HB0047S02 compared with HB0047S01

~~{deleted text}~~ shows text that was in HB0047S01 but was deleted in HB0047S02.

inserted text shows text that was not in HB0047S01 but was inserted into HB0047S02.

DISCLAIMER: This document is provided to assist you in your comparison of the two bills. Sometimes this automated comparison will NOT be completely accurate. Therefore, you need to read the actual bills. This automatically generated document could contain inaccuracies caused by: limitations of the compare program; bad input data; or other causes.

Representative James A. Dunnigan proposes the following substitute bill:

INSURANCE LAW AMENDMENTS

2013 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: John L. Valentine

LONG TITLE

General Description:

This bill modifies the Insurance Code.

Highlighted Provisions:

This bill:

- amends the definition ~~{provision}~~provisions;
- clarifies the provision related to coordination with other states;
- addresses rules related to title and escrow examinations;
- modifies the provision related to the Title and Escrow Commission and its members;
- modifies ~~{language regarding restrictions on foreign title insurers;~~
- ~~enacts provision related to closing or settlement protections;~~
- ~~modifies }~~the cap on appropriations from the Captive Insurance Restricted Account

effective July 1, 2015;

- enacts provision related to closing or settlement protections;
- modifies language regarding restrictions on foreign title insurers;
- amends provisions related to company action level events;
- prohibits discretionary clauses;
- enacts a provision regarding producer's duties related to replacement of life insurance;
- addresses death pending conversion of group life insurance policy;
- modifies preferred provider contract provisions;
- amends provisions related to health benefit plan offerings;
- ~~{modifies provisions}~~addresses car rental related ~~{to alternative coverage}~~insurance;
- amends provisions related to inducements;
- creates the concept of a "qualifying licensee" for purposes of title and escrow licenses;
- clarifies terminology of individual and agency title insurance producers;
- modifies the requirement that a title insurance producer conduct a minimum mandatory search to be a requirement of a reasonable search;
- establishes who shall conduct an escrow as provided in statute;
- clarifies reference to a title insurance agency's reserve account;
- addresses Utah mini-COBRA benefits for employer group coverage;
- addresses sharing of commissions;
- addresses powers of the board related to the Utah Comprehensive Health Insurance Pool Act;
- addresses money deposited into the Insurance Fraud Investigation Restricted Account and the Insurance Fraud Victim Restitution Account;
- amends lifetime maximum for covered benefits from the Comprehensive Health Insurance Pool;
- creates the Insurance Fraud Victim Restitution Account; and
- repeals provisions related to alternative coverage and Utah NetCare Plan;
- makes technical and conforming amendments.

Money Appropriated in this Bill:

None

Other Special Clauses:

This bill has an effective date.

Utah Code Sections Affected:

AMENDS:

31A-1-301, as last amended by Laws of Utah 2012, Chapters 151 and 253

31A-2-201.2, as enacted by Laws of Utah 2010, Chapter 68

31A-2-217, as last amended by Laws of Utah 2008, Chapter 382

31A-2-402, as last amended by Laws of Utah 2011, Chapter 289

31A-2-403, as last amended by Laws of Utah 2010, Chapters 10 and 286

31A-2-404, as last amended by Laws of Utah 2012, Chapter 253

31A-3-304 (Effective 07/01/13), as last amended by Laws of Utah 2011, Chapter 284

31A-8-301, as last amended by Laws of Utah 2005, Chapter 123

31A-14-211, as last amended by Laws of Utah 2011, Chapter 284

31A-17-603, as last amended by Laws of Utah 2001, Chapter 116

31A-19a-209, as last amended by Laws of Utah 2007, Chapter 325

31A-20-110, as last amended by Laws of Utah 2003, Chapter 298

31A-21-314, as last amended by Laws of Utah 1987, Chapter 95

31A-21-503, as last amended by Laws of Utah 2007, Chapter 307

31A-22-519, as enacted by Laws of Utah 1985, Chapter 242

31A-22-612, as last amended by Laws of Utah 2004, Chapter 108

31A-22-617, as last amended by Laws of Utah 2009, Chapter 12

31A-22-618.5, as last amended by Laws of Utah 2011, Chapters 284 and 297

~~{~~**~~31A-22-724~~**~~}~~**31A-22-722**, as last amended by Laws of Utah ~~{~~2011~~}~~2010, Chapter ~~{~~400~~}~~10

31A-23a-102, as last amended by Laws of Utah 2012, Chapter 253

31A-23a-105, as last amended by Laws of Utah 2012, Chapter 253

31A-23a-106, as last amended by Laws of Utah 2012, Chapters 151 and 253

31A-23a-202, as last amended by Laws of Utah 2011, Chapter 284

31A-23a-203.5, as enacted by Laws of Utah 2011, Chapter 337

31A-23a-204, as last amended by Laws of Utah 2011, Chapters 284 and 342

31A-23a-402, as last amended by Laws of Utah 2011, Second Special Session, Chapter 5

31A-23a-402.5, as last amended by Laws of Utah 2012, Chapters 253 and 279

31A-23a-406, as last amended by Laws of Utah 2012, Chapter 253

31A-23a-407, as renumbered and amended by Laws of Utah 2003, Chapter 298

31A-23a-413, as renumbered and amended by Laws of Utah 2003, Chapter 298

31A-23a-415, as last amended by Laws of Utah 2011, Chapter 284

31A-23a-503, as last amended by Laws of Utah 2005, Chapter 185

31A-23a-504, as last amended by Laws of Utah 2012, Chapter 253

31A-27a-104, as last amended by Laws of Utah 2012, Chapter 253

31A-29-106, as last amended by Laws of Utah 2011, Chapter 284

31A-29-113, as last amended by Laws of Utah 2007, Chapter 40

31A-30-115, as last amended by Laws of Utah 2011, Second Special Session, Chapter 5

31A-30-208, as last amended by Laws of Utah 2011, Chapter 400

31A-31-108, as last amended by Laws of Utah 2012, Chapter 253

31A-41-102, as enacted by Laws of Utah 2008, Chapter 220

31A-41-201, as enacted by Laws of Utah 2008, Chapter 220

31A-41-202, as enacted by Laws of Utah 2008, Chapter 220

49-20-410, as last amended by Laws of Utah 2012, Chapter 406

ENACTS:

31A-4-117, Utah Code Annotated 1953

31A-22-429, Utah Code Annotated 1953

31A-23a-118, Utah Code Annotated 1953

31A-23a-406.5, Utah Code Annotated 1953

31A-31-108.5, Utah Code Annotated 1953

REPEALS:

31A-22-723, as last amended by Laws of Utah 2011, Chapters 284 and 297

31A-22-724, as last amended by Laws of Utah 2011, Chapter 400

31A-30-109, as last amended by Laws of Utah 2012, Chapter 253

~~**{31A-23a-402}**~~**31A-30-202.5**, as last amended by Laws of Utah 2011, Second Special

Session, Chapter 5

~~{31A-23a-402.5}~~31A-30-205, as last amended by Laws of Utah ~~{2012, Chapters 253 and 279~~

~~31A-23a-406, as last amended by Laws of Utah 2012, Chapter 253~~

~~31A-23a-407, as renumbered and amended by Laws of Utah 2003, Chapter 298~~

~~31A-23a-413, as renumbered and amended by Laws of Utah 2003, Chapter 298~~

~~31A-23a-415, as last amended by Laws of Utah 2011, Chapter 284~~

~~31A-23a-503, as last amended by Laws of Utah 2005, Chapter 185~~

~~31A-27a-104, as last amended by Laws of Utah 2012, Chapter 253~~

~~31A-29-106, as last amended by Laws of Utah 2011, Chapter 284~~

~~31A-29-113, as last amended by Laws of Utah 2007, Chapter 40~~

~~31A-31-108, as last amended by Laws of Utah 2012, Chapter 253~~

~~31A-41-102, as enacted by Laws of Utah 2008, Chapter 220~~

~~31A-41-201, as enacted by Laws of Utah 2008, Chapter 220~~

~~31A-41-202, as enacted by Laws of Utah 2008, Chapter 220~~

~~ENACTS:~~

~~31A-4-117, Utah Code Annotated 1953~~

~~31A-22-429, Utah Code Annotated 1953~~

~~31A-23a-406.5, Utah Code Annotated 1953~~

~~31A-31-108.5, Utah Code Annotated 1953~~

~~}~~2011, Chapter 400

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

Section 1. 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) a medical care expense; 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) a long-term care contract; and

(ii) may provide:

(A) hospital coverage;

(B) surgical coverage;

(C) medical coverage;

(D) loss of income coverage;

(E) prescription drug coverage;

(F) dental coverage; or

(G) vision coverage.

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

(2) "Actuary" is as defined by the commissioner by rule, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(3) "Administrator" is defined in Subsection [~~(162)~~] (163).

(4) "Adult" means an individual who has attained the age of at least 18 years.

