suspension, or revocation as set forth in Section 31A-25-208; and

(iii) any other information as the commissioner reasonably requires.

(2) The commissioner may require documents reasonably necessary to verify the information contained in the application.

(3) The following are private records under Subsection 63-2-302(1)(g):

(a) an applicant's social security number; and

(b) an applicant's federal employer identification number.

Section 159. Section **31A-25-203** is amended to read:

31A-25-203. General requirements for license issuance.

(1) The commissioner shall issue a license to act as a third party administrator to any person who has:

(a) satisfied the character requirements under Section 31A-25-204;

(b) satisfied the financial responsibility requirement under Section 31A-25-205;

(c) if a nonresident, complied with Section 31A-25-206; and

(d) paid the applicable fees under Section 31A-3-103.

(2) The license of each third party administrator licensed under former Title 31, Chapter 15a, is continued under this chapter.

(3) (a) This Subsection (3) applies to the following persons:

(i) an applicant for a third party administrator's license; or

(ii) a licensed third party administrator.

(b) A person described in Subsection (3)(a) shall report to the commissioner:

(i) any administrative action taken against the person:

(A) in another jurisdiction; or

(B) by another regulatory agency in this state; and

(ii) any criminal prosecution taken against the person in any jurisdiction.

(c) The report required by Subsection (3)(b) shall:

(i) be filed:

(A) at the time the person applies for a third party administrator's license; or

(B) within 30 days of the initiation of an action or prosecution described in Subsection (3)(b); and

(ii) include a copy of the complaint or other relevant legal documents related to the action or prosecution described in Subsection (3)(b).

(4) (a) The department may request concerning a person applying for a third party administrator's license:

(i) criminal background information maintained pursuant to Title 53, Chapter 10, Part 2, from the Bureau of Criminal Identification; and

(ii) complete Federal Bureau of Investigation criminal background checks through the national criminal history system.

(b) Information obtained by the department from the review of criminal history records received under Subsection (4)(a) shall be used by the department for the purposes of:

(i) determining if a person satisfies the character requirements under Section 31A-25-204 for issuance or renewal of a license;

(ii) determining if a person has failed to maintain the character requirements under Section 31A-25-204; and

(iii) preventing persons who violate the federal Violent Crime Control and Law Enforcement

Act of 1994, 18 U.S.C. Secs. 1033 and 1034, from engaging in the business of insurance in the state.

(c) If the department requests the criminal background information, the department shall:

(i) pay to the Department of Public Safety the costs incurred by the Department of Public Safety in providing the department criminal background information under Subsection (4)(a)(i);

(ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau of Investigation in providing the department criminal background information under Subsection (4)(a)(ii); and

(iii) charge the person applying for a license or for renewal of a license a fee equal to the aggregate of Subsections (4)(c)(i) and (ii).

Section 160. 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~~] Subsection (2)(a) 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:

(i) the greater of:

(A) the premiums received during the previous calendar year; or

(B) claims paid through the administrator during the previous calendar year[~~,~~]; or[~~,~~]

(ii) 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 Subsection 31A-1-301[~~(90)~~](111). 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 161. Section **31A-25-206** is amended to read:

31A-25-206. Nonresident jurisdictional agreement.

(1) (a) [~~Nonresident applicants for licenses under this chapter~~] If a nonresident license applicant has a valid license from the nonresident license applicant's home state and the conditions of Subsection (1)(b) are met, the commissioner shall:

(i) waive any license requirement for a license under this chapter; and

(ii) issue the nonresident license applicant a nonresident third party administrator license.

(b) Subsection (1)(a) applies if:

(i) the nonresident license applicant:

(A) is licensed as a resident in the nonresident license applicant's home state at the time the nonresident license applicant applies for a nonresident third party administrator license;

(B) has submitted the proper request for licensure;

(C) has submitted to the commissioner:

(I) the application for licensure that the nonresident license applicant submitted to the applicant's home state; or

(II) a completed uniform application; and

(D) has paid the applicable fees under Section 31A-3-103;

(ii) the nonresident license applicant's license in the applicant's home state is in good standing; and

(iii) the nonresident license applicant's home state awards nonresident third party administrator licenses to residents of this state on the same basis as this state awards licenses to residents of that home state.

(2) A nonresident applicant shall execute in a form acceptable to the commissioner an agreement to be subject to the jurisdiction of the Utah commissioner and courts on any matter related to [~~his~~] the applicant's insurance activities in Utah, on the basis of:

(a) service of process under Sections 31A-2-309 and 31A-2-310; or

(b) other service authorized in the Utah Rules of Civil Procedure.

(3) The commissioner may verify the third party administrator's licensing status through the database maintained by:

(a) the National Association of Insurance Commissioners; or

(b) an affiliate or subsidiary of the National Association of Insurance Commissioners.

(4) The commissioner may not assess a greater fee for an insurance license or related service to a person not residing in this state based solely on the fact that the person does not reside in this state.

Section 162. Section **31A-25-207** is amended to read:

31A-25-207. Form and contents of license.

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

[~~(1)~~] (a) the name, address, and telephone number of the licensee;

[~~(2)~~] (b) the date of license issuance; and

[~~(3)~~] (c) any other information the commissioner considers advisable.

(2) A third party administrator doing business under any other name than the administrator's legal name shall notify the commissioner prior to using the assumed name in this state.

(3) (a) An organization shall be licensed as an agency if the organization acts as a third party

administrator.

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

Section 163. Section **31A-25-208** is amended to read:

31A-25-208. Termination of license.

(1) A license issued under this chapter remains in force until:

(a) revoked, suspended, or limited under Subsection (2);

(b) lapsed under Subsection (3);

(c) surrendered to and accepted by the commissioner; or

(d) the licensee dies or is adjudicated incompetent as defined under Title 75, Chapter 5, Part 3 or 4.

(2) After [~~a hearing~~] an adjudicative proceeding under Title 63, Chapter 46b, Administrative Procedures Act, the commissioner may revoke, suspend for a specified period of [~~less than~~] 12 months or less, or limit in whole or in part the license of any administrator, found to:

(a) be unqualified for a license under Section 31A-25-203;

(b) have violated an insurance statute, valid rule under Subsection 31A-2-201(3), or a valid order under Subsection 31A-2-201(4);

(c) be insolvent, or the subject of receivership, conservatorship, rehabilitation, or other delinquency proceedings in any state;

(d) have failed to pay any final judgment rendered against it in this state within 60 days after the judgment became final;

(e) have failed to meet the same good faith obligations in claims settlement as that required of admitted insurers;

(f) be affiliated with and under the same general management or interlocking directorate or ownership as another administrator which transacts business in this state without a license; [~~or~~]

(g) have refused to be examined or to produce its accounts, records, and files for examination, or have officers who have refused to give information with respect to the

administrator's affairs or to perform any other legal obligation as to an examination; [~~or~~]

(h) have provided incorrect, misleading, incomplete, or materially untrue information in the license application;

(i) have violated an insurance law, valid rule, or valid order of another state's insurance department;

(j) have obtained or attempted to obtain a license through misrepresentation or fraud;

(k) have improperly withheld, misappropriated, or converted any monies or properties received in the course of doing insurance business;

(l) have intentionally misrepresented the terms of an actual or proposed insurance contract or application for insurance;

(m) have been convicted of a felony;

(n) have admitted or been found to have committed any insurance unfair trade practice or fraud;

(o) have used fraudulent, coercive, or dishonest practices in this state or elsewhere;

(p) have demonstrated incompetence, untrustworthiness, or financial irresponsibility in the conduct of business in this state or elsewhere;

(q) have had an insurance license or its equivalent, denied, suspended, or revoked in any other state, province, district, or territory;

(r) have forged another's name to:

(i) an application for insurance; or

(ii) a document related to an insurance transaction;

(s) have improperly used notes or any other reference material to complete an examination for an insurance license;

(t) have knowingly accepted insurance business from an individual who is not licensed;

(u) have failed to comply with an administrative or court order imposing a child support obligation;

(v) have failed to:

(i) pay state income tax; or

(ii) comply with any administrative or court order directing payment of state income tax;

(w) have violated or permitted others to violate the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Secs. 1033 and 1034; or

[~~(h)~~] (x) have engaged in methods and practices in the conduct of business [~~which~~] that endanger the legitimate interests of customers and the public.

(3) (a) Any license issued under this chapter lapses if the licensee fails to:

(i) pay the fee due under Section 31A-3-103[~~,~~]; or [~~if the licensee fails to~~]

(ii) produce, when due, evidence of compliance with the financial responsibility requirement under Section 31A-25-205. [~~A~~]

(b) Subject to Subsection (3)(c) a license [~~which~~] that has lapsed under this Subsection (3) may be reinstated if the licensee[~~, within 90 days after license lapse,~~] cures the deficiency or deficiencies [~~which~~] that brought about the license lapse within 90 days after the date the license lapsed.

(c) The licensee shall pay twice the applicable license renewal fee if the cause of the license lapse was failure to pay the usual renewal fee.

(4) Notwithstanding Subsection (3), a licensee whose license lapses due to military service or some other extenuating circumstance such as a long-term medical disability may request:

(a) reinstatement; and

(b) a waiver of any of the following imposed for failure to comply with renewal procedures:

(i) an examination requirement;

(ii) a fine; or

(iii) other sanction.

(5) The commissioner shall by rule prescribe the license renewal and reinstatement procedures, in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act.

[~~(4)~~] (6) A licensee under this chapter whose license is suspended, revoked, or lapsed, but who continues to act as a licensee, is subject to the penalties for acting as an administrator without a license.

[~~(5)~~] (7) An order revoking a license under Subsection (2) may specify a time, not to exceed

five years, within which the former licensee may not apply for a new license. If no time is specified, the former licensee may not apply for five years without the express approval of the commissioner.

[~~(6)~~] (8) Any person whose license is suspended or revoked under Subsection (2) shall, when the suspension ends or a new license is issued, pay all the fees that would have been payable if the license had not been suspended or revoked, unless the commissioner by order waives the payment of the interim fees. If a new license is issued more than three years after the revocation of a similar license, this subsection applies only to the fees that would have accrued during the three years immediately following the revocation.

(9) If ordered by a court, the commissioner shall promptly withhold, suspend, restrict, or reinstate the use of a license issued under this part.

Section 164. Section **31A-26-101** is amended to read:

31A-26-101. Purposes.

The purposes of this chapter are:

(1) to promote the professional competence of those engaged in claims adjusting;

(2) to encourage fair and rapid settlement of claims;

(3) to protect claimants under insurance policies from unfair claims adjustment practices; [~~and~~]

(4) to prevent compensation arrangements for insurance adjusters that endanger the fairness of claim settlements[~~.~~]; and

(5) to govern the qualifications and procedures for the licensing of insurance adjustors.

Section 165. Section **31A-26-202** is amended to read:

31A-26-202. Application for license.

(1) (a) The application for a license as an independent adjuster or public adjuster shall be:

(i) made to the commissioner on forms and in a manner [~~he~~] the commissioner prescribes[~~.~~]; and

(ii) accompanied by the applicable fee, which is not refunded if the application is denied.

(b) The application shall provide:

(i) information about the identity[~~,~~];

(ii) the applicant's:

(A) social security number[~~,~~]; or

(B) federal employer identification number;

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

(iv) if the applicant is a natural person, whether the applicant is 18 years of age or older;

(v) whether the applicant has committed an act that is a ground for denial, suspension, or revocation as set forth in Section 31A-25-208; and

(vi) any other information as the commissioner reasonably requires.

(2) The commissioner may require documents reasonably necessary to verify the information contained in the application.

[~~(b)~~] (3) [~~An applicant's social security number is a~~] The following are private [~~record~~] records under Subsection 63-2-302(1)(g)[~~.~~]:

[~~(2) Insurance adjusters' licenses issued under former Title 31 remain in effect until their expiration date, but they are subject to any requirement or limitation generally imposed under this title on similar licenses issued after July 1, 1986. Upon timely payment of the license continuation fee under Section 31A-3-103, the commissioner shall issue to adjusters licensed under the former title new licenses conforming to the provisions of this title and rules adopted under it.~~]

(a) the applicant's social security number; and

(b) the applicant's federal employer identification number.

Section 166. Section **31A-26-203** is amended to read:

31A-26-203. Adjuster's license required.

(1) The commissioner shall issue a license to act as an independent adjuster or public adjuster to any person who, as to the license classification applied for under Section 31A-26-204, has:

[~~(1)~~] (a) satisfied the character requirements under Section 31A-26-205;

[~~(2)~~] (b) satisfied the applicable continuing education requirements under Section 31A-26-206;

[~~(3)~~] (c) satisfied the applicable examination requirements under Section 31A-26-207;

[~~(4)~~] (d) if a nonresident, complied with Section 31A-26-208; and

[~~(5)~~] (e) paid the applicable fees under Section 31A-3-103.

(2) (a) This Subsection (2) applies to the following persons:

(i) an applicant for:

(A) an independent adjuster's license; or

(B) a public adjuster's license;

(ii) a licensed independent adjuster; or

(iii) a licensed public adjuster.

(b) A person described in Subsection (2)(a) shall report to the commissioner:

(i) any administrative action taken against the person:

(A) in another jurisdiction; or

(B) by another regulatory agency in this state; and

(ii) any criminal prosecution taken against the person in any jurisdiction.

(c) The report required by Subsection (2)(b) shall:

(i) be filed:

(A) at the time the person applies for a third party administrator's license; or

(B) within 30 days of the initiation of an action or prosecution described in Subsection (2)(b); and

(ii) include a copy of the complaint or other relevant legal documents related to the action or prosecution described in Subsection (2)(b).

(3) (a) The department may request concerning a person applying for an independent or public adjuster's license:

(i) criminal background information maintained pursuant to Title 53, Chapter 10, Part 2, from the Bureau of Criminal Identification; and

(ii) complete Federal Bureau of Investigation criminal background checks through the national criminal history system.

(b) Information obtained by the department from the review of criminal history records received under Subsection (3)(a) shall be used by the department for the purposes of:

(i) determining if a person satisfies the character requirements under Section 31A-26-205 for issuance or renewal of a license;

(ii) determining if a person has failed to maintain the character requirements under Section 31A-25-204; and

(iii) preventing persons who violate the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Secs. 1033 and 1034, from engaging in the business of insurance in the state.

(c) If the department requests the criminal background information, the department shall:

(i) pay to the Department of Public Safety the costs incurred by the Department of Public Safety in providing the department criminal background information under Subsection (3)(a)(i);

(ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau of Investigation in providing the department criminal background information under Subsection (3)(a)(ii); and

(iii) charge the person applying for a license or for renewal of a license a fee equal to the aggregate of Subsections (3)(c)(i) and (ii).

Section 167. Section **31A-26-204** is amended to read:

31A-26-204. License classifications.

[~~Licenses~~] A resident or nonresident license issued under this chapter shall be issued under the classifications described under Subsections (1), (2), and (3). These classifications are intended to describe the matters to be considered under any prerequisite education and examination required of license applicants under Sections 31A-26-206 and 31A-26-207.

(1) Independent adjuster license classifications include:

(a) [~~disability~~] accident and health insurance, including related service insurance under Chapter 7 or 8;

(b) property and liability insurance, which includes:

(i) property insurance;

(ii) liability insurance;

(iii) surety bonds; and

(iv) policies containing combinations or variations of these coverages;

(c) service insurance;

(d) title insurance;

(e) credit insurance; and

(f) workers' compensation insurance.