(5) "Affiliate" means a 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 individuals manage the corporations.

(6) "Agency" means:

(a) a person other than an individual, including a sole proprietorship by which an individual does business under an assumed name; and

(b) an insurance organization licensed or required to be licensed under Section 31A-23a-301, 31A-25-207, or 31A-26-209.

(7) "Alien insurer" means an insurer domiciled outside the United States.

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

(9) "Annuity" means an agreement to make periodical payments for a period certain or over the lifetime of one or more individuals 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.

(10) "Application" means a document:

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

(ii) that contains information that is used by the insurer to evaluate risk and decide whether to:

(A) insure the risk under:

(I) the coverage as originally offered; or

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

(B) decline to insure the risk; or

(b) used by the insurer to gather information from the applicant before issuance of an annuity contract.

(11) "Articles" or "articles of incorporation" means:

(a) the original articles;

(b) a special law;

(c) a charter;

(d) an amendment;

(e) restated articles;

(f) articles of merger or consolidation;

(g) a trust instrument;

(h) another constitutive document for a trust or other entity that is not a corporation; and

(i) an amendment to an item listed in Subsections (11)(a) through (h).

(12) "Bail bond insurance" means a guarantee that a person will attend court when required, up to and including surrender of the person in execution of a sentence imposed under Subsection 77-20-7(1), as a condition to the release of that person from confinement.

(13) "Binder" is defined in Section 31A-21-102.

(14) "Blanket insurance policy" means a group policy covering a defined class of persons:

(a) without individual underwriting or application; and

(b) that is determined by definition without designating each person covered.

(15) "Board," "board of trustees," or "board of directors" means the group of persons with responsibility over, or management of, a corporation, however designated.

(16) "Bona fide office" means a physical office in this state:

(a) that is open to the public;

(b) that is staffed during regular business hours on regular business days; and

(c) at which the public may appear in person to obtain services.

(17) "Business entity" means:

(a) a corporation;

(b) an association;

(c) a partnership;

(d) a limited liability company;

(e) a limited liability partnership; or

(f) another legal entity.

(18) "Business of insurance" is defined in Subsection (88).

(19) "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 apply by reference under:

(a) Section 31A-7-201;

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

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

(20) (a) "Bylaws" means the rules adopted for the regulation or management of a corporation's affairs, however designated.

(b) "Bylaws" includes comparable rules for a trust or other entity that is not a corporation.

(21) "Captive insurance company" means:

(a) an insurer:

(i) owned by another organization; and

(ii) whose exclusive purpose is to insure risks of the parent organization and an affiliated company; or

(b) in the case of a group or association, an insurer:

(i) owned by the insureds; and

(ii) whose exclusive purpose is to insure risks of:

(A) a member organization;

(B) a group member; or

(C) an affiliate of:

(I) a member organization; or

(II) a group member.

(22) "Casualty insurance" means liability insurance.

(23) "Certificate" means evidence of insurance given to:

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

(b) a third party.

(24) "Certificate of authority" is included within the term "license."

(25) "Claim," unless the context otherwise requires, means a request or demand on an insurer for payment of a benefit according to the terms of an insurance policy.

(26) "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.

(27) (a) "Commissioner" or "commissioner of insurance" means Utah's insurance commissioner.

(b) When appropriate, the terms listed in Subsection (27)(a) apply to the equivalent supervisory official of another jurisdiction.

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

(i) provides board and lodging;

(ii) provides one or more of the following:

(A) a personal service;

(B) a nursing service;

(C) a medical service; or

(D) any other health-related service; and

(iii) provides the coverage described in this Subsection (28)(a) 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 a service described in Subsection (28)(a)(ii).

(29) (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 (29)(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.

(30) "Controlled insurer" means a licensed insurer that is either directly or indirectly controlled by a producer.

(31) "Controlling person" means a person that directly or indirectly has the power to direct or cause to be directed, the management, control, or activities of a reinsurance intermediary.

(32) "Controlling producer" means a producer who directly or indirectly controls an insurer.

(33) (a) "Corporation" means an insurance corporation, except when referring to:

(i) a corporation doing business:

(A) as:

(I) an insurance producer;

(II) a surplus lines producer;

(III) a limited line producer;

(IV) a consultant;

(V) a managing general agent;

(VI) a reinsurance intermediary;

(VII) a third party administrator; or

(VIII) an adjuster; and

(B) under:

(I) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries;

(II) Chapter 25, Third Party Administrators; or

(III) 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 a stock insurance corporation.

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

(34) (a) "Creditable coverage" has the same meaning as provided in federal regulations adopted pursuant to the Health Insurance Portability and Accountability Act.

(b) "Creditable coverage" includes coverage that is offered through a public health plan such as:

(i) the Primary Care Network Program under a Medicaid primary care network demonstration waiver obtained subject to Section 26-18-3;

(ii) the Children's Health Insurance Program under Section 26-40-106; or

(iii) the Ryan White Program Comprehensive AIDS Resources Emergency Act, Pub. L. 101-381, and Ryan White HIV/AIDS Treatment Modernization Act of 2006, Pub. L. 109-415.

(35) "Credit 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 has a disability.

(36) (a) "Credit insurance" means insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation.

(b) "Credit insurance" includes:

(i) credit accident and health insurance;

(ii) credit life insurance;

(iii) credit property insurance;

(iv) credit unemployment insurance;

(v) guaranteed automobile protection insurance;

(vi) involuntary unemployment insurance;

(vii) mortgage accident and health insurance;

(viii) mortgage guaranty insurance; and

(ix) mortgage life insurance.

(37) "Credit life insurance" means insurance on the life of a debtor in connection with an extension of credit that pays a person if the debtor dies.

(38) "Credit property insurance" means insurance:

(a) offered in connection with an extension of credit; and

(b) that protects the property until the debt is paid.

(39) "Credit unemployment insurance" means insurance:

(a) offered in connection with an extension of credit; and

(b) that provides indemnity if the debtor is unemployed for payments coming due on a:

(i) specific loan; or

(ii) credit transaction.

(40) "Creditor" means a person, including an insured, having a claim, whether:

(a) matured;

(b) unmatured;

(c) liquidated;

(d) unliquidated;

(e) secured;

(f) unsecured;

(g) absolute;

(h) fixed; or

(i) contingent.

(41) (a) "Crop insurance" means insurance providing protection against damage to

crops from unfavorable weather conditions, fire or lightning, flood, hail, insect infestation, disease, or other yield-reducing conditions or perils that is:

(i) provided by the private insurance market; or

(ii) subsidized by the Federal Crop Insurance Corporation.

(b) "Crop insurance" includes multiperil crop insurance.

(42) (a) "Customer service representative" means a person that provides an insurance service and insurance product information:

(i) for the customer service representative's:

(A) producer;

(B) surplus lines producer; or

(C) consultant employer; and

(ii) to the customer service representative's employer's:

(A) customer;

(B) client; or

(C) organization.

(b) A customer service representative may only operate within the scope of authority of the customer service representative's producer, surplus lines producer, or consultant employer.

(43) "Deadline" means a 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.

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

(45) "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.

(46) "Department" means the Insurance Department.

(47) "Director" means a member of the board of directors of a corporation.

(48) "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.

(49) "Disability income insurance" is defined in Subsection (79).

(50) "Domestic insurer" means an insurer organized under the laws of this state.

(51) "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.

(52) (a) "Eligible employee" means:

(i) an employee who:

(A) works on a full-time basis; and

(B) has a normal work week of 30 or more hours; or

(ii) a person described in Subsection (52)(b).

(b) "Eligible employee" includes, if the individual is included under a health benefit plan of a small employer:

(i) a sole proprietor;

(ii) a partner in a partnership; or

(iii) an independent contractor.

(c) "Eligible employee" does not include, unless eligible under Subsection (52)(b):

(i) an individual who works on a temporary or substitute basis for a small employer;

(ii) an employer's spouse; or

(iii) a dependent of an employer.

(53) "Employee" means an individual employed by an employer.

(54) "Employee benefits" means one or more benefits or services provided to:

(a) an employee; or

(b) a dependent of an employee.

(55) (a) "Employee welfare fund" means a fund:

(i) established or maintained, whether directly or through a trustee, 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:

(A) by or on behalf of an employer doing business in this state; or

(B) for the benefit of a person employed in this state.

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

(56) "Endorsement" means a written agreement attached to a policy or certificate to modify the policy or certificate coverage.

(57) "Enrollment date," with respect to a health benefit plan, means:

(a) the first day of coverage; or

(b) if there is a waiting period, the first day of the waiting period.

(58) (a) "Escrow" means:

[~~(i) a real estate settlement or real estate closing conducted by a third party pursuant to the requirements of a written agreement between the parties in a real estate transaction; or~~]

(i) a transaction that effects the sale, transfer, encumbering, or leasing of real property, when a person not a party to the transaction, and neither having nor acquiring an interest in the title, performs, in accordance with the written instructions or terms of the written agreement between the parties to the transaction, any of the following actions:

(A) the explanation, holding, or creation of a document; or

(B) the receipt, deposit, and disbursement of money;

(ii) a settlement or closing involving:

(A) a mobile home;

(B) a grazing right;

(C) a water right; or

(D) other personal property authorized by the commissioner.

[~~(b) "Escrow" includes the act of conducting a:~~]

[~~(i) real estate settlement; or~~]

[~~(ii) real estate closing.~~]

(b) "Escrow" does not include:

(i) the following notarial acts performed by a notary within the state:

(A) an acknowledgment;

(B) a copy certification;

(C) jurat; and

(D) an oath or affirmation;

(ii) the receipt or delivery of a document; or

(iii) the receipt of money for delivery to the escrow agent.

(59) "Escrow agent" means[~~: (a)~~] an agency title insurance producer [~~with:~~] meeting the requirements of Sections 31A-4-107, 31A-14-211, and 31A-23a-204, who is acting through an individual title insurance producer licensed with an escrow subline of authority.

[~~(i) a title insurance line of authority; and~~]

[~~(ii) an escrow subline of authority; or~~]

[~~(b) a person defined as an escrow agent in Section 7-22-101.~~]

(60) (a) "Excludes" is not exhaustive and does not mean that another thing is not also excluded.

(b) The items listed in a list using the term "excludes" are representative examples for use in interpretation of this title.

(61) "Exclusion" means for the purposes of accident and health insurance that an insurer does not provide insurance coverage, for whatever reason, for one of the following:

(a) a specific physical condition;

(b) a specific medical procedure;

(c) a specific disease or disorder; or

(d) a specific prescription drug or class of prescription drugs.

(62) "Expense reimbursement insurance" means insurance:

(a) written to provide a payment for an expense relating to hospital confinement 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.

(63) "Fidelity insurance" means insurance guaranteeing the fidelity of a person holding a position of public or private trust.

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

(i) submitted to the department as required by and in accordance with applicable statute, rule, or filing order;

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

(iii) accompanied by the appropriate fee in accordance with:

(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 (64)(a).

(65) "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;

(n) an advertisement; or

(o) an outline of coverage.

(66) "First party insurance" means an insurance policy or contract in which the insurer agrees to pay a claim submitted to it by the insured for the insured's losses.

(67) "Foreign insurer" means an insurer domiciled outside of this state, including an alien insurer.

(68) (a) "Form" means one of the following prepared for general use:

(i) a policy;

(ii) a certificate;

(iii) an application;

(iv) an outline of coverage; or

(v) an endorsement.

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

(69) "Franchise insurance" means an individual insurance policy provided through a mass marketing arrangement involving a defined class of persons related in some way other than through the purchase of insurance.

(70) "General lines of authority" include:

(a) the general lines of insurance in Subsection (71);

(b) title insurance under one of the following sublines of authority:

(i) search, including authority to act as a title marketing representative;

(ii) escrow, including authority to act as a title marketing representative; and

(iii) title marketing representative only;

(c) surplus lines;

(d) workers' compensation; and

(e) any other line of insurance that the commissioner considers necessary to recognize in the public interest.

(71) "General lines of insurance" include:

(a) accident and health;

(b) casualty;

(c) life;

(d) personal lines;

(e) property; and

(f) variable contracts, including variable life and annuity.

(72) "Group health plan" means an employee welfare benefit plan to the extent that the plan provides medical care:

(a) (i) to an employee; or

(ii) to a dependent of an employee; and

(b) (i) directly;

(ii) through insurance reimbursement; or

(iii) through another method.

(73) (a) "Group insurance policy" means a policy covering a group of persons that is issued:

(i) to a policyholder on behalf of the group; and

(ii) for the benefit of a member of the group who is selected under a procedure defined in:

(A) the policy; or

(B) an agreement that is collateral to the policy.

(b) A group insurance policy may include a member of the policyholder's family or a dependent.

(74) "Guaranteed automobile protection insurance" means insurance offered in connection with an extension of credit that pays the difference in amount between the insurance settlement and the balance of the loan if the insured automobile is a total loss.

(75) (a) Except as provided in Subsection (75)(b), "health benefit plan" means a policy or certificate that:

(i) provides health care insurance;

(ii) provides major medical expense insurance; or

(iii) is offered as a substitute for hospital or medical expense insurance, such as:

(A) a hospital confinement indemnity; or

(B) a limited benefit plan.

(b) "Health benefit plan" does not include a policy or certificate that:

(i) provides benefits solely for:

(A) accident;

(B) dental;

(C) income replacement;

(D) long-term care;

(E) a Medicare supplement;

(F) a specified disease;

(G) vision; or

(H) a short-term limited duration; or

(ii) is offered and marketed as supplemental health insurance.

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

(a) a professional service;

(b) a personal service;

(c) a facility;

(d) equipment;

(e) a device;

(f) supplies; or

(g) medicine.

(77) (a) "Health care insurance" or "health insurance" means insurance providing:

(i) a health care benefit; or

(ii) payment of an incurred health care expense.

(b) "Health care insurance" or "health insurance" does not include accident and health insurance providing a benefit for:

(i) replacement of income;

(ii) short-term accident;

(iii) fixed indemnity;

(iv) credit accident and health;

(v) supplements to liability;

(vi) workers' compensation;

(vii) automobile medical payment;

(viii) no-fault automobile;

(ix) equivalent self-insurance; or

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

(78) "Health Insurance Portability and Accountability Act" means the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936, as amended.

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

(80) "Indemnity" means the payment of an amount to offset all or part of an insured loss.

(81) "Independent adjuster" means an insurance adjuster required to be licensed under Section 31A-26-201 who engages in insurance adjusting as a representative of an insurer.

(82) "Independently procured insurance" means insurance procured under Section 31A-15-104.

(83) "Individual" means a natural person.

(84) "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.

(85) "Insolvency" means that:

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

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

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

(86) (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) a risk distributing arrangement providing for compensation or replacement for damages or loss through the provision of a service or a benefit in kind;

(ii) a contract 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) a plan in which the risk does not rest upon the person who makes an arrangement, but with a class of persons who have agreed to share the risk.

(87) "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.

(88) "Insurance business" or "business of insurance" includes:

(a) providing health care insurance by an organization that is or is required to be licensed under this title;

(b) providing a benefit to an employee in the event of a contingency not within the control of the employee, in which the employee is entitled to the benefit as a right, which benefit may be provided either:

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

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

(c) providing an annuity:

(i) including an annuity issued in return for a gift; and

(ii) except an annuity provided by a person specified in Subsections 31A-22-1305(2) and (3);

(d) providing the characteristic services of a motor club as outlined in Subsection (116);

(e) providing another person with insurance;

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

(g) transacting or proposing to transact any phase of title insurance, including:

(i) solicitation;

(ii) negotiation preliminary to execution;

(iii) execution of a contract of title insurance;

(iv) insuring; and

(v) transacting matters subsequent to the execution of the contract and arising out of the contract, including reinsurance;

(h) transacting or proposing a life settlement; and

(i) doing, or proposing to do, any business in substance equivalent to Subsections (88)(a) through (h) in a manner designed to evade this title.

(89) "Insurance consultant" or "consultant" means a person who:

(a) advises another person about insurance needs and coverages;

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

(c) except as provided in Section 31A-23a-501, is not compensated directly or indirectly by an insurer or producer for advice given.

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

(91) (a) "Insurance producer" or "producer" means a person licensed or required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

(b) (i) "Producer for the insurer" means a producer who is compensated directly or indirectly by an insurer for selling, soliciting, or negotiating an insurance product of that insurer.

(ii) "Producer for the insurer" may be referred to as an "agent."

(c) (i) "Producer for the insured" means a producer who:

(A) is compensated directly and only by an insurance customer or an insured; and

(B) receives no compensation directly or indirectly from an insurer for selling, soliciting, or negotiating an insurance product of that insurer to an insurance customer or insured.

(ii) "Producer for the insured" may be referred to as a "broker."

(92) (a) "Insured" means a person to whom or for whose benefit an insurer makes a

promise in an insurance policy and includes:

(i) a policyholder;

(ii) a subscriber;

(iii) a member; and

(iv) a beneficiary.

(b) The definition in Subsection (92)(a):

(i) applies only to this title; and

(ii) does not define the meaning of this word as used in an insurance policy or certificate.

(93) (a) "Insurer" means a person doing an insurance business as a principal including:

(i) a fraternal benefit society;

(ii) an issuer of a gift annuity other than an annuity specified in Subsections 31A-22-1305(2) and (3);

(iii) a motor club;

(iv) an employee welfare plan; and

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

(b) "Insurer" does not include a governmental entity to the extent the governmental entity is engaged in an activity described in Section 31A-12-107.