(2) Public adjuster license classifications include:

(a) [~~disability~~] accident and health insurance, including related service insurance under Chapter 7 or 8;

(b) property and liability insurance, which includes:

(i) property insurance;

(ii) liability insurance;

(iii) surety bonds; and

(iv) policies containing combinations or variations of these coverages;

(c) service insurance;

(d) title insurance;

(e) credit insurance; and

(f) workers' compensation insurance.

(3) The commissioner may by rule recognize other independent adjuster or public adjuster license classifications as to other kinds of insurance not listed under Subsection (1). The commissioner may also by rule create license classifications which grant only part of the authority arising under another license class.

Section 168. Section **31A-26-206** is amended to read:

31A-26-206. Continuing education requirements.

(1) The commissioner shall by rule prescribe continuing education requirements for each class of license under Section 31A-26-204.

(2) (a) The commissioner shall impose continuing education requirements in accordance with a two-year licensing period in which the licensee meets the requirements of this Subsection (2).

(b) Except as provided in Subsection (2)(c), for a two-year licensing period described in Subsection (2)(a) the commissioner shall require that the licensee for each line of authority held by

the licensee:

(i) receive six hours of continuing education; or

(ii) pass a line of authority continuing education examination.

(c) Notwithstanding Subsection (2)(b):

(i) the commissioner may not require continuing education for more than four lines of authority held by the licensee;

(ii) the commissioner shall require:

(A) a minimum of:

(I) 12 hours of continuing education;

(II) passage of two line of authority continuing education examinations; or

(III) a combination of Subsection (2)(c)(ii)(A)(I) and (II);

(B) that the minimum continuing education requirement of Subsection (2)(c)(ii)(A) include:

(I) at least six hours or one line of authority continuing education examination for each line of authority held by the licensee not to exceed four lines of authority held by the licensee; and

(II) three hours of ethics training, which may be taken in place of three hours of the hours required for a line of authority.

(d) (i) If a licensee completes the licensee's continuing education requirement without taking a line of authority continuing education examination, the licensee shall complete at least 1/2 of the required hours through classroom hours of insurance-related instruction.

(ii) The hours not completed through classroom hours in accordance with Subsection (2)(d)(i) may be obtained through:

(A) home study;

(B) video tape;

(C) experience credit; or

(D) other method provided by rule.

(e) (i) A licensee may obtain continuing education hours at any time during the two-year licensing period.

(ii) The licensee may not take a line of authority continuing education examination more

than 90 calendar days before the date on which the licensee's license is renewed.

(f) The commissioner shall make rules for the content and procedures for line of authority continuing education examinations.

(g) (i) Beginning May 3, 1999, a licensee is exempt from the continuing education requirements of this section if:

(A) as of April 1, 1990, the licensee has completed 20 years of licensure in good standing;

(B) the licensee requests an exemption from the department; and

(C) the department approves the exemption.

(ii) If the department approves the exemption under Subsection (2)(g)(i), the licensee is not required to apply again for the exemption.

(h) A licensee with a variable annuity line of authority is exempt from the requirement for continuing education for that line of authority so long as:

(i) the National Association of Securities Dealers requires continuing education for licensees having a securities license; and

(ii) the licensee complies with the National Association of Securities Dealers' continuing education requirements for securities licensees.

(i) The commissioner shall by rule:

(i) publish a list of insurance professional designations whose continuing education requirements can be used to meet the requirements for continuing education under Subsection (2)(c); and

(ii) authorize professional adjuster associations to:

(A) offer qualified programs for all classes of licenses on a geographically accessible basis; and

(B) collect reasonable fees for funding and administration of the continuing education programs, subject to the review and approval of the commissioner.

(j) (i) The fees permitted under Subsection (2)(i) that are charged to fund and administer a program shall reasonably relate to the costs of administering the program.

(ii) Nothing in this section shall prohibit a provider of continuing education programs or

courses from charging fees for attendance at courses offered for continuing education credit.

(iii) The fees permitted under Subsection (2)(i)(ii) that are charged for attendance at an association program may be less for an association member, based on the member's affiliation expense, but shall preserve the right of a nonmember to attend without affiliation.

(3) The requirements of this section apply only to licensees who are natural persons.

(4) The requirements of this section do not apply to members of the Utah State Bar.

(5) The commissioner shall designate courses that satisfy the requirements of this section, including those presented by insurers.

(6) A nonresident adjuster is considered to have satisfied this state's continuing education requirements if:

(a) the nonresident adjuster satisfies the nonresident producer's home state's continuing education requirements for a licensed insurance adjuster; and

(b) on the same basis the nonresident adjuster's home state considers satisfaction of Utah's continuing education requirements for a producer as satisfying the continuing education requirements of the home state.

Section 169. Section **31A-26-207** is amended to read:

31A-26-207. Examination requirements.

(1) The commissioner may require applicants for any particular class of license under Section 31A-26-204 to pass an examination as a requirement to receiving a license. The examination shall reasonably relate to the specific license class for which it is prescribed. The examinations may be administered by the commissioner or as specified by rule.

(2) The commissioner [~~may~~] shall waive the requirement of an examination for a nonresident applicant who [~~has held a similar license in his home state for the two years immediately preceding application in this state, but only if the applicant's state of residence has imposed upon the applicant examination requirements which are substantially as rigorous as those of this state.~~]:

(a) applies for an insurance adjuster license in this state;

(b) has been licensed for the same line of authority in another state; and

(c) (i) is licensed in the state described in Subsection (2)(b) at the time the applicant applies

for an insurance producer license in this state; or

(ii) if the application is received within 90 days of the cancellation of the applicant's previous license:

(A) the prior state certifies that at the time of cancellation, the applicant was in good standing in that state; or

(B) the state's producer database records maintained by the National Association of Insurance Commissioners or the National Association of Insurance Commissioner's affiliates or subsidiaries, indicates that the producer is or was licensed in good standing for the line of authority requested.

(3) (a) To become a resident licensee in accordance with Sections 31A-26-202 and 31A-26-203, a person licensed as an insurance producer in another state who moves to this state shall make application within 90 days of establishing legal residence in this state.

(b) A person who becomes a resident licensee under Subsection (3)(a) may not be required to meet prelicensing education or examination requirements to obtain any line of authority previously held in the prior state unless:

(i) the prior state would require a prior resident of this state to meet the prior state's prelicensing education or examination requirements to become a resident licensee; or

(ii) the commissioner imposes the requirements by rule.

[~~(3)~~] (4) The requirements of this section only apply to applicants who are natural persons.

[~~(4)~~] (5) The requirements of this section do not apply to members of the Utah State Bar.

Section 170. Section **31A-26-208** is amended to read:

31A-26-208. Nonresident jurisdictional agreement.

(1) (a) [~~Nonresident applicants for licenses under this chapter~~] If a nonresident license applicant has a valid license from the nonresident license applicant's home state and the conditions of Subsection (1)(b) are met, the commissioner shall:

(i) waive any license requirement for a license under this chapter; and

(ii) issue the nonresident license applicant a nonresident adjuster's license.

(b) Subsection (1)(a) applies if:

(i) the nonresident license applicant:

(A) is licensed as a resident in the nonresident license applicant's home state at the time the nonresident license applicant applies for a nonresident adjuster license;

(B) has submitted the proper request for licensure;

(C) has submitted to the commissioner:

(I) the application for licensure that the nonresident license applicant submitted to the applicant's home state; or

(II) a completed uniform application; and

(D) has paid the applicable fees under Section 31A-3-103;

(ii) the nonresident license applicant's license in the applicant's home state is in good standing; and

(iii) the nonresident license applicant's home state awards nonresident adjuster licenses to residents of this state on the same basis as this state awards licenses to residents of that home state.

(2) A nonresident applicant shall execute in a form acceptable to the commissioner an agreement to be subject to the jurisdiction of the commissioner and courts of this state on any matter related to [~~his~~] the adjuster's insurance activities in this state, on the basis of:

(a) service of process under Sections 31A-2-309 and 31A-2-310; or

(b) other service authorized under the Utah Rules of Civil Procedure or Section 78-27-25.

(3) The commissioner may verify the third party administrator's licensing status through the database maintained by:

(a) the National Association of Insurance Commissioners; or

(b) an affiliate or subsidiary of the National Association of Insurance Commissioners.

(4) The commissioner may not assess a greater fee for an insurance license or related service to a person not residing in this state based solely on the fact that the person does not reside in this state.

Section 171. Section **31A-26-209** is amended to read:

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

(1) Licenses issued under this chapter shall be in the form the commissioner prescribes and

shall set forth:

(a) the name, address, and telephone number of the licensee;

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

(c) the date of license issuance; and

(d) any other information the commissioner considers advisable.

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

[~~(2)~~] (3) (a) An organization [~~acting~~] shall be licensed as an agency if the organization acts as:

(i) an independent adjuster [~~shall be licensed under this chapter as an organization.~~]; or

(ii) a public adjuster.

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

(3) (a) So far as is practicable, the commissioner shall issue a single license to each licensed adjuster for a single fee.

(b) For fee purposes, the less expensive license is [~~subsumed~~] included within the most expensive license.

Section 172. Section **31A-26-213** is amended to read:

31A-26-213. Termination of license.

(1) A license issued under this chapter remains in force until:

(a) revoked, suspended, or limited under Subsection (2);

(b) lapsed under Subsection (3);

(c) surrendered to and accepted by the commissioner; or

(d) the licensee dies or is adjudicated incompetent as defined under Title 75, Chapter 5, Part 3 or 4.

[~~(2) After a hearing, the commissioner may revoke, suspend, or limit in whole or in part the license of any person licensed under this chapter whom the commissioner finds is unqualified for~~

~~his license or who has violated an insurance statute, valid rule under Subsection 31A-2-201(3), or a valid order under Subsection 31A-2-201(4), or if the licensee's methods and practices in the conduct of business endanger the legitimate interests of customers and the public. Every order suspending a license issued under this chapter shall specify the period for which the suspension is to be effective, but in no event may the period exceed 12 months.~~]

(2) After an adjudicative proceeding under Title 63, Chapter 46b, Administrative Procedures Act, the commissioner may revoke, suspend for a specified period of 12 months or less, or limit in whole or in part the license of any adjuster, found to:

(a) be unqualified for a license under Section 31A-26-203;

(b) have violated:

(i) an insurance statute;

(ii) a valid rule under Subsection 31A-2-201(3); or

(iii) a valid order under Subsection 31A-2-201(4);

(c) be insolvent, or the subject of receivership, conservatorship, rehabilitation, or other delinquency proceedings in any state;

(d) fail to pay any final judgment rendered against it in this state within 60 days after the judgment became final;

(e) fail to meet the same good faith obligations in claims settlement as that required of admitted insurers;

(f) be affiliated with and under the same general management or interlocking directorate or ownership as another adjuster which transacts business in this state without a license;

(g) refuse to be examined or to produce its accounts, records, and files for examination;

(h) have an officer who:

(i) refuses to give information with respect to the administrator's affairs; or

(ii) to perform any other legal obligation as to an examination;

(i) have provided incorrect, misleading, incomplete, or materially untrue information in the license application;

(j) have violated any insurance law, valid rule, or valid order of another state's insurance

department;

(k) have obtained or attempted to obtain a license through misrepresentation or fraud;

(l) have improperly withheld, misappropriated, or converted any monies or properties received in the course of doing insurance business;

(m) have intentionally misrepresented the terms of an actual or proposed insurance contract or application for insurance;

(n) have been convicted of a felony;

(o) have admitted or been found to have committed any insurance unfair trade practice or fraud;

(p) have used fraudulent, coercive, or dishonest practices in the conduct of business in this state or elsewhere;

(q) have demonstrated incompetence, untrustworthiness, or financial irresponsibility in the conduct of business in this state or elsewhere;

(r) have had an insurance license, or its equivalent, denied, suspended, or revoked in any other state, province, district, or territory;

(s) have forged another's name to:

(i) an application for insurance; or

(ii) any document related to an insurance transaction;

(t) have improperly used notes or any other reference material to complete an examination for an insurance license;

(u) have knowingly accepted insurance business from an individual who is not licensed;

(v) have failed to comply with an administrative or court order imposing a child support obligation;

(w) have failed to:

(i) pay state income tax; or

(ii) comply with any administrative or court order directing payment of state income tax;

(x) have violated or permitted others to violate the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Secs. 1033 and 1034; or

(y) have engaged in methods and practices in the conduct of business which endanger the legitimate interests of customers and the public.

(3) (a) Any license issued under this chapter lapses if the licensee fails to pay when due any fee under Section 31A-3-103.

(b) A licensee whose license lapses due to military service or some other extenuating circumstance such as a long-term medical disability may request:

(i) reinstatement; and

(ii) a waiver of any of the following imposed for failure to comply with renewal procedures:

(A) an examination requirement;

(B) a fine; or

(C) other sanction.

(c) The commissioner shall by rule prescribe the license renewal and reinstatement procedures, in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act.

(4) A licensee under this chapter whose license is suspended, revoked, or lapsed, but who continues to act as a licensee, is subject to the penalties for conducting an insurance business without a license.

(5) An order revoking a license under Subsection (2) may specify a time not to exceed five years within which the former licensee may not apply for a new license. If no time is specified, the former licensee may not apply for a new license for five years without the express approval of the commissioner.

(6) Any person whose license is suspended or revoked under Subsection (2) shall, when the suspension ends or a new license is issued, pay all fees that would have been payable if the license had not been suspended or revoked, unless the commissioner by order waives the payment of the interim fees. If a new license is issued more than three years after the revocation of a similar license, this subsection applies only to the fees that would have accrued during the three years immediately following the revocation.

(7) The division shall promptly withhold, suspend, restrict, or reinstate the use of a license issued under this part if so ordered by a court.

Section 173. Section **31A-26-215** is enacted to read:

31A-26-215. Temporary license -- Appointment of trustee for terminated licensee's business.

(1) (a) The commissioner may issue a temporary insurance adjuster license:

(i) to a person listed in Subsection (1)(b):

(A) if the commissioner considers that the temporary license is necessary:

(I) for the servicing of an insurance business in the public interest; and

(II) to provide continued service to the insureds who are being serviced in a circumstance described in Subsection (1)(b);

(B) for a period not to exceed 180 days; and

(C) without requiring an examination; or

(ii) in any other circumstance:

(A) if the commissioner considers the public interest will best be served by issuing the temporary license;

(B) for a period not to exceed 180 days; and

(C) without requiring an examination.

(b) The commissioner may issue a temporary insurance producer license in accordance with Subsection (1)(a) to:

(i) the surviving spouse or court-appointed personal representative of a licensed insurance adjuster who dies or becomes mentally or physically disabled to allow adequate time for:

(A) the sale of the insurance business owned by the adjuster;

(B) recovery or return of the adjuster to the business; or

(C) the training and licensing of new personnel to operate the adjuster's business;

(ii) to a member or employee of a business entity licensed as an insurance adjuster upon the death or disability of an individual designated in:

(A) the business entity application; or

(B) the license; or

(iii) the designee of a licensed insurance adjuster entering active service in the armed forces

of the United States of America.

(2) If a person's license is terminated under Section 31A-26-213, the commissioner may appoint a trustee to provide in the public interest continuing service to the insureds who procured insurance through the person whose license is terminated:

(a) at the request of the person whose license is terminated; or

(b) upon the commissioner's own initiative.

(3) This section does not apply if the deceased or disabled adjuster has not owned or does not own an ownership interest in the accounts and associated expiration lists that were previously serviced by the adjuster.