(94) "Interinsurance exchange" is defined in Subsection [~~(145)~~] (146).

(95) "Involuntary unemployment insurance" means insurance:

(a) offered in connection with an extension of credit; and

(b) that provides indemnity if the debtor is involuntarily unemployed for payments coming due on a:

(i) specific loan; or

(ii) credit transaction.

(96) "Large employer," in connection with a health benefit plan, means an employer who, with respect to a calendar year and to a plan year:

(a) employed an average of at least 51 eligible employees on each business day during the preceding calendar year; and

(b) employs at least two employees on the first day of the plan year.

(97) "Late enrollee," with respect to an employer health benefit plan, means an individual whose enrollment is a late enrollment.

(98) "Late enrollment," with respect to an employer health benefit plan, means enrollment of an individual other than:

(a) on the earliest date on which coverage can become effective for the individual under the terms of the plan; or

(b) through special enrollment.

(99) (a) Except for a retainer contract or legal assistance described in Section 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for a specified legal expense.

(b) "Legal expense insurance" includes an arrangement that creates a reasonable expectation of an enforceable right.

(c) "Legal expense insurance" does not include the provision of, or reimbursement for, legal services incidental to other insurance coverage.

(100) (a) "Liability insurance" means insurance against liability:

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

(A) Subsection (110) for medical malpractice insurance;

(B) Subsection [~~(137)~~] (138) for professional liability insurance; and

(C) Subsection [~~(171)~~] (172) for workers' compensation insurance;

(ii) for a medical, hospital, surgical, and funeral benefit to a person other than the insured who is 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 a human being, exclusive of the coverages under:

(A) Subsection (110) for medical malpractice insurance;

(B) Subsection [~~(137)~~] (138) for professional liability insurance; and

(C) Subsection [~~(171)~~] (172) for workers' compensation insurance;

(iii) for loss or damage to property resulting from an accident to or explosion of a boiler, pipe, pressure container, machinery, or apparatus;

(iv) for loss or damage to property caused by:

(A) the breakage or leakage of a sprinkler, water pipe, or water container; or

(B) water entering through a leak or opening in a building; or

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

(b) "Liability insurance" includes:

(i) vehicle liability insurance;

(ii) residential dwelling liability insurance; and

(iii) making inspection of, and issuing a certificate of inspection upon, an elevator, boiler, machinery, or apparatus of any kind when done in connection with insurance on the elevator, boiler, machinery, or apparatus.

(101) (a) "License" means authorization issued by the commissioner to engage in an activity that is part of or related to the insurance business.

(b) "License" includes a certificate of authority issued to an insurer.

(102) (a) "Life insurance" means:

(i) insurance on a human life; and

(ii) insurance pertaining to or connected with human life.

(b) The business of life insurance includes:

(i) granting a death benefit;

(ii) granting an annuity benefit;

(iii) granting an endowment benefit;

(iv) granting an additional benefit in the event of death by accident;

(v) granting an additional benefit to safeguard the policy against lapse; and

(vi) providing an optional method of settlement of proceeds.

(103) "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.

(104) "Limited line credit insurance" includes the following forms of insurance:

(a) credit life;

(b) credit accident and health;

(c) credit property;

(d) credit unemployment;

(e) involuntary unemployment;

(f) mortgage life;

(g) mortgage guaranty;

(h) mortgage accident and health;

(i) guaranteed automobile protection; and

(j) another form of insurance offered in connection with an extension of credit that:

(i) is limited to partially or wholly extinguishing the credit obligation; and

(ii) the commissioner determines by rule should be designated as a form of limited line credit insurance.

(105) "Limited line credit insurance producer" means a person who sells, solicits, or negotiates one or more forms of limited line credit insurance coverage to an individual through a master, corporate, group, or individual policy.

(106) "Limited line insurance" includes:

(a) bail bond;

(b) limited line credit insurance;

(c) legal expense insurance;

(d) motor club insurance;

(e) car rental related insurance;

(f) travel insurance;

(g) crop insurance;

(h) self-service storage insurance;

(i) guaranteed asset protection waiver;

(j) portable electronics insurance; and

(k) another form of limited insurance that the commissioner determines by rule should be designated a form of limited line insurance.

(107) "Limited lines authority" includes:

(a) the lines of insurance listed in Subsection (106); and

(b) a customer service representative.

(108) "Limited lines producer" means a person who sells, solicits, or negotiates limited lines insurance.

(109) (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 a 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 (109)(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 on the basis of:

(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 the following are not conditioned on the receipt of long-term care:

(I) benefits; or

(II) eligibility; 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.

(110) "Medical malpractice insurance" means insurance against legal liability incident to the practice and provision of a medical service other than the practice and provision of a dental service.

(111) "Member" means a person having membership rights in an insurance corporation.

(112) "Minimum capital" or "minimum required capital" means the capital that must be constantly maintained by a stock insurance corporation as required by statute.

(113) "Mortgage accident and health insurance" means insurance offered in connection with an extension of credit that provides indemnity for payments coming due on a mortgage while the debtor has a disability.

(114) "Mortgage guaranty insurance" means surety insurance under which a mortgagee

or other creditor is indemnified against losses caused by the default of a debtor.

(115) "Mortgage life insurance" means insurance on the life of a debtor in connection with an extension of credit that pays if the debtor dies.

(116) "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 one or more:

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

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

(iii) (A) trip reimbursement;

(B) towing services;

(C) emergency road services;

(D) stolen automobile services;

(E) a combination of the services listed in Subsections (116)(b)(iii)(A) through (D); or

(F) other services given in Subsections 31A-11-102(1)(b) through (f).

(117) "Mutual" means a mutual insurance corporation.

(118) "Network plan" means health care insurance:

(a) that is issued by an insurer; and

(b) under which the financing and delivery of medical care is provided, in whole or in part, through a defined set of providers under contract with the insurer, including the financing and delivery of an item paid for as medical care.

(119) "Nonparticipating" means a plan of insurance under which the insured is not entitled to receive a dividend representing a share of the surplus of the insurer.

(120) "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, money, 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.

(121) "Order" means an order of the commissioner.

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

(123) "Participating" means a plan of insurance under which the insured is entitled to receive a dividend representing a share of the surplus of the insurer.

(124) "Participation," as used in a health benefit plan, means a requirement relating to the minimum percentage of eligible employees that must be enrolled in relation to the total number of eligible employees of an employer reduced by each eligible employee who voluntarily declines coverage under the plan because the employee:

(a) has other group health care insurance coverage; or

(b) receives:

(i) Medicare, under the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965; or

(ii) another government health benefit.

(125) "Person" includes:

(a) an individual;

(b) a partnership;

(c) a corporation;

(d) an incorporated or unincorporated association;

(e) a joint stock company;

(f) a trust;

(g) a limited liability company;

(h) a reciprocal;

(i) a syndicate; or

(j) another similar entity or combination of entities acting in concert.

(126) "Personal lines insurance" means property and casualty insurance coverage sold

for primarily noncommercial purposes to:

(a) an individual; or

(b) a family.

(127) "Plan sponsor" is as defined in 29 U.S.C. Sec. 1002(16)(B).

(128) "Plan year" means:

(a) the year that is designated as the plan year in:

(i) the plan document of a group health plan; or

(ii) a summary plan description of a group health plan;

(b) if the plan document or summary plan description does not designate a plan year or there is no plan document or summary plan description:

(i) the year used to determine deductibles or limits;

(ii) the policy year, if the plan does not impose deductibles or limits on a yearly basis; or

(iii) the employer's taxable year if:

(A) the plan does not impose deductibles or limits on a yearly basis; and

(B) (I) the plan is not insured; or

(II) the insurance policy is not renewed on an annual basis; or

(c) in a case not described in Subsection (128)(a) or (b), the calendar year.

(129) (a) "Policy" means a document, including an attached endorsement or application that:

(i) purports to be an enforceable contract; and

(ii) memorializes in writing some or all of the terms of an insurance contract.

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

(i) a motor club under Chapter 11, Motor Clubs;

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

(iii) a corporation licensed under:

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

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

(c) "Policy" does not include:

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

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

(130) "Policyholder" means a person who controls a policy, binder, or oral contract by ownership, premium payment, or otherwise.

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

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

(133) "PPACA" means the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, and related federal regulations and guidance.

[~~(133)~~] (134) "Preexisting condition," with respect to a health benefit plan:

(a) means a condition that was present before the effective date of coverage, whether or not medical advice, diagnosis, care, or treatment was recommended or received before that day; and

(b) does not include a condition indicated by genetic information unless an actual diagnosis of the condition by a physician has been made.

[~~(134)~~] (135) (a) "Premium" means the monetary consideration for an insurance policy.

(b) "Premium" includes, however designated:

(i) an assessment;

(ii) a membership fee;

(iii) a required contribution; or

(iv) monetary consideration.

(c) (i) "Premium" does not include consideration paid to a third party administrator for the third party administrator's services.

(ii) "Premium" includes an amount paid by a third party administrator to an insurer for insurance on the risks administered by the third party administrator.

[~~(135)~~] (136) "Principal officers" for a corporation means the officers designated under Subsection 31A-5-203(3).

[~~(136)~~] (137) "Proceeding" includes an action or special statutory proceeding.

[~~(137)~~] (138) "Professional liability insurance" means insurance against legal liability incident to the practice of a profession and provision of a professional service.

[~~(138)~~] (139) (a) Except as provided in Subsection [~~(138)~~] (139)(b), "property

insurance" means insurance against loss or damage to real or personal property of every kind and any interest in that property:

(i) from all hazards or causes; and

(ii) against loss consequential upon the loss or damage including vehicle comprehensive and vehicle physical damage coverages.

(b) "Property insurance" does not include:

(i) inland marine insurance; and

(ii) ocean marine insurance.

[~~(139)~~] (140) "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 Sections 7702B(b) and (e), Internal Revenue Code.

[~~(140)~~] (141) "Qualified United States financial institution" means an institution that:

(a) is:

(i) organized under the laws of the United States or any state; or

(ii) in the case of a 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 a United States federal or state authority having regulatory authority over a bank or trust company; and

(c) meets the standards of financial condition and standing that are considered necessary and appropriate to regulate the quality of a financial institution whose letters of credit will be acceptable to the commissioner as determined by:

(i) the commissioner by rule; or

(ii) the Securities Valuation Office of the National Association of Insurance Commissioners.

[~~(141)~~] (142) (a) "Rate" means:

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

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

(A) a single number; or

(B) a pure premium rate, adjusted before the 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.

[~~(142)~~] (143) (a) Except as provided in Subsection [~~(142)~~] (143)(b), "rate service organization" means a person who assists an insurer 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) an individual serving as an actuarial or legal consultant.

[~~(143)~~] (144) "Rating manual" means any of the following used to determine initial and renewal policy premiums:

(a) a manual of rates;

(b) a classification;

(c) a rate-related underwriting rule; and

(d) a rating formula that describes steps, policies, and procedures for determining initial and renewal policy premiums.

[~~(144)~~] (145) "Received by the department" means:

(a) the date delivered to and stamped received by the department, if delivered in person;

(b) the post mark date, if delivered by mail;

(c) the delivery service's post mark or pickup date, if delivered by a delivery service;

(d) the received date recorded on an item delivered, if delivered by:

(i) facsimile;

(ii) email; or

(iii) another electronic method; or

(e) a date specified in:

(i) a statute;

(ii) a rule; or

(iii) an order.

[~~(145)~~] (146) "Reciprocal" or "interinsurance exchange" means an unincorporated association of persons:

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

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

[~~(146)~~] (147) "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."

[~~(147)~~] (148) "Reinsurer" means a person licensed in this state as an insurer with the authority to assume reinsurance.

[~~(148)~~] (149) "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.

[~~(149)~~] (150) (a) "Retrocession" means reinsurance with another insurer of a liability assumed under a reinsurance contract.

(b) A reinsurer "retrocedes" when the reinsurer reinsures with another insurer part of a liability assumed under a reinsurance contract.

[~~(150)~~] (151) "Rider" means an endorsement to:

(a) an insurance policy; or

(b) an insurance certificate.

[~~(151)~~] (152) (a) "Security" means a:

(i) note;

(ii) stock;

(iii) bond;

(iv) debenture;

(v) evidence of indebtedness;

(vi) certificate of interest or participation in a 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) 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 [~~(151)~~] (152)(a)(i) through (xiv); or

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

(b) "Security" does not include:

(i) any of the following under which an insurance company promises to pay money in a specific lump sum or periodically for life or some other specified period:

(A) insurance;

(B) an endowment policy; or

(C) an annuity contract; or

(ii) a burial certificate or burial contract.

[~~(152)~~] (153) "Secondary medical condition" means a complication related to an exclusion from coverage in accident and health insurance.

[~~(153)~~] (154) (a) "Self-insurance" means an arrangement under which a person provides for spreading its own risks by a systematic plan.

(b) Except as provided in this Subsection [~~(153)~~] (154), "self-insurance" does not include an arrangement under which a number of persons spread their risks among themselves.

(c) "Self-insurance" includes:

(i) an arrangement by which a governmental entity undertakes to indemnify an employee for liability arising out of the employee's employment; and

(ii) 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 that is related to the relationship or employment.

(d) "Self-insurance" does not include an arrangement with an independent contractor.

[~~(154)~~] (155) "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.

[~~(155)~~] (156) "Short-term care insurance" means an 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.

[~~(156)~~] (157) "Significant break in coverage" means a period of 63 consecutive days during each of which an individual does not have creditable coverage.

[~~(157)~~] (158) "Small employer," in connection with a health benefit plan, means an employer who, with respect to a calendar year and to a plan year:

(a) employed an average of at least two employees but not more than 50 eligible employees on each business day during the preceding calendar year; and

(b) employs at least two employees on the first day of the plan year.

[~~(158)~~] (159) "Special enrollment period," in connection with a health benefit plan, has the same meaning as provided in federal regulations adopted pursuant to the Health Insurance Portability and Accountability Act.

[~~(159)~~] (160) (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.

[~~(160)~~] (161) Subject to Subsection (86)(b), "surety insurance" includes:

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

(b) bail bond insurance; and

(c) fidelity insurance.

[~~(161)~~] (162) (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~~] an insurer or organization that is designated by the insurer or organization as permanent.

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

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

(c) "Excess surplus" means:

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

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

(I) 3.0; and

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

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

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).

[~~(162)~~] (163) "Third party administrator" or "administrator" means a 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 administering a:

(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 the following, but only for a line of insurance for which the insurer holds a license in this state:

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

(ii) Chapter 7, Nonprofit Health Service Insurance Corporations;

(iii) Chapter 8, Health Maintenance Organizations and Limited Health Plans;

(iv) Chapter 9, Insurance Fraternals; or

(v) Chapter 14, Foreign Insurers;

(e) a person:

(i) licensed or exempt from licensing under:

(A) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries; or

(B) Chapter 26, Insurance Adjusters; and

(ii) whose activities are limited to those authorized under the license the person holds or for which the person is exempt; or

(f) an institution, bank, or financial institution:

(i) that is:

(A) an institution whose deposits and accounts are to any extent insured by a federal deposit insurance agency, including the Federal Deposit Insurance Corporation or National Credit Union Administration; or

(B) a bank or other financial institution that is subject to supervision or examination by a federal or state banking authority; and

(ii) that does not adjust claims without a third party administrator license.

[~~(163)~~] (164) "Title insurance" means the insuring, guaranteeing, or indemnifying of an owner of real or personal property or the holder 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.

[~~(164)~~] (165) "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) another item provided by the RBC instructions, as RBC instructions is defined in Section 31A-17-601.

[~~(165)~~] (166) (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.

[~~(166)~~] (167) (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.

[~~(167)~~] (168) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

[~~(168)~~] (169) "Vehicle liability insurance" means insurance against liability resulting from or incident to ownership, maintenance, or use of a land vehicle or aircraft, exclusive of a vehicle comprehensive or vehicle physical damage coverage under Subsection [~~(138)~~] (139).

[~~(169)~~] (170) "Voting security" means a security with voting rights, and includes a security convertible into a security with a voting right associated with the security.

[~~(170)~~] (171) "Waiting period" for a health benefit plan means the period that must pass before coverage for an individual, who is otherwise eligible to enroll under the terms of the health benefit plan, can become effective.

[~~(171)~~] (172) "Workers' compensation insurance" means:

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

(i) a compensable accidental injury; and

(ii) occupational disease disability;

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

(c) insurance assuring to a person entitled to workers' compensation benefits the compensation provided by law.

Section 2. Section **31A-2-201.2** is amended to read:

31A-2-201.2. Evaluation of health insurance market.

(1) Each year the commissioner shall:

(a) conduct an evaluation of the state's health insurance market;

(b) report the findings of the evaluation to the Health and Human Services Interim Committee before October 1 of each year; and

(c) publish the findings of the evaluation on the department website.

(2) The evaluation required by this section shall:

(a) analyze the effectiveness of the insurance regulations and statutes in promoting a healthy, competitive health insurance market that meets the needs of the state, and includes an analysis of:

(i) the availability and marketing of individual and group products;

(ii) rate changes;

(iii) coverage and demographic changes;

(iv) benefit trends;

(v) market share changes; and

(vi) accessibility;

(b) assess complaint ratios and trends within the health insurance market, which assessment shall include complaint data from the Office of Consumer Health Assistance within the department;

(c) contain recommendations for action to improve the overall effectiveness of the health insurance market, administrative rules, and statutes; and

(d) include claims loss ratio data for each health insurance company doing business in the state.