(4) (a) A person issued a temporary license under Subsection (1) receives the license and shall perform the duties under the license subject to the commissioner's authority to:

(i) require a temporary licensee to have a suitable sponsor who:

(A) is a licensed producer; and

(B) assumes responsibility for all acts of the temporary licensee; or

(ii) impose other requirements that are:

(A) designed to protect the insureds and the public; and

(B) similar to the condition described in Subsection (4)(a)(i).

(b) A trustee appointed under Subsection (2) shall receive the trustee's appointment and perform the trustee's duties subject to the conditions listed in Subsections (4)(b)(i) through (xv).

(i) A trustee appointed under this section shall be licensed under this chapter to perform the services required by the trustor's clients.

(ii) When possible, the commissioner shall appoint a trustee who is no longer actively engaged on the trustee's own behalf in business as an adjuster.

(iii) The commissioner shall only select a person to act as trustee who is trustworthy and competent to perform the necessary services.

(iv) If the deceased, disabled, or unlicensed person for whom the trustee is acting is an associated adjuster, the insurers through or with which the former adjuster's business was associated shall cooperate with the trustee in allowing the trustee to service the claims associated with or

through the insurer.

(v) The trustee shall abide by the terms of any agreement between the former adjuster and the associated insurer, except that terms in those agreements terminating the agreement upon the death, disability, or license termination of the former agent do not bar the trustee from continuing to act under the agreement.

(vi) The commissioner shall set the trustee's compensation which:

(A) may be stated in terms of a percentage of commissions;

(B) shall be equitable; and

(C) paid exclusively from:

(I) the commissions generated by the former adjuster's accounts serviced by the trustee; and

(II) other funds the former adjuster or the former adjuster's successor in interest agree to pay.

(vii) The trustee has no special priority to commissions over the former adjuster's creditors.

(viii) The following may not be held liable for errors or omissions of the former adjuster or the trustee:

(A) the commissioner; or

(B) the state.

(ix) The trustee may not be held liable for errors and omissions that were caused in any material way by the negligence of the former adjuster.

(x) The trustee may be held liable for errors and omissions that arise solely from the trustee's negligence.

(xi) The trustee's compensation level shall be sufficient to allow the trustee to purchase errors and omissions coverage, if that coverage is not provided to the trustee by:

(A) the former adjuster; or

(B) the former adjuster's successor in interest.

(xii) It is a breach of the trustee's fiduciary duty to capture the accounts of trustor's clients, either directly or indirectly.

(xiii) The trustee may not purchase the accounts or expiration lists of the former adjuster, unless the commissioner expressly ratifies the terms of the sale.

(xiv) The commissioner may adopt rules that:

(A) further define the trustee's fiduciary duties; and

(B) explain how the trustee is to carry out the trustee's responsibilities.

(xv) The trust may be terminated by:

(A) the commissioner; or

(B) the person that requested the trust be established.

(c) A person described in Subsection (4)(b)(vi)(B) shall terminate the trust by sending written notice to:

(i) the trustee; and

(ii) the commissioner.

(5) (a) The commissioner may by order limit the authority of any temporary licensee or trustee in any way considered necessary to protect:

(i) persons being serviced; and

(ii) the public.

(b) The commissioner may by order revoke a temporary license or trustee's appointment if the interest of persons being serviced or the public are endangered.

(c) A temporary license or trustee's appointment may not continue after the owner or personal representative disposes of the business.

Section 174. Section **31A-26-302** is amended to read:

31A-26-302. Settlement of claims in credit life and accident and health insurance.

(1) The creditor shall promptly report all claims to the insurer or its designated claim representative. The insurer shall maintain adequate claims files. All claims shall be settled as soon as possible in accordance with the terms of the insurance contract.

(2) The insurer shall pay all claims either by draft drawn upon the insurer or by check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or upon direction of that claimant to another.

(3) [~~No~~] A person other than the insurer or its designated claim representative may not settle or adjust claims. The creditor may not be designated as a claims representative.

Section 175. Section **31A-27-311.5** is repealed and reenacted to read:

31A-27-311.5. Continuance of coverage -- Health maintenance organizations.

(1) As used in this section:

(a) "basic health care services" is as defined in Section 31A-8-101;

(b) "enrollee" is as defined in Section 31A-8-101;

(c) "health care" is as defined in Section 31A-1-301;

(d) "health maintenance organization" is as defined in Section 31A-8-101;

(e) "limited health plan" is as defined in Section 31A-8-101;

(f) (i) "managed care organization" means any entity licensed by, or holding a certificate of authority from, the department to furnish health care services or health insurance;

(ii) "managed care organization" includes:

(A) a limited health plan;

(B) a health maintenance organization;

(C) a preferred provider organization;

(D) a fraternal benefit society; or

(E) any entity similar to an entity described in Subsections (1)(f)(ii)(A) through (D);

(iii) "managed care organization" does not include:

(A) an insurer or other person that is eligible for membership in a guaranty association under Chapter 28;

(B) a mandatory state pooling plan;

(C) a mutual assessment company or any entity that operates on an assessment basis; or

(D) any entity similar to an entity described in Subsections (1)(f)(iii)(A) through (C);

(g) "participating provider" means a provider who, under a contract with a managed care organization authorized under Section 31A-8-407, has agreed to provide health care services to enrollees with an expectation of receiving payment, directly or indirectly, from the managed care organization, other than copayment;

(h) "participating provider contract" means the agreement between a participating provider and a managed care organization authorized under Section 31A-8-407;

(i) "preferred provider" means a provider who agrees to provide health care services under an agreement authorized under Subsection 31A-22-617(1);

(j) "preferred provider contract" means the written agreement between a preferred provider and a managed care organization authorized under Subsection 31A-22-617(1);

(k) "preferred provider organization" means any person, other than an insurer licensed under Chapter 7 or an individual who contracts to render professional or personal services that the individual performs himself, that:

(i) furnishes at a minimum, through preferred providers, basic health care services to an enrollee in return for prepaid periodic payments in an amount agreed to prior to the time during which the health care may be furnished;

(ii) is obligated to the enrollee to arrange for the services described in Subsection (1)(k)(i); and

(iii) permits the enrollee to obtain health care services from providers who are not preferred providers;

(l) "provider" is as defined in Section 31A-8-101; and

(m) "uncovered expenditure" means the costs of health care services that are covered by an organization for which an enrollee is liable in the event of the managed care organization's insolvency.

(2) The rehabilitator or liquidator may take one or more of the actions described in Subsections (2)(a) through (f) to assure continuation of health care coverage for enrollees of an insolvent managed care organization.

(a) (i) Subject to Subsection (2)(a)(ii), a rehabilitator or liquidator may require a participating provider and preferred provider of health care services to continue to provide the health care services the provider is required to provide under the respective participating provider contract or preferred provider contract until the later of:

(A) 90 days from the date of the filing of a petition for rehabilitation or the petition for liquidation; or

(B) the date the term of the contract ends.

(ii) A requirement by the rehabilitator or liquidator under Subsection (2)(a)(i) that a participating provider or preferred provider continue to provide health care services under a provider's participating provider contract or preferred providers contract expires when health care coverage for all enrollees of the insolvent managed care organization is obtained from another managed care organization or insurer.

(b) (i) Subject to Subsection (2)(b)(ii), a rehabilitator or liquidator may reduce the fees a participating provider or preferred provider is otherwise entitled to receive from the managed care organization under its participating provider contract or preferred provider contract during the time period in Subsection (2)(a)(i).

(ii) Notwithstanding Subsection (2)(b)(i) a rehabilitator or liquidator may not reduce a fee to less than 75% of the regular fee set forth in the respective participating provider contract or preferred provider contract.

(iii) An enrollee shall continue to pay the same copayments, deductibles, and other payments for services received from the participating provider or preferred provider that the enrollee was required to pay before the date of filing of:

(A) the petition for rehabilitation; or

(B) the petition for liquidation.

(c) (i) A participating provider or preferred provider shall:

(A) accept the amounts specified in Subsection (2)(b) as payment in full; and

(B) relinquish the right to collect additional amounts from the insolvent managed care organization's enrollee.

(ii) Subsection (2)(b) and Subsections (2)(c)(i)(A) and (B) shall apply to the fees paid to a provider who agrees to provide health care services to an enrollee but is not a preferred or participating provider.

(d) If the managed care organization is a health maintenance organization, Subsections (2)(d)(i) through (v) apply.

(i) Subject to Subsections (2)(d)(ii) and (iv), upon notification from and subject to the direction of the rehabilitator or liquidator of a health maintenance organization licensed under

Chapter 8, a solvent health maintenance organization licensed under Chapter 8 and operating within a portion of the insolvent health maintenance organization's service area shall extend to the enrollees all rights, privileges, and obligations of being an enrollee in the accepting health maintenance organization, except that the accepting health maintenance organization shall give credit to an enrollee for any waiting period already satisfied under the provisions of the enrollee's contract with the insolvent health maintenance organization.

(ii) A health maintenance organization accepting an enrollee of an insolvent health maintenance organization under Subsection (2)(d)(i) shall charge the enrollee the premiums applicable to the existing business of the accepting health maintenance organization.

(iii) A health maintenance organization's obligation to accept an enrollee under Subsection (2)(d)(i) is limited in number to its pro rata share of all health maintenance organization enrollees in this state, as determined after excluding the enrollees of the insolvent insurer.

(iv) The rehabilitator or liquidator of an insolvent health maintenance organization shall take those measures that are possible to ensure that no health maintenance organization is required to accept more than its pro rata share of the adverse risk represented by the enrollees of the insolvent health maintenance organization. As long as the methodology used by the rehabilitator or liquidator to assign an enrollee is one which can be expected to produce a reasonably equitable distribution of adverse risk, that methodology and its results are acceptable under this Subsection (2)(d)(iv).

(v) (A) Notwithstanding Section 31A-27-311, the rehabilitator or liquidator may require all solvent health maintenance organizations to pay for the covered claims incurred by the enrollees of the insolvent health maintenance organization.

(B) As determined by the rehabilitator or liquidator, payments required under this Subsection (2)(d)(v) may:

(I) begin as of the filing of the petition for reorganization or the petition for liquidation; and

(II) continue for a maximum period through the time all enrollees are assigned pursuant to this section.

(C) If the rehabilitator or liquidator makes an assessment under this Subsection (2)(d)(v), the rehabilitator or liquidator shall assess each solvent health maintenance organization its pro rata

share of the total assessment based upon its premiums from the previous calendar year.

(e) A rehabilitator or liquidator may transfer, through sale, or otherwise, the group and individual health care obligations of the insolvent managed care organization to other managed care organizations or other insurers, if those other managed care organizations and other insurers are licensed or have a certificate of authority to provide the same health care services in this state that the insolvent managed care organization has.

(i) The rehabilitator or liquidator may combine group and individual health care obligations of the insolvent managed care organization in any manner the rehabilitator or liquidator considers best to provide for continuous health care coverage for the maximum number of enrollees of the insolvent managed care organization.

(ii) If the terms of a proposed transfer of the same combination of group and individual policy obligations to more than one other managed care organization or insurer are otherwise equal, the rehabilitator or liquidator shall give preference to the transfer of the group and individual policy obligations of an insolvent managed care organization as follows:

(A) from one category of managed care organization to another managed care organization of the same category, as follows:

(I) from a limited health plan to a limited health plan;

(II) from a health maintenance organization to a health maintenance organization;

(III) from a preferred provider organization to a preferred provider organization;

(IV) from a fraternal benefit society to a fraternal benefit society; and

(V) from any entity similar to any of the above to a category that is similar;

(B) from one category of managed care organization to another managed care organization, regardless of the category of the transferee managed care organization; and

(C) from a managed care organization to a nonmanaged care provider of health care coverage, including insurers.

(f) A rehabilitator or liquidator may use the insolvent managed care organization's required capital or permanent surplus, and compulsory surplus, to continue to provide coverage for the insolvent managed care organization's enrollees, including paying uncovered expenditures.

Section 176. Section **31A-28-102** is amended to read:

31A-28-102. Purpose.

(1) The purpose of this part is to protect, subject to certain limitations, the persons specified in Subsection 31A-28-103(1) against failure in the performance of contractual obligations, under the life and [~~disability~~] accident and health insurance policies and annuity contracts specified in Subsection 31A-28-103(2), because of the impairment or insolvency of the member insurer that issued the policies or contracts.

(2) To provide the protection described in Subsection (1), the Utah Life and Disability Insurance Guaranty Association, which currently exists, is continued in order to pay benefits and to continue coverages as limited in this part, and members of the association are subject to assessment to provide funds to carry out the purpose of this part.

Section 177. Section **31A-28-103** is amended to read:

31A-28-103. Coverage and limitations.

(1) This part provides coverage for the policies and contracts specified in Subsection (2) to persons who are:

(a) beneficiaries, assignees, or payees of the persons covered under Subsection (1)(b), regardless of where they reside, except for nonresident certificate holders under group policies or contracts;

(b) owners of or certificate holders under such policies or contracts; or, in the case of unallocated annuity contracts, to the persons who are the contract holders, and who are:

(i) residents of Utah; or

(ii) not residents of Utah, but only under the following conditions:

(A) the insurers which issued the policies or contracts are domiciled in this state;

(B) the insurers never held a license or certificate of authority in the states in which the persons reside;

(C) the states have associations similar to the association created by this chapter; and

(D) the persons are not eligible for coverage by the associations described in Subsection (1)(b)(ii)(C).

(2) (a) Except as otherwise limited by this part, this part provides coverage to the persons specified in Subsection (1) for direct, nongroup life, [~~disability~~] accident and health, annuity and supplemental policies or contracts, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers. Annuity contracts and certificates under group annuity contracts include guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, structured settlement agreements, lottery contracts, and any immediate or deferred annuity contracts.

(b) This part does not provide coverage for:

(i) any portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract holder;

(ii) any policy or contract of reinsurance, unless assumption certificates have been issued;

(iii) any portion of a policy or contract to the extent that the rate of interest on which it is based:

(A) averaged over the period of four years prior to the date on which the association becomes obligated with respect to the policy or contract, exceeds a rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for the corresponding lesser period if the policy or contract was issued less than four years before the association became obligated; and

(B) on or after the date on which the association becomes obligated with respect to the policy or contract, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available;

(iv) any plan or program of an employer, association, or similar entity to provide life, [~~disability~~] accident and health, or annuity benefits to its employees or members to the extent that the plan or program is self-funded or uninsured, including benefits payable by an employer, association, or similar entity under:

(A) a multiple employer welfare arrangement as defined in Section 514 of the Employee Retirement Income Security Act of 1974, as amended;

(B) a minimum premium group insurance plan;

(C) a stop-loss group insurance plan; or

(D) an administrative services only contract;

(v) any portion of a policy or contract to the extent that it provides dividends or experience rating credits, or provides that any fees or allowances be paid to any person, including the policy or contract holder, in connection with the service to or administration of the policy or contract;

(vi) any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;

(vii) any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation; and

(viii) any portion of any unallocated annuity contract which is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan or a government lottery.

(c) The benefits for which the association may become liable shall in no event exceed the lesser of:

(i) the contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(ii) (A) with respect to any one life, regardless of the number of policies or contracts:

(I) $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

(II) $100,000 in [~~disability~~] accident and health insurance benefits, including any net cash surrender and net cash withdrawal values;

(III) $100,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

(B) with respect to each individual participating in a governmental retirement plan established under Section 401(k), 403(b), or 457 of the Internal Revenue Code covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate, $100,000 in present value of annuity benefits, including net cash surrender and net cash withdrawal values;

(C) however, in no event shall the association be liable to expend more than $300,000 in the aggregate with respect to any one individual under Subsections (2)(c)(ii)(A) and (ii)(B);

(iii) with respect to any one contract holder covered by any unallocated annuity contract not included in Subsection (2)(c)(ii)(B), $5,000,000 in benefits, irrespective of the number of contracts held by that contract holder.