(3) When preparing the evaluation required by this section, the commissioner shall include a report of:

(a) the types of health benefit plans sold in the Health Insurance Exchange created in Section 63M-1-2504;

(b) the number of insurers participating in the defined contribution arrangement health benefit plans in the Health Insurance Exchange; and

(c) the number of employers and covered lives in the defined contribution arrangement market in the Health Insurance Exchange[~~; and~~].

[~~(d) the number of lives covered by health benefit plans that do not include state mandates as permitted by Subsection 31A-30-109(2).~~]

(4) When preparing the evaluation and report required by this section, the commissioner may seek the input of insurers, employers, insured persons, providers, and others with an interest in the health insurance market.

(5) The commissioner may adopt administrative rules for the purpose of collecting the data required by this section, taking into account the business confidentiality of the insurers.

(6) Records submitted to the commissioner under this section shall be maintained by the commissioner as protected records under Title 63G, Chapter 2, Government Records Access and Management Act.

Section ~~(2)~~3. Section **31A-2-217** is amended 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~~] a state governmental regulatory agency, within and outside of this state, or with the National Association of Insurance Commissioners to address state regulatory issues limited to:

(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 and Labor 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 63I-1-231.

Section ~~{3}~~4. Section **31A-2-402** is amended to read:

31A-2-402. Definitions.

As used in this part:

(1) "Commission" means the Title and Escrow Commission created in Section 31A-2-403.

(2) "Concurrence" means the entities given a concurring role must jointly agree for the action to be taken.

(3) "Dual licensed title licensee" means a title licensee who holds:

(a) [~~a~~] an individual title insurance producer license as a title licensee; and

(b) a license or certificate under:

(i) Title 61, Chapter 2c, Utah Residential Mortgage Practices and Licensing Act;

(ii) Title 61, Chapter 2f, Real Estate Licensing and Practices Act; or

(iii) Title 61, Chapter 2g, Real Estate Appraiser Licensing and Certification Act.

(4) "Real Estate Commission" means the Real Estate Commission created in Section 61-2f-103.

(5) "Title licensee" means a person licensed under this title as:

(a) an agency title insurance producer with a title insurance line of authority;

(b) [~~a~~] an individual title insurance producer with:

(i) a general title insurance line of authority; or

(ii) a specific category of authority for title insurance; or

(c) a title insurance adjuster.

Section ~~{4}~~5. Section **31A-2-403** is amended to read:

31A-2-403. Title and Escrow Commission created.

(1) (a) Subject to Subsection (1)(b), there is created within the department the Title and Escrow Commission that is comprised of five members appointed by the governor with the

consent of the Senate as follows beginning July 1, 2013:

[~~(i) four members shall each:~~]

(i) two members shall be an employee of a title insurer;

(ii) two members shall:

(A) be an employee of a Utah agency title insurance producer;

[~~(A)~~] (B) be or have been licensed under the title insurance line of authority;

[~~(B)~~] (C) as of the day on which the member is appointed, be or have been licensed with the search or escrow subline of authority for at least five years; and

[~~(C)~~] (D) as of the day on which the member is appointed, not be from the same county as another member appointed under this Subsection (1)(a)[~~(i)~~](ii); and

[~~(ii)~~] (iii) one member shall be a member of the general public from any county in the state.

(b) No more than one commission member may be appointed from a single company or an affiliate or subsidiary of the company.

(2) (a) Subject to Subsection (2)(c), a commission member shall file with the commissioner a disclosure of any position of employment or ownership interest that the commission member has with respect to a person that is subject to the jurisdiction of the commissioner.

(b) The disclosure statement required by this Subsection (2) shall be:

(i) filed by no later than the day on which the person begins that person's appointment; and

(ii) amended when a significant change occurs in any matter required to be disclosed under this Subsection (2).

(c) A commission member is not required to disclose an ownership interest that the commission member has if the ownership interest is in a publicly traded company or held as part of a mutual fund, trust, or similar investment.

(3) (a) Except as required by Subsection (3)(b), as terms of current commission members expire, the governor shall appoint each new commission member to a four-year term ending on June 30.

(b) Notwithstanding the requirements of Subsection (3)(a), the governor shall, at the time of appointment, adjust the length of terms to ensure that the terms of the commission

members are staggered so that approximately half of the [~~commission is~~] members appointed under Subsection (1)(a)(i) and half of the members appointed under Subsection (1)(a)(ii) are appointed every two years.

(c) A commission member may not serve more than one consecutive term.

(d) When a vacancy occurs in the membership for any reason, the governor, with the consent of the Senate, shall appoint a replacement for the unexpired term.

(e) Notwithstanding the other provisions of this Subsection (3), a commission member serves until a successor is appointed by the governor with the consent of the Senate.

(4) A commission member may not receive compensation or benefits for the commission member's service, but may receive per diem and travel expenses in accordance with:

(a) Section 63A-3-106;

(b) Section 63A-3-107; and

(c) rules made by the Division of Finance pursuant to Sections 63A-3-106 and 63A-3-107.

(5) Members of the commission shall annually select one commission member to serve as chair.

(6) (a) The commission shall meet at least monthly. Notwithstanding Section 52-4-207, a commission member shall physically attend a regularly scheduled monthly meeting of the commission and may not attend through electronic means. A commission member may attend subcommittee meetings, emergency meetings, or other not regularly scheduled meetings electronically in accordance with Section 52-4-207.

(b) The commissioner may call additional meetings:

(i) at the commissioner's discretion;

(ii) upon the request of the chair of the commission; or

(iii) upon the written request of three or more commission members.

(c) (i) Three commission members constitute a quorum for the transaction of business.

(ii) The action of a majority of the commission members when a quorum is present is the action of the commission.

(7) The commissioner shall staff the commission.

Section ~~{5}~~6. Section **31A-2-404** is amended to read:

31A-2-404. Duties of the commissioner and Title and Escrow Commission.

(1) Notwithstanding the other provisions of this chapter, to the extent provided in this part, the commissioner shall administer and enforce the provisions in this title related to:

(a) title insurance; and

(b) escrow conducted by a title licensee or title insurer.

(2) The commission shall:

(a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and subject to Subsection [~~(3)~~] (4), make rules for the administration of the provisions in this title related to title insurance including rules related to:

(i) rating standards and rating methods for a title licensee, as provided in Section 31A-19a-209;

(ii) the licensing for a title licensee, including the licensing requirements of Section 31A-23a-204;

(iii) continuing education requirements of Section 31A-23a-202; and

[~~(iv) examination procedures, after consultation with the commissioner and the commissioner's test administrator when required by Section 31A-23a-204; and~~]

[~~(v)~~] (iv) standards of conduct for a title licensee;

(b) concur in the issuance and renewal of a license in accordance with Section 31A-23a-105 or 31A-26-203;

(c) in accordance with Section 31A-3-103, establish, with the concurrence of the commissioner, the fees imposed by this title on a title licensee;

(d) in accordance with Section 31A-23a-415 determine, after consulting with the commissioner, the assessment on a title insurer as defined in Section 31A-23a-415;

(e) conduct an administrative hearing not delegated by the commission to an administrative law judge related to the:

(i) licensing of an applicant;

(ii) conduct of a title licensee; or

(iii) approval of a continuing education program required by Section 31A-23a-202;

(f) with the concurrence of the commissioner, approve a continuing education program required by Section 31A-23a-202;

(g) with the concurrence of the commissioner, impose a penalty:

(i) under this title related to:

(A) title insurance; or

(B) escrow conducted by a title licensee;

(ii) after investigation by the commissioner in accordance with Part 3, Procedures and Enforcement; and

(iii) that is enforced by the commissioner;

(h) advise the commissioner on the administration and enforcement of any matter affecting the title insurance industry;

(i) advise the commissioner on matters affecting the commissioner's budget related to title insurance; and

(j) perform other duties as provided in this title.

(3) The commission may make rules establishing an examination for a license that will satisfy Section 31A-23a-204:

(a) after consultation with the commissioner and the commissioner's test administrator;

(b) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and

(c) subject to Subsection (4).

[~~(3)~~] (4) The commission may make a rule under this title only if at the time the commission files its proposed rule and rule analysis with the Division of Administrative Rules in accordance with Section 63G-3-301, the commission provides the Real Estate Commission that same information.

[~~(4)~~] (5) (a) The commissioner shall annually report the information described in Subsection [~~(4)~~] (5)(b) in writing to:

(i) the commission; and

(ii) the Business and Labor Interim Committee.

(b) The information required to be reported under this Subsection [~~(4)~~] (5):

(i) may not identify a person; and

(ii) shall include:

(A) the number of complaints the commissioner receives with regard to transactions involving title insurance or a title licensee during the calendar year immediately proceeding the report;

(B) the type of complaints described in Subsection [~~(4)~~] (5)(b)(ii)(A); and

(C) for each complaint described in Subsection [~~(4)~~] (5)(b)(ii)(A):

(I) any action taken by the commissioner with regard to the complaint; and

(II) the time-period beginning the day on which a complaint is made and ending the day on which the commissioner determines it will take no further action with regard to the complaint.