Section 178. Section **31A-28-106** is amended to read:

31A-28-106. Continuation of the association.

(1) There is continued under this chapter the nonprofit legal entity known as the Utah Life and Disability Insurance Guaranty Association created under former provisions of this title. All member insurers shall be and remain members of the association as a condition of their authority to transact business in this state. The association shall perform its functions under the plan of operation established and approved under Section 31A-28-110 and shall exercise its powers through a board of directors under the provisions of Section 31A-28-107. For purposes of administration and assessment the association shall maintain two accounts:

(a) the life and annuity account, which includes the following subaccounts:

(i) Life Insurance Account;

(ii) Annuity Account; and

(iii) Unallocated Annuity Account, which includes contracts qualified under Sections 401(k), 403(b), or 457 of the Internal Revenue Code; and

(b) the [~~disability~~] accident and health insurance account.

(2) The association shall come under the immediate supervision of the commissioner and shall be subject to the applicable provisions of the insurance laws of this state. Meetings or records of the association may be opened to the public upon majority vote of the board of directors of the association.

Section 179. Section **31A-28-108** is amended to read:

31A-28-108. Powers and duties of the association.

(1) If a member insurer is an impaired domestic insurer, the association in its discretion and subject to any conditions imposed by the association that do not impair the contractual obligations

of the impaired insurer that are approved by the commissioner, and also by the impaired insurer, except in cases of court-ordered conservation or rehabilitation, may:

(a) guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the policies or contracts of the impaired insurer;

(b) provide the necessary monies, pledges, notes, guarantees or other means to effectuate Subsection (1)(a) and assure payment of the contractual obligations of the impaired insurer pending action under Subsection (1)(a); or

(c) loan money to the impaired insurer.

(2) (a) If a member insurer is an impaired insurer, whether domestic, foreign, or alien, and the insurer is not paying claims timely, the association shall in its discretion and subject to the preconditions specified in Subsection (2)(b), either:

(i) take any of the actions specified in Subsection (1), subject to the conditions specified in Subsection (1); or

(ii) provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for [~~disability~~] accident and health claims, periodic annuity benefit payments, death benefits, supplemental benefits, and cash withdrawals for policy or contract owners who petition for such benefits under claims of emergency or hardship in accordance with the standards proposed by the association and approved by the commissioner.

(b) The association is subject to the requirements of Subsection (2)(a) only if:

(i) the laws of the impaired insurer's state of domicile provide that until all payments of, or an account of, the impaired insurer's contractual obligations by all guaranty associations, along with all expenses of the obligation and interest on all such payments and expenses, have been repaid to the guaranty associations or a plan of repayment by the impaired insurer has been approved by the guaranty associations:

(A) the delinquency proceeding shall not be dismissed;

(B) neither the impaired insurer nor its assets shall be returned to the control of its shareholders or private management;

(C) it shall not be permitted to solicit or accept new business or have any suspended or

revoked license restored; and

(ii) (A) if the impaired insurer is a domestic insurer, it has been placed under an order of rehabilitation by a court of competent jurisdiction in this state; or

(B) if the impaired insurer is a foreign or alien insurer:

(I) it has been prohibited from soliciting or accepting new business in this state;

(II) its certificate of authority has been suspended or revoked in this state; and

(III) a petition for rehabilitation or liquidation has been filed in a court of competent jurisdiction in its state of domicile by the commissioner of the state.

(3) If a member insurer is an insolvent insurer, the association in its discretion shall either:

(a) (i) guaranty, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the policies or contracts of the insolvent insurer; or

(ii) assure payment of the contractual obligations of the insolvent insurer; and

(iii) provide such monies, pledges, guarantees, or other means as are reasonably necessary to discharge such duties; or

(b) with respect only to [~~disability~~] accident and health insurance policies, provide benefits and coverages in accordance with Subsection (4).

(4) When proceeding under Subsections (2)(a)(ii) or (3)(b), with respect only to [~~disability~~] accident and health insurance policies, the association shall:

(a) assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability, that would have been payable under the policies of the insolvent insurer, for claims incurred:

(i) with respect to group policies, not later than the earlier of the next renewal date under the policies or contracts or 45 days, but in no event less than 30 days, after the date on which the association becomes obligated with respect to the policies;

(ii) with respect to individual policies, not later than the earlier of the next renewal date, if any, under the policies or one year, but in no event less than 30 days, from the date on which the association becomes obligated with respect to the policies;

(b) make diligent efforts to provide 30 days' notice of the termination of the benefits

provided to all known insureds, or group policyholders with respect to group policies;

(c) make available substitute coverage on an individual basis, in accordance with the provisions of Subsection (4)(d), to each known insured or owner under an individual policy, and to each individual formerly insured under a group policy who is not eligible for replacement group coverage, if the insured had a right under law or the terminated policy to convert coverage to individual coverage or to continue an individual policy in force until a specified age or for a specified

time during which the insurer had no right unilaterally to make changes in any provision of the policy or had a right only to make changes in premium by class.

(d) (i) In providing the substitute coverage required under Subsection (4)(c), the association may offer either to reissue the terminated coverage or to issue an alternative policy.

(ii) Alternate or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy.

(iii) The association may reinsure any alternative or reissued policy.

(e) (i) Alternative policies adopted by the association shall be subject to the approval of the commissioner. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency.

(ii) Alternative policies shall contain at least the minimum statutory provisions required in this state and provide benefits that are not unreasonable in relation to the premium charged. The association shall set the premium in accordance with its table of adopted rates. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured. For alternative policies issued to insureds under individual policies of the impaired or insolvent insurer, age shall be determined in accordance with the original policy provisions and class of risk shall be the class of risk under the original policy. For alternative policies issued to individuals insured under a group policy, age and class of risk shall be determined by the association in accordance with the alternative policy provisions and risk classification standards approved by the commissioner. However, the premium may not reflect any changes in the health of the insured after the original policy was last underwritten.

(iii) Any alternative policy issued by the association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association.

(f) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to the approval of the commissioner or by a court of competent jurisdiction.

(g) The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy shall cease on the date the coverage or policy is replaced by another similar policy by the policyholder, the insured, or the association.

(h) With respect to claims unpaid as of the date of insolvency and claims incurred during the period defined in Subsection (4)(a), a provider of health care services, by accepting a payment from the association upon a claim of the provider against an insured whose health care insurer is an insolvent member insurer, agrees to forgive the insured of 20% of the debt which otherwise would be paid by the insurer had it not been insolvent, subject to a maximum of $4,000 being required to be forgiven by any one provider as to each claimant. The obligations of solvent insurers to pay all or part of the covered claim are not diminished by the forgiveness provided for in this section.

(5) When proceeding under Subsection (2)(a)(ii) or (3) with respect to any policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with Subsection 31A-28-103(2)(b)(iii).

(6) Nonpayment of premiums within 31 days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage shall terminate the association's obligations under the policy or coverage under this chapter with respect to the policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this chapter.

(7) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association, and the association shall be liable for unearned premiums due to policy or contract owners of the insurer after the entry of the order.

(8) The protection provided by this chapter does not apply if any guaranty protection is

provided to residents of this state by laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

(9) In carrying out its duties under this subsection and Subsections (2) and (3), and subject to approval by the court, the association may:

(a) impose permanent policy or contract liens in connection with any guarantee, assumption, or reinsurance agreement, if the association finds that the amounts which can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the association's duties under this chapter, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of the permanent policy or contract liens to be in the public interest;

(b) impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value.

(10) If the association fails to act within a reasonable period of time as provided in Subsections (2)(a)(ii), (3), and (4), the commissioner shall have the powers and duties of the association under this chapter with respect to impaired or insolvent insurers.

(11) The association may render assistance and advice to the commissioner, upon his request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

(12) The association has standing to appear before any court in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this chapter. Standing extends to all matters germane to the powers and duties of the association, including proposals for reinsuring, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association also has the right to appear or intervene before a court in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over a third party against whom the association may have rights through subrogation of the insurer's policyholders.

(13) (a) Any person receiving benefits under this chapter shall be considered to have assigned the rights under, and any causes of action relating to the covered policy or contract to the association to the extent of the benefits received because of this chapter, whether the benefits are payments of, or on account of, contractual obligations, continuation of coverage, or provision of substitute or alternative coverages. The association may require an assignment to it of these rights and causes of action by any payee, policy or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any right or benefits conferred by this chapter upon that person.

(b) The subrogation rights obtained by the association under this subsection become third class claims under Section 31A-27-335.

(c) In addition to Subsections (13)(a) and (b), the association has all common law rights of subrogation and any other equitable or legal remedy which would have been available to the impaired or insolvent insurer or holder of a policy or contract with respect to the policy or contract.

(14) The association may:

(a) enter into contracts which are necessary or proper to carry out the provisions and purposes of this chapter;

(b) sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under Section 31A-28-109 and to settle claims or potential claims against it;

(c) borrow money to effect the purposes of this chapter, and any notes or other evidence or indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

(d) employ or retain necessary staff members to handle the financial transactions of the association, and to perform other functions as become necessary or proper under this chapter;

(e) take necessary legal action to avoid payment of improper claims;

(f) exercise, for the purposes of this chapter and to the extent approved by the commissioner, the powers of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligation under this chapter; or

(g) act as a special deputy liquidator if appointed by the commissioner.

(15) The association may join an organization of one or more other state associations of

similar purposes to further the purposes and administer the powers and duties of the association.

Section 180. Section **31A-28-109** is amended to read:

31A-28-109. Assessments.

(1) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at the time and for the amounts that the board finds necessary. Assessments are due not less than 30 days after prior written notice to the member insurers. Class B assessments, described in Subsection (2)(b), shall accrue interest at 10% per annum on and after the due date.

(2) There are two classes of assessment:

(a) Class A assessments shall be made for the purpose of meeting administrative and legal costs and other expenses and examinations conducted under the authority of Subsection 31A-28-112(5). Class A assessments may be made whether or not related to a particular impaired or insolvent insurer.

(b) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the association under Section 31A-28-108 with regard to an impaired or an insolvent insurer.

(3) (a) The amount of any Class A assessment shall be determined by the board and may be made on a pro rata or non-pro rata basis. If the assessment is pro rata, the board may credit the assessment against future Class B assessments. A non-pro rata assessment may not exceed $150 per member insurer in any one calendar year.

(b) The amount of any Class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or based on any other standard determined by the board in its sole discretion to be fair and reasonable under the circumstances.

(c) (i) Class B assessments against member insurers for each account and subaccount shall be in the proportion that the premiums received on business in this state by each assessed member insurer bears to the premiums received on business in this state for the same calendar years by all assessed member insurers.

(ii) "Premiums received" is based on policies or contracts covered by each account for the three most recent calendar years for which information is available, which precede the year in which the insurer became impaired or insolvent.

(d) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer may not be made until necessary to implement the purposes of this chapter. Classification of assessments under Subsection (3)(b) and computation of assessments under this Subsection (3) shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(4) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

(5) (a) The total of all assessments upon a member insurer for the life and annuity account, and for each subaccount, may not in any one calendar year exceed 2% and the [~~disability~~] accident and health account may not in any one calendar year exceed 2% of the insurer's yearly average premiums received in this state on the policies and contracts covered by the account during the three calendar years preceding the year in which the insurer became an impaired or insolvent insurer. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon as permitted by this chapter.

(b) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(c) If a 1% assessment for any subaccount of the life and annuity account in any one year does not provide an amount sufficient to carry out the responsibilities of the association, the board shall assess all subaccounts of the life and annuity account for the necessary additional amount

pursuant to Subsection (3)(b), subject to the maximum stated in Subsection (5)(a).

(6) The board may, by an equitable method established in the plan of operation, refund to member insurers in proportion to the contribution of each insurer to that account the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains, and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses.

(7) It shall be proper for any member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance within the scope of this chapter, to consider the amount reasonably necessary to meet its assessment obligations under this chapter.

(8) The association shall issue to each insurer paying an assessment under this chapter, other than a Class A assessment, a certificate of contribution, in a form approved by the commissioner, for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the commissioner may approve.

Section 181. Section **31A-28-202** is amended to read:

31A-28-202. Scope.

This part applies to protect resident policyowners and insureds under all types of direct insurance, except:

(1) life[~~,~~];

(2) title[~~,~~];

(3) surety[~~, disability,~~];

(4) accident and health;

(5) credit, [~~(~~]including mortgage guarantee[~~),~~];

(6) ocean marine insurance[~~,~~];

(7) insurance of warranties or service contracts[~~,~~];

(8) financial guarantee[;]; and

(9) all insurance coverages guaranteed by the United States Government.

Section 182. Section **31A-29-103** is amended to read:

31A-29-103. Definitions.

As used in this chapter:

(1) "Board" means the board of directors of the pool created in Section 31A-29-104.

(2) "Health care facility" means any entity providing health care services which is licensed under Title 26, Chapter 21.

(3) "Health care provider" has the same meaning as provided in Section 78-14-3.

(4) "Health care services" means any service or product used in furnishing to any individual medical care or hospitalization, or incidental to furnishing medical care or hospitalization, and any other service or product furnished for the purpose of preventing, alleviating, curing, or healing human illness or injury.

(5) (a) "Health insurance" means any:

(i) hospital and medical expense-incurred policy;

(ii) nonprofit health care service plan contract; and

(iii) health maintenance organization subscriber contract.

(b) "Health insurance" does not include any insurance arising out of the Workers' Compensation Act or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is required by law to be contained in any liability insurance policy[;].

(6) "Health maintenance organization" has the same meaning as provided in Section 31A-8-101.

(7) "Health plan" means any arrangement by which a person, including a dependent or spouse, covered or making application to be covered under the pool has access to hospital and medical benefits or reimbursement including group or individual insurance or subscriber contract; coverage through a health maintenance organization, preferred provider prepayment, group practice, or individual practice plan; coverage under an uninsured arrangement of group or group-type

contracts including employer self-insured, cost-plus, or other benefits methodologies not involving insurance; coverage under a group type contract which is not available to the general public and can be obtained only because of connection with a particular organization or group; and coverage by medicare or other governmental benefit. The term includes coverage through health insurance.

(8) "Insured" means an individual resident of this state who is eligible to receive benefits from any insurer, health maintenance organization, or other health plan.

(9) "Insurer" means an insurance company authorized to transact [~~disability~~] accident and health insurance business in this state, health maintenance organization, and a self-insurer not subject to federal preemption.

(10) "Medicaid" means coverage under Title XIX of the Social Security Act, 42 U.S.C. Sec. 1396 et seq., as amended.

(11) "Medicare" means coverage under both Part A and B of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq., as amended.

(12) "Plan of operation" means the plan developed by the board in accordance with Section 31A-29-105 and includes the articles, bylaws, and operating rules adopted by the board under Section 31A-29-106.

(13) "Pool" means the Utah Comprehensive Health Insurance Pool created in Section 31A-29-104.

(14) "Pool Fund" means the Comprehensive Health Insurance Pool Enterprise Fund created in Section 31A-29-120.

(15) "Pool policy" means an insurance policy issued under this chapter.

(16) "Third-party administrator" has the same meaning as provided in Section 31A-1-301.

Section 183. 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:

(a) small employer index premium rates as of March 1 of the current and preceding year[.]; and

(b) average percentage change in the index premium rate 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 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 184. Section **31A-30-103** is amended to read:

31A-30-103. Definitions.

As used in this part:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual approved by the commissioner that a covered carrier is in compliance with the provisions of Section 31A-30-106, based upon the examination of the covered

carrier, including review of the appropriate records and of the actuarial assumptions and methods utilized by the covered carrier in establishing premium rates for applicable health benefit plans.

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

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

(4) "Basic coverage" means the coverage provided in the Basic Health Care Plan established by the Health Benefit Plan Committee under Subsection 31A-22-613.5[~~(8)~~] (6).

(5) "Carrier" means any person or entity that provides health insurance in this state including an insurance company, a prepaid hospital or medical care plan, a health maintenance organization, a multiple employer welfare arrangement, and any other person or entity providing a health insurance plan under this title.

(6) "Case characteristics" means demographic or other objective characteristics of a covered insured that are considered by the carrier in determining premium rates for the covered insured. However, duration of coverage since the policy was issued, claim experience, and health status, are not case characteristics for the purposes of this chapter.

(7) "Class of business" means all or a separate grouping of covered insureds established under Section 31A-30-105.

(8) "Conversion policy" means a policy providing coverage under the conversion provisions required in Title 31A, Chapter 22, Part VII, Group [~~Disability~~] Accident and Health Insurance.

(9) "Covered carrier" means any individual carrier or small employer carrier subject to this act.

(10) "Covered individual" means any individual who is covered under a health benefit plan subject to this act.

(11) "Covered insureds" means small employers and individuals who are issued a health

benefit plan that is subject to this act.

(12) "Dependent" means individuals to the extent they are defined to be a dependent by:

(a) the health benefit plan covering the covered individual; and

(b) the provisions of Chapter 22, Part VI, Disability Insurance.

(13) (a) "Eligible employee" means:

(i) an employee who works on a full-time basis and has a normal work week of 30 or more hours, and includes a sole proprietor, and a partner of a partnership, if the sole proprietor or partner is included as an employee under a health benefit plan of a small employer; or

(ii) an independent contractor if the independent contractor is included under a health benefit plan of a small employer.

(b) "Eligible employee" does not include:

(i) an employee who works on a part-time, temporary, or substitute basis; or

(ii) the spouse or dependents of the employer.

(14) "Established geographic service area" means a geographical area approved by the commissioner within which the carrier is authorized to provide coverage.

(15) "Health benefit plan" means any certificate under a group health insurance policy, or any health insurance policy, except that health benefit plan does not include coverage only for:

(a) accident;

(b) dental;

(c) vision;

(d) Medicare supplement;

(e) long-term care; or

(f) the following when offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance:

(i) specified disease;

(ii) hospital confinement indemnity; or

(iii) limited benefit plan.

(16) "Index rate" means, for each class of business as to a rating period for covered insureds

with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(17) "Individual carrier" means a carrier that offers health benefit plans covering insureds in this state under individual policies.

(18) "Individual conversion policy" means a conversion policy issued by a health benefit plan as defined in Subsection (15) to:

(a) an individual; or

(b) an individual with a family.

[~~(18)~~] (19) "Individual coverage count" means the number of natural persons covered under a carrier's health benefit plans that are individual policies.

[~~(19)~~] (20) "Individual enrollment cap" means the percentage set by the commissioner in accordance with Section 31A-30-110.

[~~(20)~~] (21) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or that could have been charged or offered, by the carrier to covered insureds with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

[~~(21)~~] (22) "Premium" means all monies paid by covered insureds and covered individuals as a condition of receiving coverage from a covered carrier, including any fees or other contributions associated with the health benefit plan.

[~~(22)~~] (23) "Rating period" means the calendar period for which premium rates established by a covered carrier are assumed to be in effect, as determined by the carrier. However, a covered carrier may not have more than one rating period in any calendar month, and no more than 12 rating periods in any calendar year.

[~~(23)~~] (24) "Resident" means an individual who has resided in this state for at least 12 consecutive months immediately preceding the date of application.

[~~(24)~~] (25) "Small employer" means any person, firm, corporation, partnership, or association actively engaged in business that, on at least 50% of its working days during the preceding calendar quarter, employed at least two and no more than 50 eligible employees, the

majority of whom were employed within this state. In determining the number of eligible employees, companies that are affiliated or that are eligible to file a combined tax return for purposes of state taxation are considered one employer.

[~~(25)~~] (26) "Small employer carrier" means a carrier that offers health benefit plans covering eligible employees of one or more small employers in this state.

[~~(26)~~] (27) "Uninsurable" means an individual who:

(a) is eligible for the Comprehensive Health Insurance Pool coverage under the underwriting criteria established in Subsection 31A-29-111(4); or

(b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and

(ii) has a condition of health that does not meet consistently applied underwriting criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(k) and (l) for which coverage the applicant is applying.

[~~(27)~~] (28) "Uninsurable percentage" for a given calendar year equals UC/CI where, for purposes of this formula:

(a) "UC" means the number of uninsurable individuals who were issued an individual policy on or after July 1, 1997; and

(b) "CI" means the carrier's individual coverage count as of December 31 of the preceding year.

Section 185. Section **31A-30-104** is amended to read:

31A-30-104. Applicability and scope.

(1) This chapter applies to any:

(a) health benefit plan that provides coverage to:

(i) individuals;

(ii) small employer groups; or

(iii) both Subsections (1)(a)(i) and (ii); or

(b) individual conversion policy for purposes of [~~Section~~] Sections 31A-30-106.5 and 31A-30-107.

(2) (a) Except as provided in Subsection (2)(b), for the purposes of this chapter, carriers that

are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by this chapter shall apply as if all health benefit plans delivered or issued for delivery to covered insureds in this state by the affiliated carriers were issued by one carrier.

(b) An affiliated carrier that is a health maintenance organization having a certificate of authority under this title may be considered to be a separate carrier for the purposes of this chapter.

(c) Unless otherwise authorized by the commissioner, a covered carrier may not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to covered insureds in this state if such arrangements would result in less than 50% of the insurance obligation or risk for such health benefit plans being retained by the ceding carrier.

(d) The provisions of Section 31A-22-1201 apply if a covered carrier cedes or assumes all of the insurance obligation or risk with respect to one or more health benefit plans delivered or issued for delivery to covered insureds in this state.

(3) (a) A Taft Hartley trust created in accordance with Section 302(c)(5) of the Federal Labor Management Relations Act, or a carrier with the written authorization of such a trust, may make a written request to the commissioner for a waiver from the application of any of the provisions of Subsection 31A-30-106(1) with respect to a health benefit plan provided to the trust.

(b) The commissioner may grant such a waiver if the commissioner finds that application with respect to the trust would:

(i) have a substantial adverse effect on the participants and beneficiaries of the trust; and

(ii) require significant modifications to one or more collective bargaining arrangements under which the trust is established or maintained.

(c) A waiver granted under this Subsection (3) may not apply to an individual if the person participates in such a trust as an associate member of any employee organization.

(4) A carrier who offers individual and small employer health benefit plans may use the small employer index rates to establish the rate limitations for individual policies, even if some individual policies are rated below the small employer base rate.

(5) Sections 31A-30-106, 31A-30-106.5, 31A-30-106.7, 31A-30-107, 31A-30-108, and

31A-30-111 apply to:

(a) any insurer engaging in the business of insurance related to the risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of its employees provided as an employee benefit; and

(b) any contract of an insurer, other than a workers' compensation policy, related to the risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of its employees provided as an employee benefit.

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

(a) an insurer and its agent;

(b) an insurance broker; and

(c) an insurance consultant.

Section 186. Section **31A-30-106** is amended to read:

31A-30-106. Premiums -- Rating restrictions -- Disclosure.

(1) Premium rates for health benefit plans under this chapter are subject to the following provisions:

(a) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than 20%.

(b) For a class of business, the premium rates charged during a rating period to covered insureds with similar case characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system for that class of business, may not vary from the index rate by more than 30% of the index rate, except as provided in Section 31A-22-625.

(c) The percentage increase in the premium rate charged to a covered insured for a new rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the covered carrier is no longer enrolling new covered insureds, the covered carrier shall

use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the covered carrier is actively enrolling new covered insureds;

(ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the covered individuals as determined from the covered carrier's rate manual for the class of business, except as provided in Section 31A-22-625; and

(iii) any adjustment due to change in coverage or change in the case characteristics of the covered insured as determined from the covered carrier's rate manual for the class of business.

(d) Adjustments in rates for claims experience, health status, and duration from issue may not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

(e) A covered carrier may utilize industry as a case characteristic in establishing premium rates, provided that the highest rate factor associated with any industry classification does not exceed the lowest rate factor associated with any industry classification by more than 15%.

(f) In the case of health benefit plans issued prior to July 1, 1994, a premium rate for a rating period, adjusted pro rata for rating period of less than a year, may exceed the ranges under Subsections (1)(a) and (b) until July 1, 1996. In that case, the percentage increase in the premium rate charged to a covered insured for a new rating period may not exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case where a covered carrier is not issuing any new policies the covered carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the covered carrier is actively enrolling new covered insureds; and

(ii) any adjustment due to change in coverage or change in the case characteristics of the covered insured as determined from the carrier's rate manual for the class of business.

(g) The commissioner may grant a one-year extension of the July 1, 1996, deadline specified

in Subsection (1)(f) if the commissioner determines that an extension is needed to avoid significant disruption of the health insurance market subject to this chapter or to insure the financial stability of carriers in the market.

(h) (i) Covered carriers shall apply rating factors, including case characteristics, consistently with respect to all covered insureds in a class of business. Rating factors shall produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

(ii) A covered carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(i) For the purposes of this subsection, a health benefit plan that utilizes a restricted network provision shall not be considered similar coverage to a health benefit plan that does not utilize such a network, provided that utilization of the restricted network provision results in substantial difference in claims costs.

(j) The covered carrier shall not, without prior approval of the commissioner, use case characteristics other than age, gender, industry, geographic area, family composition, and group size.

(k) The commissioner may establish regulations in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, to implement the provisions of this chapter and to assure that rating practices used by covered carriers are consistent with the purposes of this chapter, including regulations that:

(i) assure that differences in rates charged for health benefit plans by covered carriers are reasonable and reflect objective differences in plan design (not including differences due to the nature of the groups assumed to select particular health benefit plans);

(ii) prescribe the manner in which case characteristics may be used by covered carriers;

(iii) require insurers, as a condition of transacting business with regard to health care insurance [~~disability~~] policies after January 1, 1995, to reissue a health care insurance [~~disability~~] policy to any policyholder whose health care insurance [~~disability~~] policy has, after January 1, 1994, been terminated by the insurer for reasons other than those listed in Subsections 31A-30-107(1)(a) through (1)(e) or not renewed by the insurer after January 1, 1994. The commissioner may prescribe

terms for the reissue of coverage that the commissioner determines are reasonable and necessary to provide continuity of coverage to insured individuals;

(iv) implement the individual enrollment cap under Section 31A-30-110, including specifying the contents for certification, auditing standards, underwriting criteria for uninsurable classification, and limitations on high risk enrollees under Section 31A-30-111; and

(v) establish the individual enrollment cap under Subsection 31A-30-110(1).

(l) Before implementing regulations for underwriting criteria for uninsurable classification, the commissioner shall contract with an independent consulting organization to develop industry-wide underwriting criteria for uninsurability based on an individual's expected claims under open enrollment coverage exceeding 200% of that expected for a standard insurable individual with the same case characteristics.

(m) The commissioner shall revise rules issued for Sections 31A-22-602 and 31A-22-605 regarding individual [~~disability~~] accident and health policy rates to allow rating in accordance with this section.

(2) A covered carrier shall not transfer a covered insured involuntarily into or out of a class of business. A covered carrier shall not offer to transfer a covered insured into or out of a class of business unless such offer is made to transfer all covered insureds in the class of business without regard to case characteristics, claim experience, health status, or duration of coverage since issue.

(3) Upon offering for sale any health benefit plan to a small employer, or individual, the covered carrier shall, as part of its solicitation and sales materials, disclose or make available all of the following:

(a) the extent to which premium rates for a specified covered insured are established or adjusted in part based on the actual or expected variation in claims costs or actual or expected variation in health status of covered individuals;

(b) provisions concerning the covered carrier's right to change premium rates and the factors other than claim experience which affect changes in premium rates;

(c) provisions relating to renewability of policies and contracts; and

(d) provisions relating to any preexisting condition provision.

(4) (a) Each covered carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(b) Each covered carrier shall file with the commissioner, on or before March 15 of each year, in a form, manner, and containing such information as prescribed by the commissioner, an actuarial certification certifying that the covered carrier is in compliance with this chapter and that the rating methods of the covered carrier are actuarially sound. A copy of that certification shall be retained by the covered carrier at its principal place of business.

(c) A covered carrier shall make the information and documentation described in this subsection available to the commissioner upon request.

(d) Records submitted to the commissioner under the provisions of this section shall be maintained by the commissioner as protected records under Title 63, Chapter 2, Government Records Access and Management Act.

Section 187. Section **31A-30-106.5** is amended to read:

31A-30-106.5. Conversion policy -- Premiums -- Rating restrictions.

(1) All provisions of Section 31A-30-106, except Subsection 31A-30-106(1)(b), apply to conversion policies.

(2) Conversion policy premium rates may not exceed by more than 35% the index rate for individuals with similar case characteristics for any class of business in which the policy form has been approved.

(3) An insurer may not consider pregnancy of a covered insured in determining its conversion policy premium rates.

Section 188. 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[~~.~~]; and

(iii) provide a plan of orderly withdrawal as required by Section 31A-4-115.

(2) Notice under 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.

(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.

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

(5) Health benefit plans covering covered insureds shall comply with 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.

(iii) An individual insurer shall offer a health benefit plan in compliance with Subsections (5)(a)(i) and (ii), and may, when the insurer and the insured mutually agree in writing to a condition-specific exclusion rider, offer to issue an individual policy that excludes a specific physical condition consistent with Subsections (5)(a)(iv) and (v).

(iv) The commissioner shall establish, in rule, a list of nonlife threatening [~~and nondegenerative~~] physical conditions that may be the subject of a condition-specific exclusion rider.

(v) A condition-specific exclusion rider shall be limited to the excluded condition and may not extend to any secondary medical condition that may or may not be directly related to the excluded condition.

(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 63 <u>full</u> 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 (5)(b)(i)(A) 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 the plan.

(iii) Credit for previous coverage as provided under Subsection (5)(b)(i)(A) need not be given for any condition which was previously excluded under a condition-specific exclusion rider. A new preexisting waiting period may be applied to any condition that was excluded by a rider under the terms of previous individual coverage.

Section 189. Section **31A-32a-102** is amended to read:

31A-32a-102. Definitions.

As used in this chapter:

(1) "Account administrator" means any of the following:

(a) a depository institution as defined in Section 7-1-103;

(b) a trust company as defined in Section 7-1-103;

(c) an insurance company authorized to do business in this state under this title;

(d) a third party administrator licensed under Section 31A-25-203; and

(e) an employer if the employer has a self-insured health plan under ERISA.

(2) "Account holder" means the resident individual who establishes a medical care savings account or for whose benefit a medical care savings account is established.

(3) "Deductible" means the total deductible for an employee and all the dependents of that employee for a calendar year.