(6) The commission may not impose a penalty in a manner inconsistent with Subsection (2)(g) or make a rule that conflicts with Subsection (2)(g).

Section 7. Section **31A-3-304 (Effective 07/01/13)** is amended to read:

31A-3-304 (Effective 07/01/13). Annual fees -- Other taxes or fees prohibited -- Captive Insurance Restricted Account.

(1) (a) A captive insurance company shall pay an annual fee imposed under this section to obtain or renew a certificate of authority.

(b) The commissioner shall:

(i) determine the annual fee pursuant to Section 31A-3-103; and

(ii) consider whether the annual fee is competitive with fees imposed by other states on captive insurance companies.

(2) A captive insurance company that fails to pay the fee required by this section is subject to the relevant sanctions of this title.

(3) (a) Except as provided in Subsection (3)(d) and notwithstanding Title 59, Chapter 9, Taxation of Admitted Insurers, the following constitute the sole taxes, fees, or charges under the laws of this state that may be levied or assessed on a captive insurance company:

(i) a fee under this section;

(ii) a fee under Chapter 37, Captive Insurance Companies Act; and

(iii) a fee under Chapter 37a, Special Purpose Financial Captive Insurance Company Act.

(b) The state or a county, city, or town within the state may not levy or collect an occupation tax or other tax, fee, or charge not described in Subsections (3)(a)(i) through (iii) against a captive insurance company.

(c) The state may not levy, assess, or collect a withdrawal fee under Section 31A-4-115 against a captive insurance company.

(d) A captive insurance company is subject to real and personal property taxes.

(4) A captive insurance company shall pay the fee imposed by this section to the commissioner by June 20 of each year.

(5) (a) Money received pursuant to a fee described in Subsection (3)(a) shall be deposited into the Captive Insurance Restricted Account.

(b) There is created in the General Fund a restricted account known as the "Captive Insurance Restricted Account."

(c) The Captive Insurance Restricted Account shall consist of the fees described in Subsection (3)(a).

(d) The commissioner shall administer the Captive Insurance Restricted Account. Subject to appropriations by the Legislature, the commissioner shall use the money deposited into the Captive Insurance Restricted Account to:

(i) administer and enforce:

(A) Chapter 37, Captive Insurance Companies Act; and

(B) Chapter 37a, Special Purpose Financial Captive Insurance Company Act; and

(ii) promote the captive insurance industry in Utah.

(e) An appropriation from the Captive Insurance Restricted Account is nonlapsing, except that at the end of each fiscal year, money received by the commissioner in excess of [~~$950,000~~] $1,250,000 shall be treated as free revenue in the General Fund.

Section 85. Section **31A-4-117** is enacted to read:

31A-4-117. Closing or settlement protection.

(1) A title insurer may issue closing or settlement protection in the form of a closing protection letter filed with the department to a person who is a party to a transaction in which a title insurance policy is issued.

(2) Closing or settlement protection may indemnify a person who is a party to a transaction referred to in Subsection (1) against loss that the title insurer approves for the closing or settlement protection, under the terms and conditions of the closing protection letter issued by the title insurer, because of one or more of the following acts of a title insurance policy issuing individual title insurance producer or agency title insurance producer or other settlement service provider:

(a) theft or misappropriation of settlement funds in connection with a transaction in which one or more title insurance policies are issued by or on behalf of the title insurer issuing

the closing or settlement protection, but only to the extent that the theft or misappropriation relates to the status of the title to that interest in land or to the validity, enforceability, and priority of the lien of the mortgage on that interest in land; or

(b) failure to comply with the written closing instructions when agreed to by the settlement agent, title agent, or employee of the title insurer, but only to the extent that the failure to follow the written closing instructions relates to the status of the title to that interest in land or the validity, enforceability, and priority of the lien of the mortgage on that interest in land.

(3) A title insurer may not make the fee charged by a title insurer for each party receiving closing or settlement protection coverage subject to any agreement requiring a division of fees or premiums collected on behalf of the title insurer. The fee charged for a closing or settlement coverage protection letter will be filed by the title insurer with the department 30 days before use.

(4) A title insurer may not provide any other protection that purports to contractually indemnify against improper acts or omissions of a person who is a party to a transaction referred to in Subsection (1) with regard to settlement or closing services.

Section 9. Section **31A-8-301** is amended to read:

31A-8-301. Requirements for doing business in state.

(1) Only a corporation incorporated and licensed under Part 2, Domestic Organizations, may do business in this state as an organization.

(2) To do business in this state as an organization, a foreign [~~corporations~~] corporation doing a similar business in other states shall incorporate a subsidiary and license [~~if~~] it under Part 2, Domestic Organizations, for its Utah business. Except as to Chapter 16, Insurance Holding Companies, the laws applicable to a domestic [~~organizations~~] organization apply only to the domestic organization and not to its foreign parent corporation.

Section 10. Section **31A-14-211** is amended to read:

31A-14-211. Restrictions on foreign title insurers.

(1) An authorized foreign title insurer may [~~not~~] only insure property in this state [~~except~~]:

(a) through [~~a~~] an agency title insurance producer who is a resident in Utah; or

(b) [~~through~~] if the authorized foreign title insurer has a bona fide office in Utah:

(i) that is under the direction and control of the authorized foreign title insurer;

(ii) for which the authorized foreign title insurer pays the expenses, including compensation of the employees of the bona fide office;

(iii) at which a person may request information about title services related to a real estate transaction for which the person is a party;

(iv) at which a person may deliver written communications to the authorized foreign title insurer as required by the real estate transaction for which the person is a party; and

(v) at which a person may deliver escrow money related to a real estate transaction for which the person is a party.

(2) This section does not apply to reinsurance.

Section 11. 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 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~~] 3.0; and

[~~(B) a negative trend, determined in accordance with the "trend test calculation" included in the RBC instructions;~~]

(B) triggers the trend test determined in accordance with the trend test calculation included in the life or fraternal RBC instructions; or

(iii) if a property and casualty 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 3.0; and

(B) triggers the trend test determined in accordance with the trend test calculation included in the property and casualty 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;

(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 12. Section **31A-19a-209** is amended to read:

31A-19a-209. Special provisions for title insurance.

(1) (a) (i) The Title and Escrow Commission shall adopt rules subject to Section 31A-2-404, establishing rate standards and rating methods for [~~title agencies and producers~~] individual title insurance producers and agency title insurance producers.

(ii) The commissioner shall determine compliance with rate standards and rating methods for title insurance insurers[~~, agencies, and producers~~], individual title insurance producers, and agency title insurance producers.

(b) In addition to the considerations in determining compliance with rate standards and rating methods as set forth in Sections 31A-19a-201 and 31A-19a-202, including for title insurers, the commissioner and the Title and Escrow Commission shall consider the costs and expenses incurred by title insurance insurers[~~, agencies, and producers~~], individual title insurance producers, and agency title insurance producers peculiar to the business of title insurance including:

(i) the maintenance of title plants; and

(ii) the searching and examining of public records to determine insurability of title to real redevelopment property.

(2) (a) Every title insurance insurer[~~,~~] or agency[~~, and~~] title insurance producer, and every individual title insurance producer who is not designated by an agency title insurance producer, shall file with the commissioner:

(i) a schedule of the escrow charges that the title insurance insurer[~~, agency, or~~], individual title insurance producer, or agency title insurance producer proposes to use in this state for services performed in connection with the issuance of policies of title insurance; and

(ii) any changes to the schedule of the escrow charges described in Subsection (2)(a)(i).

(b) Except for a schedule filed by a title insurance insurer under this Subsection (2), a schedule filed under this Subsection (2) is subject to review by the Title and Escrow Commission.

(c) (i) The schedule of escrow charges required to be filed by Subsection (2)(a)(i) takes effect on the day on which the schedule of escrow charges is filed.

(ii) Any changes to the schedule of the escrow charges required to be filed by Subsection (2)(a)(ii) take effect on the day specified in the change to the schedule of escrow charges except that the effective date may not be less than 30 calendar days after the day on which the change to the schedule of escrow charges is filed.

(3) A title insurance insurer[~~, agency, or producer~~], individual title insurance producer, or agency title insurance producer may not file or use any rate or other charge relating to the business of title insurance, including rates or charges filed for escrow that would cause the title insurance company[~~, agency, or producer~~], individual title insurance producer, or agency title insurance producer to:

(a) operate at less than the cost of doing:

(i) the insurance business; or

(ii) the escrow business; or

(b) fail to adequately underwrite a title insurance policy.

(4) (a) All or any of the schedule of rates or schedule of charges, including the schedule of escrow charges, may be changed or amended at any time, subject to the limitations in this Subsection (4).