(4) "Dependent" means the same as "dependent" under Section 31A-30-103.

(5) "Eligible medical expense" means an expense paid by the taxpayer for:

(a) medical care described in Section 213(d), Internal Revenue Code;

(b) the purchase of a health coverage policy, certificate, or contract, including a qualified higher deductible health plan; or

(c) premiums on long-term care insurance policies as defined in Section [~~31A-22-1402~~] 31A-1-301.

(6) "Employee" means the individual for whose benefit or for the benefit of whose dependents a medical care savings account is established. Employee includes a self-employed individual.

(7) "ERISA" means the Employee Retirement Income Security Act of 1974, Public Law 93-406, 88 Stat. 829.

(8) "Higher deductible" means a deductible of not less than $1,000.

(9) "Medical care savings account" or "account" means a trust account established at a depository institution in this state pursuant to a medical care savings account program to pay the eligible medical expenses of:

(a) an employee or account holder; and

(b) the dependents of the employee or account holder.

(10) "Medical care savings account program" or "program" means one of the following programs:

(a) a program established by an employer in which the employer:

(i) purchases a qualified higher deductible health plan for the benefit of an employee and the employee's dependents; and

(ii) contributes on behalf of an employee into a medical care savings account; or

(b) a program established by an account holder in which the account holder:

(i) purchases a qualified higher deductible health plan for the benefit of the account holder and the account holder's dependents; and

(ii) contributes an amount to the medical care savings account.

(11) "Qualified higher deductible health plan" means a health coverage policy, certificate, or contract that:

(a) provides for payments for covered benefits that exceed the higher deductible; and

(b) is purchased by:

(i) an employer for the benefit of an employee for whom the employer makes deposits into a medical care savings account; or

(ii) an account holder.

Section 190. Section **31A-33-103.5** is amended to read:

31A-33-103.5. Powers of Fund -- Limitations.

(1) The fund may form or acquire subsidiaries or enter into a joint enterprise:

(a) in accordance with Section 31A-33-107; and

(b) except as limited by this section and applicable insurance rules and statutes.

(2) Subject to applicable insurance rules and statutes, the fund may only offer:

(a) workers' compensation insurance in Utah;

(b) workers' compensation insurance in a state other than Utah to the extent necessary to:

(i) accomplish its purpose under Subsection 31A-33-102(1)(b); and

(ii) provide workers' compensation or occupational disease insurance coverage to Utah employers and their employees engaged in interstate commerce; and

(c) workers' compensation products and services in Utah or other states.

(3) Subject to applicable insurance rules and statutes, a subsidiary of the fund may:

(a) offer workers' compensation insurance coverage only:

(i) in a state other than Utah; and

(ii) (A) to insure the following against liability for compensation based on job-related accidental injuries and occupational diseases[~~;~~]:

(I) an employer, as defined in Section 34A-2-103, that has a majority of its employees, as defined in Section 34A-2-104, hired or regularly employed in Utah;

(II) an employer, as defined in Section 34A-2-103, whose principal administrative office is located in Utah; or

(III) a subsidiary or affiliate of an employer described in Subsection (3)(a)(ii)(A)(I) or (II); or

(B) for a state fund organization that is not an admitted insurer in the other state:

(I) on a fee for service basis; and

(II) without bearing any insurance risk; and

(b) offer workers' compensation products and services in Utah and other states.

(4) The fund shall write workers' compensation insurance in accordance with Section 31A-22-1001.

(5) (a) The fund may enter into a joint enterprise that offers workers' compensation insurance and other coverage only in the state, provided:

(i) the joint enterprise offers only property or liability insurance in addition to workers' compensation insurance;

(ii) the fund may not bear any insurance risk associated with the insurance coverage other than risk associated with workers' compensation insurance; and

(iii) the offer of other insurance shall be part of an insurance program that includes workers' compensation insurance coverage that is provided by the fund.

(b) The fund or a subsidiary of the fund may not offer, or enter into a joint enterprise that offers, or otherwise participate in the offering of accident and health [~~or disability~~] insurance.

Section 191. Section **31A-33-113** is amended to read:

31A-33-113. Cancellation of policies.

The Workers' Compensation Fund may cancel a policy [~~prior to the conclusion of the policy period only:~~] as provided in Section 31A-22-1002.

[~~(1) (a) by agreeing to the cancellation with the policyholder; and~~]

[~~(b) sending notice of the cancellation to the Labor Commission;~~]

[~~(2) for nonpayment of premium, after 30 days' notice to:~~]

[~~(a) the Labor Commission; and~~]

[~~(b) the policyholder; or~~]

[~~(3) for failure on the part of the policyholder to comply with the contractual provisions of the policy, after 30 days' notice to:~~]

[~~(a) the Labor Commission; and~~]

[~~(b) the policyholder.~~]

Section 192. Section **34A-2-103** is amended to read:

34A-2-103. Employers enumerated and defined -- Regularly employed -- Statutory employers.

(1) (a) The state, and each county, city, town, and school district in the state are considered employers under this chapter and Chapter 3, Utah Occupational Disease Act.

(b) For the purposes of the exclusive remedy in this chapter and Chapter 3, Utah Occupational Disease Act prescribed in Sections 34A-2-105 and 34A-3-102, the state is considered

to be a single employer and includes any office, department, agency, authority, commission, board, institution, hospital, college, university, or other instrumentality of the state.

(2) Except as provided in Subsection (4), each person, including each public utility and each independent contractor, who regularly employs one or more workers or operatives in the same business, or in or about the same establishment, under any contract of hire, express or implied, oral or written, is considered an employer under this chapter and Chapter 3, Utah Occupational Disease Act. As used in this Subsection (2):

(a) "Independent contractor" means any person engaged in the performance of any work for another who, while so engaged, is:

(i) independent of the employer in all that pertains to the execution of the work;

(ii) not subject to the routine rule or control of the employer;

(iii) engaged only in the performance of a definite job or piece of work; and

(iv) subordinate to the employer only in effecting a result in accordance with the employer's design.

(b) "Regularly" includes all employments in the usual course of the trade, business, profession, or occupation of the employer, whether continuous throughout the year or for only a portion of the year.

(3) (a) The client company in an employee leasing arrangement under Title 58, Chapter 59, Professional Employer Organization Licensing Act, is considered the employer of leased employees and shall secure workers' compensation benefits for them by complying with Subsection 34A-2-201(1) or (2) and commission rules.

(b) Insurance carriers may underwrite workers' compensation secured in accordance with Subsection (3)(a) showing the leasing company as the named insured and each client company as an additional insured by means of individual endorsements.

(c) Endorsements shall be filed with the division as directed by commission rule.

(d) The division shall promptly inform the Division of Occupation and Professional Licensing within the Department of Commerce if the division has reason to believe that an employee leasing company is not in compliance with Subsection 34A-2-201(1) or (2) and commission rules.

(4) A domestic employer who does not employ one employee or more than one employee at least 40 hours per week is not considered an employer under this chapter and Chapter 3, Utah Occupational Disease Act.

(5) (a) As used in this Subsection (5):

(i) (A) "agricultural employer" means a person who employs agricultural labor as defined in Subsections 35A-4-206(1) and (2) and does not include employment as provided in Subsection 35A-4-206(3); and

(B) notwithstanding Subsection (5)(a)(i)(A), only for purposes of determining who is a member of the employer's immediate family under Subsection (5)(a)(ii), if the agricultural employer is a corporation, partnership, or other business entity, "agricultural employer" means an officer, director, or partner of the business entity;

(ii) "employer's immediate family" means:

(A) an agricultural employer's:

(I) spouse;

(II) grandparent;

(III) parent;

(IV) sibling;

(V) child;

(VI) grandchild;

(VII) nephew; or

(VIII) niece;

(B) a spouse of any person provided in Subsection [~~(4)~~] (5)(a)(ii)(A)(II) through (VIII); or

(C) an individual who is similar to those listed in Subsections [~~(4)~~] (5)(a)(ii)(A) or (B) as defined by rules of the commission; and

(iii) "non-immediate family" means a person who is not a member of the employer's immediate family.

(b) For purposes of this chapter and Chapter 3, Utah Occupational Disease Act, an agricultural employer is not considered an employer of a member of the employer's immediate

family.

(c) For purposes of this chapter and Chapter 3, Utah Occupational Disease Act, an agricultural employer is not considered an employer of a non-immediate family employee if:

(i) for the previous calendar year the agricultural employer's total annual payroll for all non-immediate family employees was less than $8,000; or

(ii) (A) for the previous calendar year the agricultural employer's total annual payroll for all non-immediate family employees was equal to or greater than $8,000 but less than $50,000; and

(B) the agricultural employer maintains insurance that covers job-related injuries of the employer's non-immediate family employees in at least the following amounts:

(I) $300,000 liability insurance, as defined in Section 31A-1-301; and

(II) $5,000 for [~~medical, hospital, and surgical~~] health care benefits similar to benefits under health care insurance as [~~described~~] defined in [~~Subsection~~] Section 31A-1-301[~~(50)(a)(ii)~~].

(d) For purposes of this chapter and Chapter 3, Utah Occupational Disease Act, an agricultural employer is considered an employer of a non-immediate family employee if:

(i) for the previous calendar year the agricultural employer's total annual payroll for all non-immediate family employees is equal to or greater than $50,000; or

(ii) (A) for the previous year the agricultural employer's total payroll for non-immediate family employees was equal to or exceeds $8,000 but is less than $50,000; and

(B) the agricultural employer fails to maintain the insurance required under Subsection (5)(c)(ii).

(6) An employer of agricultural laborers or domestic servants who is not considered an employer under this chapter and Chapter 3, Utah Occupational Disease Act, may come under this chapter and Chapter 3, Utah Occupational Disease Act, by complying with:

(a) this chapter and Chapter 3, Utah Occupational Disease Act; and

(b) the rules of the commission.

(7) (a) If any person who is an employer procures any work to be done wholly or in part for the employer by a contractor over whose work the employer retains supervision or control, and this work is a part or process in the trade or business of the employer, the contractor, all persons

employed by the contractor, all subcontractors under the contractor, and all persons employed by any of these subcontractors, are considered employees of the original employer for the purposes of this chapter and Chapter 3, Utah Occupational Disease Act.

(b) Any person who is engaged in constructing, improving, repairing, or remodelling a residence that the person owns or is in the process of acquiring as the person's personal residence may not be considered an employee or employer solely by operation of Subsection (7)(a).

(c) A partner in a partnership or an owner of a sole proprietorship may not be considered an employee under Subsection (7)(a) if the employer who procures work to be done by the partnership or sole proprietorship obtains and relies on either:

(i) a valid certification of the partnership's or sole proprietorship's compliance with Section 34A-2-201 indicating that the partnership or sole proprietorship secured the payment of workers' compensation benefits pursuant to Section 34A-2-201; or

(ii) if a partnership or sole proprietorship with no employees other than a partner of the partnership or owner of the sole proprietorship, a workers' compensation policy issued by an insurer pursuant to Subsection 31A-21-104(8) stating that:

(A) the partnership or sole proprietorship is customarily engaged in an independently established trade, occupation, profession, or business; and

(B) the partner or owner personally waives the partner's or owner's entitlement to the benefits of this chapter and Chapter 3, Utah Occupational Disease Act, in the operation of the partnership or sole proprietorship.

(d) A director or officer of a corporation may not be considered an employee under Subsection (7)(a) if the director or officer is excluded from coverage under Subsection 34A-2-104(4).

(e) A contractor or subcontractor is not an employee of the employer under Subsection (7)(a), if the employer who procures work to be done by the contractor or subcontractor obtains and relies on either:

(i) a valid certification of the contractor's or subcontractor's compliance with Section 34A-2-201; or

(ii) if a partnership, corporation, or sole proprietorship with no employees other than a partner of the partnership, officer of the corporation, or owner of the sole proprietorship, a workers' compensation policy issued by an insurer pursuant to Subsection 31A-21-104(8) stating that:

(A) the partnership, corporation, or sole proprietorship is customarily engaged in an independently established trade, occupation, profession, or business; and

(B) the partner, corporate officer, or owner personally waives the partner's, corporate officer's, or owner's entitlement to the benefits of this chapter and Chapter 3, Utah Occupational Disease Act, in the operation of the partnership's, corporation's, or sole proprietorship's enterprise under a contract of hire for services.

Section 193. Section **58-67-501** is amended to read:

58-67-501. Unlawful conduct.

(1) "Unlawful conduct" includes, in addition to the definition in Section 58-1-501:

(a) buying, selling, or fraudulently obtaining, any medical diploma, license, certificate, or registration;

(b) aiding or abetting the buying, selling, or fraudulently obtaining of any medical diploma, license, certificate, or registration;

(c) substantially interfering with a licensee's lawful and competent practice of medicine in accordance with this chapter by:

(i) any person or entity that manages, owns, operates, or conducts a business having a direct or indirect financial interest in the licensee's professional practice; or

(ii) anyone other than another physician licensed under this title, who is engaged in direct clinical care or consultation with the licensee in accordance with the standards and ethics of the profession of medicine; or

(d) entering into a contract that limits a licensee's ability to advise the licensee's patients fully about treatment options or other issues that affect the health care of the licensee's patients.

(2) "Unlawful conduct" does not include:

(a) establishing, administering, or enforcing the provisions of a policy of [~~disability~~] accident and health insurance by an insurer doing business in this state in accordance with Title 31A,

Insurance Code;

(b) adopting, implementing, or enforcing utilization management standards related to payment for a licensee's services, provided that:

(i) utilization management standards adopted, implemented, and enforced by the payer have been approved by a physician or by a committee that contains one or more physicians; and

(ii) the utilization management standards does not preclude a licensee from exercising independent professional judgment on behalf of the licensee's patients in a manner that is independent of payment considerations;

(c) developing and implementing clinical practice standards that are intended to reduce morbidity and mortality or developing and implementing other medical or surgical practice standards related to the standardization of effective health care practices, provided that:

(i) the practice standards and recommendations have been approved by a physician or by a committee that contains one or more physicians; and

(ii) the practice standards do not preclude a licensee from exercising independent professional judgment on behalf of the licensee's patients in a manner that is independent of payment considerations;

(d) requesting or recommending that a patient obtain a second opinion from a licensee;

(e) conducting peer review, quality evaluation, quality improvement, risk management, or similar activities designed to identify and address practice deficiencies with health care providers, health care facilities, or the delivery of health care;

(f) providing employment supervision or adopting employment requirements that do not interfere with the licensee's ability to exercise independent professional judgment on behalf of the licensee's patients, provided that employment requirements that may not be considered to interfere with an employed licensee's exercise of independent professional judgment include:

(i) an employment requirement that restricts the licensee's access to patients with whom the licensee's employer does not have a contractual relationship, either directly or through contracts with one or more third-party payers; or

(ii) providing compensation incentives that are not related to the treatment of any particular

patient;

(g) providing benefit coverage information, giving advice, or expressing opinions to a patient or to a family member of a patient to assist the patient or family member in making a decision about health care that has been recommended by a licensee; or

(h) any otherwise lawful conduct that does not substantially interfere with the licensee's ability to exercise independent professional judgment on behalf of the licensee's patients and that does not constitute the practice of medicine as defined in this chapter.

Section 194. Section **58-68-501** is amended to read:

58-68-501. Unlawful conduct.

(1) "Unlawful conduct" includes, in addition to the definition in Section 58-1-501:

(a) buying, selling, or fraudulently obtaining any osteopathic medical diploma, license, certificate, or registration; and

(b) aiding or abetting the buying, selling, or fraudulently obtaining of any osteopathic medical diploma, license, certificate, or registration;

(c) substantially interfering with a licensee's lawful and competent practice of medicine in accordance with this chapter by:

(i) any person or entity that manages, owns, operates, or conducts a business having a direct or indirect financial interest in the licensee's professional practice; or

(ii) anyone other than another physician licensed under this title, who is engaged in direct clinical care or consultation with the licensee in accordance with the standards and ethics of the profession of medicine; or

(d) entering into a contract that limits a licensee's ability to advise the licensee's patients fully about treatment options or other issues that affect the health care of the licensee's patients.

(2) "Unlawful conduct" does not include:

(a) establishing, administering, or enforcing the provisions of a policy of [~~disability~~] accident and health insurance by an insurer doing business in this state in accordance with Title 31A, Insurance Code;

(b) adopting, implementing, or enforcing utilization management standards related to

payment for a licensee's services, provided that:

(i) utilization management standards adopted, implemented, and enforced by the payer have been approved by a physician or by a committee that contains one or more physicians; and

(ii) the utilization management standards does not preclude a licensee from exercising independent professional judgment on behalf of the licensee's patients in a manner that is independent of payment considerations;

(c) developing and implementing clinical practice standards that are intended to reduce morbidity and mortality or developing and implementing other medical or surgical practice standards related to the standardization of effective health care practices, provided that:

(i) the practice standards and recommendations have been approved by a physician or by a committee that contains one or more physicians; and

(ii) the practice standards do not preclude a licensee from exercising independent professional judgment on behalf of the licensee's patients in a manner that is independent of payment considerations;

(d) requesting or recommending that a patient obtain a second opinion from a licensee;

(e) conducting peer review, quality evaluation, quality improvement, risk management, or similar activities designed to identify and address practice deficiencies with health care providers, health care facilities, or the delivery of health care;

(f) providing employment supervision or adopting employment requirements that do not interfere with the licensee's ability to exercise independent professional judgment on behalf of the licensee's patients, provided that employment requirements that may not be considered to interfere with an employed licensee's exercise of independent professional judgment include:

(i) an employment requirement that restricts the licensee's access to patients with whom the licensee's employer does not have a contractual relationship, either directly or through contracts with one or more third-party payers; or

(ii) providing compensation incentives that are not related to the treatment of any particular patient;

(g) providing benefit coverage information, giving advice, or expressing opinions to a patient

or to a family member of a patient to assist the patient or family member in making a decision about health care that has been recommended by a licensee; or

(h) any otherwise lawful conduct that does not substantially interfere with the licensee's ability to exercise independent professional judgment on behalf of the licensee's patients and that does not constitute the practice of medicine as defined in this chapter.

Section 195. Section **59-10-114** is amended to read:

59-10-114. Additions to and subtractions from federal taxable income of an individual.

(1) There shall be added to federal taxable income of a resident or nonresident individual:

(a) the amount of any income tax imposed by this or any predecessor Utah individual income tax law and the amount of any income tax imposed by the laws of another state, the District of Columbia, or a possession of the United States, to the extent deducted from federal adjusted gross income, as defined by Section 62, Internal Revenue Code, in determining federal taxable income;

(b) a lump sum distribution allowable as a deduction under Section 402(d)(3), Internal Revenue Code, to the extent deductible under Section 62(a)(8), Internal Revenue Code, in determining federal adjusted gross income;

(c) 25% of the personal exemptions, as defined and calculated in the Internal Revenue Code;

(d) a withdrawal from a medical care savings account and any penalty imposed in the taxable year if:

(i) the taxpayer did not deduct or include the amounts on his federal tax return pursuant to Section 220, Internal Revenue Code; and

(ii) the withdrawal is subject to Subsections 31A-32a-105(1) and (2); and

(e) the amount refunded to a participant under Title 53B, Chapter 8a, Higher Education Savings Incentive Program, in the year in which the amount is refunded.

(2) There shall be subtracted from federal taxable income of a resident or nonresident individual:

(a) the interest or dividends on obligations or securities of the United States and its possessions or of any authority, commission, or instrumentality of the United States, to the extent includable in gross income for federal income tax purposes but exempt from state income taxes

under the laws of the United States, but the amount subtracted under this subsection shall be reduced by any interest on indebtedness incurred or continued to purchase or carry the obligations or securities described in this subsection, and by any expenses incurred in the production of interest or dividend income described in this subsection to the extent that such expenses, including amortizable bond premiums, are deductible in determining federal taxable income;

(b) 1/2 of the net amount of any income tax paid or payable to the United States after all allowable credits, as reported on the United States individual income tax return of the taxpayer for the same taxable year;

(c) the amount of adoption expenses which, for purposes of this subsection, means any actual medical and hospital expenses of the mother of the adopted child which are incident to the child's birth and any welfare agency, child placement service, legal, and other fees or costs relating to the adoption;

(d) amounts received by taxpayers under age 65 as retirement income which, for purposes of this section, means pensions and annuities, paid from an annuity contract purchased by an employer under a plan which meets the requirements of Section 404(a)(2), Internal Revenue Code, or purchased by an employee under a plan which meets the requirements of Section 408, Internal Revenue Code, or paid by the United States, a state, or political subdivision thereof, or the District of Columbia, to the employee involved or the surviving spouse;

(e) for each taxpayer age 65 or over before the close of the taxable year, a $7,500 personal retirement exemption;

(f) 75% of the amount of the personal exemption, as defined and calculated in the Internal Revenue Code, for each dependent child with a disability and adult with a disability who is claimed as a dependent on a taxpayer's return;

(g) any amount included in federal taxable income that was received pursuant to any federal law enacted in 1988 to provide reparation payments, as damages for human suffering, to United States citizens and resident aliens of Japanese ancestry who were interned during World War II;

(h) subject to the limitations of Subsection (3)(e), amounts a taxpayer pays during the taxable
year for health care insurance, as defined in Title 31A, Chapter 1, General Provisions:

(i) for:

(A) the taxpayer;

(B) the taxpayer's spouse; and

(C) the taxpayer's dependents; and

(ii) to the extent the taxpayer does not deduct the amounts under Section 125, 162, or 213, Internal Revenue Code, in determining federal taxable income for the taxable year;

(i) except as otherwise provided in this subsection, the amount of a contribution made in the tax year on behalf of the taxpayer to a medical care savings account and interest earned on a contribution to a medical care savings account established pursuant to Title 31A, Chapter 32a, Medical Care Savings Account Act, to the extent the contribution is accepted by the account administrator as provided in the Medical Care Savings Account Act, and if the taxpayer did not deduct or include amounts on his federal tax return pursuant to Section 220, Internal Revenue Code. A contribution deductible under this subsection may not exceed either of the following:

(i) the maximum contribution allowed under the Medical Care Savings Account Act for the tax year multiplied by two for taxpayers who file a joint return, if neither spouse is covered by health care insurance as defined in Section 31A-1-301 or self-funded plan that covers the other spouse, and each spouse has a medical care savings account; or

(ii) the maximum contribution allowed under the Medical Care Savings Account Act for the tax year for taxpayers:

(A) who do not file a joint return; or

(B) who file a joint return, but do not qualify under Subsection (2)(i)(i); and

(j) the amount included in federal taxable income that was derived from money paid by the taxpayer to the program fund under Title 53B, Chapter 8a, Higher Education Savings Incentive Program, not to exceed amounts determined under Subsection 53B-8a-106(1)(d) and investment income earned on participation agreements under Subsection 53B-8a-106(1) when used for higher education costs of the beneficiary;

(k) for tax years beginning on or after January 1, 2000, any amounts paid for premiums on long-term care insurance policies as defined in Section [~~31A-22-1402~~] 31A-1-301 to the extent the

amounts paid for long-term care insurance were not deducted under Section 213, Internal Revenue Code, in determining federal taxable income; and

(l) for taxable years beginning on or after January 1, 2000, if the conditions of Subsection (4)(a) are met, the amount of income derived by a Ute tribal member:

(i) during a time period that the Ute tribal member resides on homesteaded land diminished from the Uintah and Ouray Reservation; and

(ii) from a source within the Uintah and Ouray Reservation.

(3) (a) For purposes of Subsection (2)(d), the amount of retirement income subtracted for taxpayers under 65 shall be the lesser of the amount included in federal taxable income, or $4,800, except that:

(i) for married taxpayers filing joint returns, for each $1 of adjusted gross income earned over $32,000, the amount of the retirement income exemption that may be subtracted shall be reduced by 50 cents;

(ii) for married taxpayers filing separate returns, for each $1 of adjusted gross income earned over $16,000, the amount of the retirement income exemption that may be subtracted shall be reduced by 50 cents; and

(iii) for individual taxpayers, for each $1 of adjusted gross income earned over $25,000, the amount of the retirement income exemption that may be subtracted shall be reduced by 50 cents.

(b) For purposes of Subsection (2)(e), the amount of the personal retirement exemption shall be further reduced according to the following schedule:

(i) for married taxpayers filing joint returns, for each $1 of adjusted gross income earned over $32,000, the amount of the personal retirement exemption shall be reduced by 50 cents;

(ii) for married taxpayers filing separate returns, for each $1 of adjusted gross income earned over $16,000, the amount of the personal retirement exemption shall be reduced by 50 cents; and

(iii) for individual taxpayers, for each $1 of adjusted gross income earned over $25,000, the amount of the personal retirement exemption shall be reduced by 50 cents.

(c) For purposes of Subsections (3)(a) and (b), adjusted gross income shall be calculated by adding to federal adjusted gross income any interest income not otherwise included in federal

adjusted gross income.

(d) For purposes of determining ownership of items of retirement income common law doctrine will be applied in all cases even though some items may have originated from service or investments in a community property state. Amounts received by the spouse of a living retiree because of the retiree's having been employed in a community property state are not deductible as retirement income of such spouse.

(e) For purposes of Subsection (2)(h), a subtraction for an amount paid for health care insurance as defined in Title 31A, Chapter 1, General Provisions, is not allowed:

(i) for an amount that is reimbursed or funded in whole or in part by the federal government, the state, or an agency or instrumentality of the federal government or the state; and

(ii) for a taxpayer who is eligible to participate in a health plan maintained and funded in whole or in part by the taxpayer's employer or the taxpayer's spouse's employer.

(4) (a) A subtraction for an amount described in Subsection (2)(l) is allowed only if:

(i) the taxpayer is a Ute tribal member; and

(ii) the governor and the Ute tribe execute and maintain an agreement meeting the requirements of this Subsection (4).

(b) The agreement described in Subsection (4)(a):

(i) may not:

(A) authorize the state to impose a tax in addition to a tax imposed under this chapter;

(B) provide a subtraction under this section greater than or different from the subtraction described in Subsection (2)(l); or

(C) affect the power of the state to establish rates of taxation; and

(ii) shall:

(A) provide for the implementation of the subtraction described in Subsection (2)(l);

(B) be in writing;

(C) be signed by:

(I) the governor; and

(II) the chair of the Business Committee of the Ute tribe;

(D) be conditioned on obtaining any approval required by federal law; and

(E) state the effective date of the agreement.

(c) (i) The governor shall report to the commission by no later than February 1 of each year regarding whether or not an agreement meeting the requirements of this Subsection (4) is in effect.

(ii) If an agreement meeting the requirements of this Subsection (4) is terminated, the subtraction permitted under Subsection (2)(l) is not allowed for taxable years beginning on or after the January 1 following the termination of the agreement.

(d) For purposes of Subsection (2)(l) and in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, the commission may make rules:

(i) for determining whether income is derived from a source within the Uintah and Ouray Reservation; and

(ii) that are substantially similar to how federal adjusted gross income derived from Utah sources is determined under Section 59-10-117.

Section 196. Section **62A-11-326.1** is amended to read:

62A-11-326.1. Enrollment of child in accident and health insurance plan -- Order -- Notice.

(1) The office may issue a notice to existing and future employers or unions to enroll a dependent child in [~~a disability~~] an accident and health insurance plan that is available through [~~his~~] the dependent child's parent or legal guardian's employer or union, when the following conditions are satisfied:

(a) the parent or legal guardian is already required to obtain insurance coverage for the child by a prior court or administrative order; and

(b) the parent or legal guardian has failed to provide written proof to the office that:

(i) the child has been enrolled in [~~a disability~~] an accident and health insurance plan in accordance with the court or administrative order; or

(ii) the coverage required by the order was not available at group rates through the employer or union 30 or more days prior to the date of the mailing of the notice to enroll.

(2) The office shall provide concurrent notice to the parent or legal guardian in accordance

with Section 62A-11-304.4 of:

(a) the notice to enroll sent to the employer or union; and

(b) the opportunity to contest the enrollment due to a mistake of fact by filing a written request for an adjudicative proceeding with the office within 15 days of the notice being sent.

(3) A notice to enroll shall result in the enrollment of the child in the parent's [~~disability~~] accident and health insurance plan, unless the parent successfully contests the notice based on a mistake of fact.

(4) A notice to enroll issued under this section may be considered a "qualified medical support order" for the purposes of enrolling a dependent child in a group [~~disability~~] accident and health insurance plan as defined in Section 609(a), Federal Employee Retirement Income Security Act of 1974.

Section 197. Section **62A-11-326.2** is amended to read:

62A-11-326.2. Compliance with order -- Enrollment of dependent child for insurance.

(1) An employer or union shall comply with a notice to enroll issued by the office under Section 62A-11-326.1 by enrolling the dependent child that is the subject of the notice in the:

(a) [~~disability~~] accident and health insurance plan in which the parent or legal guardian is enrolled, if the plan satisfies the prior court or administrative order; or

(b) least expensive plan, assuming equivalent benefits, offered by the employer or union that complies with the prior court or administrative order which provides coverage [~~which~~] that is reasonably accessible to the dependent child.

(2) The employer, union, or insurer may not refuse to enroll a dependent child pursuant to a notice to enroll because a parent or legal guardian has not signed an enrollment application.

(3) Upon enrollment of the dependent child, the employer shall deduct the appropriate premiums from the parent or legal guardian's wages and remit them directly to the insurer.

(4) The insurer shall provide proof of insurance to the office upon request.

(5) The signature of the custodial parent of the insured dependent is a valid authorization to the insurer for purposes of processing any insurance reimbursement claim.

Section 198. Section **63-25a-413** is amended to read:

63-25a-413. Collateral sources.

(1) Collateral source shall include any source of benefits or advantages for economic loss otherwise reparable under this chapter which the victim or claimant has received, or which is readily available to the victim from:

(a) the offender;

(b) the insurance of the offender;

(c) the United States government or any of its agencies, a state or any of its political subdivisions, or an instrumentality of two or more states, except in the case on nonobligatory state-funded programs;

(d) social security, Medicare, and Medicaid;

(e) state-required temporary nonoccupational income replacement insurance or disability income insurance;

(f) workers' compensation;

(g) wage continuation programs of any employer;

(h) proceeds of a contract of insurance payable to the victim for the loss he sustained because of the criminally injurious conduct;

(i) a contract providing prepaid hospital and other health care services or benefits for disability; or

(j) veteran's benefits, including veteran's hospitalization benefits.

(2) (a) An order of restitution shall not be considered readily available as a collateral source.

(b) Receipt of an award of reparations under this chapter shall be considered an assignment of the victim's rights to restitution from the offender.

(3) The victim shall not discharge a claim against a person or entity without the state's written permission and shall fully cooperate with the state in pursuing its right of reimbursement, including providing the state with any evidence in his possession.

(4) The state's right of reimbursement applies regardless of whether the victim has been fully compensated for his losses.

(5) Notwithstanding the collateral source provisions in [~~Subsections~~] Subsection (1) and

Subsection 63-25a-412(1)(a) [~~and 63-25a-413(1)~~], a victim of a sexual offense who requests testing of himself may be reimbursed for the costs of the HIV test only as provided in Subsection 76-5-503(4).

Section 199. Section **63-55-231** is amended to read:

63-55-231. Repeal dates, Title 31A.

(1) Section 31A-2-208.5, Comparison tables, is repealed July 1, 2005.

(2) Section 31A-2-217, Coordination with other states, is repealed July 1, 2003.

[~~(2)~~] (3) Section 31A-22-315, Motor Vehicle Insurance Reporting, is repealed July 1, 2010.

[~~(3)~~] (4) Section 31A-22-625, Catastrophic Coverage of Mental Health Conditions, is repealed July 1, 2011.

[~~(4)~~] (5) Title 31A, Chapter 31, Insurance Fraud Act, is repealed July 1, 2007.

Section 200. Section **67-22-1** is amended to read:

67-22-1. Compensation -- Constitutional offices.

(1) The Legislature fixes salaries for the constitutional offices as follows:

(a) Governor	$96,700
(b) Lieutenant Governor	$75,200
(c) Attorney General	$81,300
(d) State Auditor	$77,600
(e) State Treasurer	$75,200

(2) The Legislature fixes benefits for the constitutional offices as follows:

(a) Governor:

(i) a vehicle for official and personal use;

(ii) housing;

(iii) household and security staff;

(iv) household expenses;

(v) retirement benefits as provided in Title 49;

(vi) health insurance;

(vii) dental insurance;

(viii) basic life insurance;

(ix) workers' compensation;

(x) required employer contribution to Social Security;

(xi) long-term disability income insurance; and

(xii) the same additional state paid life insurance available to other noncareer service employees.

(b) Lieutenant governor, attorney general, state auditor, and state treasurer:

(i) a vehicle for official and personal use;

(ii) the option of participating in a state retirement system established by Title 49, Chapter 2, Public Employees' Retirement Act, or Chapter 3, Public Employees' Noncontributory Retirement Act, or in a deferred compensation plan administered by the State Retirement Office, in accordance with the Internal Revenue Code and its accompanying rules and regulations;

(iii) health insurance;

(iv) dental insurance;

(v) basic life insurance;

(vi) workers' compensation;

(vii) required employer contribution to social security;

(viii) long-term disability income insurance; and

(ix) the same additional state paid life insurance available to other noncareer service employees.

(c) Each constitutional office shall pay the cost of the additional state-paid life insurance for its constitutional officer from its existing budget.

Section 201. Section **67-22-2** is amended to read:

67-22-2. Compensation -- Other state officers.

(1) The governor shall establish salaries for the following state officers within the following salary ranges fixed by the Legislature:

State Officer	Salary Range
Director, Health Policy Commission	$57,900 - $78,400

Commissioner of Agriculture and Food	$62,100 - $84,100
Commissioner of Insurance	$62,100 - $84,100
Commissioner of the Labor Commission	$62,100 - $84,100
Director, Alcoholic Beverage Control Commission	$62,100 - $84,100
Commissioner, Department of Financial Institutions	$62,100 - $84,100
Members, Board of Pardons and Parole	$62,100 - $84,100
Executive Director, Department of Commerce	$62,100 - $84,100
Executive Director, Commission on Criminal and Juvenile Justice	$62,100 - $84,100
Adjutant General	$62,100 - $84,100
Chair, Tax Commission	$67,200 - $90,700
Commissioners, Tax Commission	$67,200 - $90,700
Executive Director, Department of Community and Economic Development	$67,200 - $90,700
Executive Director, Tax Commission	$67,200 - $90,700
Chair, Public Service Commission	$67,200 - $90,700
Commissioner, Public Service Commission	$67,200 - $90,700
Executive Director, Department of Corrections	$73,100 - $98,700
Commissioner, Department of Public Safety	$73,100 - $98,700
Executive Director, Department of Natural Resources	$73,100 - $98,700
Director, Office of Planning and Budget	$73,100 - $98,700

Executive Director, Department of Administrative Services	$73,100 - $98,700
Executive Director, Department of Human Resource Management	$73,100 - $98,700
Executive Director, Department of Environmental Quality	$73,100 - $98,700
State Olympic Officer	$79,600 - $107,500
Executive Director, Department of Workforce Services	$79,600 - $107,500
Executive Director, Department of Health	$79,600 - $107,500
Executive Director, Department of Human Services	$79,600 - $107,500
Executive Director, Department of Transportation	$79,600 - $107,500
Chief Information Officer	$79,600 - $107,500

(2) (a) The Legislature fixes benefits for the state offices outlined in Subsection (1) as follows:

(i) the option of participating in a state retirement system established by Title 49, Utah State Retirement Act, or in a deferred compensation plan administered by the State Retirement Office in accordance with the Internal Revenue Code and its accompanying rules and regulations;

(ii) health insurance;

(iii) dental insurance;

(iv) basic life insurance;

(v) unemployment compensation;

(vi) workers' compensation;

(vii) required employer contribution to Social Security;

(viii) long-term disability <u>income</u> insurance;

(ix) the same additional state-paid life insurance available to other noncareer service employees;

(x) the same severance pay available to other noncareer service employees;

(xi) the same sick leave, converted sick leave, educational allowances, and holidays granted to Schedule B state employees, and the same annual leave granted to Schedule B state employees with more than ten years of state service;

(xii) the option to convert accumulated sick leave to cash or insurance benefits as provided by law or rule upon resignation or retirement according to the same criteria and procedures applied to Schedule B state employees;

(xiii) the option to purchase additional life insurance at group insurance rates according to the same criteria and procedures applied to Schedule B state employees; and

(xiv) professional memberships if being a member of the professional organization is a requirement of the position.

(b) Each department shall pay the cost of additional state-paid life insurance for its executive director from its existing budget.

(3) The Legislature fixes the following additional benefits:

(a) for the executive director of the State Tax Commission a vehicle for official and personal use;

(b) for the executive director of the Department of Transportation a vehicle for official and personal use;

(c) for the executive director of the Department of Natural Resources a vehicle for commute and official use;

(d) for the Commissioner of Public Safety:

(i) an accidental death insurance policy if POST certified; and

(ii) a public safety vehicle for official and personal use;

(e) for the executive director of the Department of Corrections:

(i) an accidental death insurance policy if POST certified; and

(ii) a public safety vehicle for official and personal use;

(f) for the Adjutant General a vehicle for official and personal use; and

(g) for each member of the Board of Pardons and Parole a vehicle for commute and official use.

(4) (a) The governor has the discretion to establish a specific salary for each office listed in Subsection (1), and, within that discretion, may provide salary increases within the range fixed by the Legislature.

(b) The governor shall apply the same overtime regulations applicable to other FLSA exempt positions.

(c) The governor may develop standards and criteria for reviewing the performance of the state officers listed in Subsection (1).

(5) Salaries for other Schedule A employees, as defined in Section 67-19-15, which are not provided for in this chapter, or in Title 67, Chapter 8, Utah Executive and Judicial Salary Act, shall be established as provided in Section 67-19-15.

Section 202. Section **78-14-4.5** is amended to read:

78-14-4.5. Amount of award reduced by amounts of collateral sources available to plaintiff -- No reduction where subrogation right exists -- Collateral sources defined -- Procedure to preserve subrogation rights -- Evidence admissible -- Exceptions.

(1) In all malpractice actions against health care providers as defined in Section 78-14-3 in which damages are awarded to compensate the plaintiff for losses sustained, the court shall reduce the amount of such award by the total of all amounts paid to the plaintiff from all collateral sources which are available to him; however, there shall be no reduction for collateral sources for which a subrogation right exists as provided in this section nor shall there be a reduction for any collateral payment not included in the award of damages. Upon a finding of liability and an awarding of damages by the trier of fact, the court shall receive evidence concerning the total amounts of collateral sources which have been paid to or for the benefit of the plaintiff or are otherwise available to him. The court shall also take testimony of any amount which has been paid, contributed, or forfeited by, or on behalf of the plaintiff or members of his immediate family to secure his right to any collateral source benefit which he is receiving as a result of his injury, and shall offset any

reduction in the award by such amounts. No evidence shall be received and no reduction made with respect to future collateral source benefits except as specified in Subsection (4).

(2) For purposes of this section "collateral source" means payments made to or for the benefit of the plaintiff for:

(a) medical expenses and disability payments payable under the United States Social Security Act, any federal, state, or local income disability act, or any other public program, except the federal programs which are required by law to seek subrogation;

(b) any health, sickness, or income [~~disability~~] replacement insurance, automobile accident insurance that provides health benefits or income [~~disability~~] replacement coverage, and any other similar insurance benefits, except life insurance benefits available to the plaintiff, whether purchased by the plaintiff or provided by others;

(c) any contract or agreement of any person, group, organization, partnership, or corporation to provide, pay for, or reimburse the costs of hospital, medical, dental, or other health care services, except benefits received as gifts, contributions, or assistance made gratuitously; and

(d) any contractual or voluntary wage continuation plan provided by employers or any other system intended to provide wages during a period of disability.

(3) To preserve subrogation rights for amounts paid or received prior to settlement or judgment, a provider of collateral sources shall serve at least 30 days before settlement or trial of the action a written notice upon each health care provider against whom the malpractice action has been asserted. The written notice shall state the name and address of the provider of collateral sources, the amount of collateral sources paid, the names and addresses of all persons who received payment, and the items and purposes for which payment has been made.

(4) Evidence is admissible of government programs that provide payments or benefits available in the future to or for the benefit of the plaintiff to the extent available irrespective of the recipient's ability to pay. Evidence of the likelihood or unlikelihood that such programs, payments, or benefits will be available in the future is also admissible. The trier of fact may consider such evidence in determining the amount of damages awarded to a plaintiff for future expenses.

(5) [~~No~~] A provider of collateral sources is not entitled to recover the amounts of such

benefits from a health care provider, the plaintiff, or any other person or entity as reimbursement for collateral source payments made prior to settlement or judgment, including any payments made under Title 26, Chapter 19, Medical Benefits Recovery Act, except to the extent that subrogation rights to amounts paid prior to settlement or judgment are preserved as provided in this section. All policies of insurance providing benefits affected by this section are construed in accordance with this section.

Section 203. Section **78-45-7.5** is amended to read:

78-45-7.5. Determination of gross income -- Imputed income.

(1) As used in the guidelines, "gross income" includes:

(a) prospective income from any source, including nonearned sources, except under Subsection (3); and

(b) income from salaries, wages, commissions, royalties, bonuses, rents, gifts from anyone, prizes, dividends, severance pay, pensions, interest, trust income, alimony from previous marriages, annuities, capital gains, social security benefits, workers' compensation benefits, unemployment compensation, income replacement disability insurance benefits, and payments from "nonmeans-tested" government programs.

(2) Income from earned income sources is limited to the equivalent of one full-time 40-hour job. However, if and only if during the time prior to the original support order, the parent normally and consistently worked more than 40 hours at his job, the court may consider this extra time as a pattern in calculating the parent's ability to provide child support.

(3) Specifically excluded from gross income are:

(a) cash assistance provided under Title 35A, Chapter 3, Part 3, Family Employment Program;

(b) benefits received under a housing subsidy program, the Job Training Partnership Act, Supplemental Security Income, Social Security Disability Insurance, Medicaid, Food Stamps, or General Assistance; and

(c) other similar means-tested welfare benefits received by a parent.

(4) (a) Gross income from self-employment or operation of a business shall be calculated

by subtracting necessary expenses required for self-employment or business operation from gross receipts. The income and expenses from self-employment or operation of a business shall be reviewed to determine an appropriate level of gross income available to the parent to satisfy a child support award. Only those expenses necessary to allow the business to operate at a reasonable level may be deducted from gross receipts.

(b) Gross income determined under this subsection may differ from the amount of business income determined for tax purposes.

(5) (a) When possible, gross income should first be computed on an annual basis and then recalculated to determine the average gross monthly income.

(b) Each parent shall provide verification of current income. Each parent shall provide year-to-date pay stubs or employer statements and complete copies of tax returns from at least the most recent year unless the court finds the verification is not reasonably available. Verification of income from records maintained by the Department of Workforce Services may be substituted for pay stubs, employer statements, and income tax returns.

(c) Historical and current earnings shall be used to determine whether an underemployment or overemployment situation exists.

(6) Gross income includes income imputed to the parent under Subsection (7).

(7) (a) Income may not be imputed to a parent unless the parent stipulates to the amount imputed, the party defaults, or, in contested cases, a hearing is held and a finding made that the parent is voluntarily unemployed or underemployed.

(b) If income is imputed to a parent, the income shall be based upon employment potential and probable earnings as derived from work history, occupation qualifications, and prevailing earnings for persons of similar backgrounds in the community, or the median earning for persons in the same occupation in the same geographical area as found in the statistics maintained by the Bureau of Labor Statistics.

(c) If a parent has no recent work history or their occupation is unknown, income shall be imputed at least at the federal minimum wage for a 40-hour work week. To impute a greater income, the judge in a judicial proceeding or the presiding officer in an administrative proceeding shall enter

specific findings of fact as to the evidentiary basis for the imputation.

(d) Income may not be imputed if any of the following conditions exist:

(i) the reasonable costs of child care for the parents' minor children approach or equal the amount of income the custodial parent can earn;

(ii) a parent is physically or mentally disabled to the extent he cannot earn minimum wage;

(iii) a parent is engaged in career or occupational training to establish basic job skills; or

(iv) unusual emotional or physical needs of a child require the custodial parent's presence in the home.

(8) (a) Gross income may not include the earnings of a minor child who is the subject of a child support award nor benefits to a minor child in the child's own right such as Supplemental Security Income.

(b) Social Security benefits received by a child due to the earnings of a parent shall be credited as child support to the parent upon whose earning record it is based, by crediting the amount against the potential obligation of that parent. Other unearned income of a child may be considered as income to a parent depending upon the circumstances of each case.

Section 204. **Repealer.**

This act repeals:

Section **31A-8-210, Solvency standards.**

Section **31A-8-212, Solvency standards transition.**

Section 205. **Coordination clause.**

If this bill and H.B. 109, Amendments to the Insurance Law, both pass, it is the intent of the Legislature that the Office of Legislative Research and General Counsel in preparing the Utah Code database for publication, shall:

(1) in Subsection 31A-28-102(2), change "Utah Life and Disability Insurance Guaranty Association" to "Utah Life and Health Insurance Guaranty Association";

(2) in Subsection 31A-28-103(3)(b)(iii), change "disability" to "accident and health";

(3) in Subsection 31A-28-103(3)(b)(iii)(A) and (B), change "basic hospital and medical or major medical" to "health insurance";

(4) in Subsection 31A-28-105(1), change "Utah Life and Disability Insurance Guaranty Association" to "Utah Life and Health Insurance Guaranty Association";

(5) in Subsection 31A-28-105(23)(b), change "disability" to "accident and health";

(6) in Subsection 31A-28-106(1)(a), change "Utah Life and Disability Insurance Guaranty Association" to "Utah Life and Health Insurance Guaranty Association";

(7) in Subsection 31A-28-108(4)(a)(iii), change "disability" to "accident and health"; and

(8) in Subsection 31A-28-109(3)(c)(ii), change "disability" to "accident and health".