(b) Each change or amendment shall:

(i) be filed with the commissioner, subject to review by the Title and Escrow Commission; and

(ii) state the effective date of the change or amendment, which may not be less than 30 calendar days after the day on which the change or amendment is filed.

(c) Any change or amendment remains in force for a period of at least 90 calendar days from the change or amendment's effective date.

(5) While the schedule of rates and schedule of charges are effective, a copy of each shall be:

(a) retained in each of the offices of:

(i) the title insurance insurer in this state;

(ii) the title insurance insurer's individual title insurance producers or agency title insurance producers in this state; and

(b) upon request, furnished to the public.

(6) Except in accordance with the schedules of rates and charges filed with the commissioner, a title insurance insurer[~~, agency, or producer~~], individual title insurance producer, or agency title insurance producer may not make or impose any premium or other charge:

(a) in connection with the issuance of a policy of title insurance; or

(b) for escrow services performed in connection with the issuance of a policy of title insurance.

Section 13. Section **31A-20-110** is amended to read:

31A-20-110. Underwriting rules for title insurance.

(1) [~~No~~] A title insurance policy may not be written until the title insurer or its individual title insurance producer or agency title insurance producer has conducted a reasonable search and examination of the title and has made a determination of insurability of title under sound underwriting principles. Evidence of this search and reasonable determination shall be retained in the files of the title insurer or its individual title insurance producer or agency title insurance producer for not less than 15 years after the policy has been issued, either in its original form or as recorded by any process which can accurately and reliably reproduce the original. This section does not apply to a company assuming liability through a contract of reinsurance, or to a company acting as coinsurer, if another coinsuring company has complied with this section.

(2) [~~No~~] A title insurance policy may not be issued except by a title [~~insurance company or by a~~] insurer, an individual title insurance producer who is appointed by an insurer, or agency title insurance producer licensed under Section 31A-23a-105.

(3) This section is enforceable only by the commissioner. It does not create, eliminate, or modify any private cause of action or remedy.

Section 14. Section **31A-21-314** is amended to read:

31A-21-314. Prohibited provisions.

[~~No~~] An insurance policy subject to this chapter may not contain any provision:

(1) requiring it to be construed according to the laws of another jurisdiction except as necessary to meet the requirements of compulsory insurance laws of other jurisdictions;

(2) depriving Utah courts of jurisdiction over an action against the insurer, except as

provided in permissible arbitration provisions; [~~or~~]

(3) limiting the right of action against the insurer to less than three years from the date the cause of action accrues[~~.~~]; or

(4) purporting to give to an insurer, plan administrator, or claim administrator full and final discretion in interpreting benefits in an insurance policy.

Section 15. 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 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~~] Section 31A-22-612 [~~and 31A-22-723~~] under a group 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 on the basis of the physical or mental condition of an insured or applicant if the underwriting is on the basis of 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 16. Section **31A-22-429** is enacted to read:

31A-22-429. Producer's duties related to replacement of life insurance or annuity.

(1) In connection with or as part of each application for life insurance or annuities, the applicant shall complete and the producer shall submit to the insurer the statements required by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as to:

(a) whether the applicant has existing policies or contracts; and

(b) whether the proposed life insurance or annuity will replace, discontinue, or change an existing policy or contract.

(2) If an applicant for life insurance or an annuity answers "yes" to the question regarding replacement, discontinuance, or change of an existing policy or contract referred to in Subsection (1), the producer shall present to, and leave with, the applicant, not later than at the time of taking the application, the notice regarding replacements in the form adopted by the commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, or other substantially similar document filed with the commissioner. However, a filing is not required when an amendment to the notice is limited to the omission of a reference not applicable to the product being sold or replaced. With respect to an electronically completed application and notice, the producer is not required to leave a copy of the electronically completed notice with the applicant.

(3) (a) The notice described in Subsection (2) shall:

(i) list each existing policy or contract contemplated to be replaced, properly identified by name of insurer, the insured or annuitant, and policy or contract number if available; and

(ii) include a statement as to whether each policy or contract will be replaced or whether a policy will be used as a source of financing for the new policy or contract.

(b) If a policy or contract number has not been issued by the existing insurer, alternative identification, such as an application or receipt number, shall be listed.

(4) In connection with a replacement transaction, the producer shall leave with the applicant by no later than at the time of policy or contract delivery the original or a copy of all printed sales material. With respect to electronically presented sales material, it shall be provided to the policy or contract holder in printed form no later than at the time of policy or contract delivery.

(5) Except as provided in rule made by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, in connection with a replacement transaction, the producer shall submit to the insurer to which an application for a policy or contract is presented:

(a) a copy of each document required by this section;

(b) a statement identifying any preprinted or electronically presented company approved sales materials used; and

(c) copies of any individualized sales materials, including any illustrations related to the specific policy or contract purchased.

Section 17. Section **31A-22-519** is amended to read:

31A-22-519. Death pending conversion.

If a person insured under a group life insurance policy, or the insured dependent of that person, dies during the period of eligibility for conversion under Section 31A-22-517 or 31A-22-518 and before the individual policy becomes effective, the amount of life insurance to which [~~he~~] the insured would have been entitled to have issued under the individual policy is payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium has been made.

Section 18. Section **31A-22-612** is amended to read:

31A-22-612. Conversion privileges for insured former spouse.

(1) 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 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 accident and health insurance policies[~~: (a)~~] offered on a group blanket basis[~~; or~~].

[~~(b) that comply with Section 31A-22-723.~~]

Section 19. 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 78B-3-403 under which the health care providers agree to supply services, at prices specified in the contracts, to persons insured by an insurer.

(a) (i) 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.

(ii) In any dispute involving a provider's claim for reimbursement, the same shall be determined in accordance with applicable law, the provider contract, the subscriber contract, and the insurer's written payment policies in effect at the time services were rendered.

(iii) If the parties are unable to resolve their dispute, the matter shall be subject to binding arbitration by a jointly selected arbitrator. Each party is to bear its own expense except the cost of the jointly selected arbitrator shall be equally shared. This Subsection (1)(a)(iii) does not apply to the claim of a general acute hospital to the extent it is inconsistent with the hospital's provider agreement.

(iv) An organization may not penalize a provider solely for pursuing a claims dispute or otherwise demanding payment for a sum believed owing.

(v) If an insurer permits another entity with which it does not share common ownership or control to use or otherwise lease one or more of the organization's networks of participating providers, the organization shall ensure, at a minimum, that the entity pays participating providers in accordance with the same fee schedule and general payment policies as the organization would for that network.

(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;

(iv) other copayments; or

(v) any other reasonable manner.

(c) If the insurer is a managed care organization, as defined in Subsection 31A-27a-403(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 earlier of:

(I) 90 days after 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 Subsection 31A-27a-403(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)~~](e), 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, Utah Health Code and 58, Occupations and Professions~~] is

subject to the reimbursement requirements in Section 31A-8-501 on or after January 1, 2014.

[~~(b) (i) Until July 1, 2012, 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.~~]

[~~(ii) Notwithstanding Subsection (2)(b)(i), an insurer may offer a health plan that complies with the provisions of Subsection 31A-22-618.5(3).~~]

[~~(iii) The commissioner may adopt a rule dealing with the determination of what constitutes 75% of the average amount paid by the insurer under Subsection (2)(b)(i) for comparable services of preferred health care providers who are members of the same class of health care providers.~~]

[~~(c)~~] (b) 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~~]

(c) An insurer using preferred health care provider contracts may impose a deductible on coverage of health care providers not under contract.

[~~(e)~~] (d) 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)~~] (e) For purposes of this section, unfair discrimination between classes of health care providers [~~shall include~~] includes:

(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~~] used 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 adverse benefit determination 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 adverse benefit determinations 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) 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~~] Except as provided in Subsection 31A-22-618.5(3)(a), 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 20. Section **31A-22-618.5** is amended to read:

31A-22-618.5. Health benefit plan offerings.

(1) The purpose of this section is to increase the range of health benefit plans available in the small group, small employer group, large group, and individual insurance markets.

(2) A health maintenance organization that is subject to Chapter 8, Health Maintenance Organizations and Limited Health Plans:

(a) shall offer to potential purchasers at least one health benefit plan that is subject to the requirements of Chapter 8, Health Maintenance Organizations and Limited Health Plans; and

(b) may offer to a potential purchaser one or more health benefit plans that:

(i) are not subject to one or more of the following:

(A) the limitations on insured indemnity benefits in Subsection 31A-8-105(4);

(B) the limitation on point of service products in Subsections 31A-8-408(3) through (6);

(C) except as provided in Subsection (2)(b)(ii), basic health care services as defined in Section 31A-8-101; or

(D) coverage mandates enacted after January 1, 2009 that are not required by federal

law, provided that the insurer offers one plan under Subsection (2)(a) that covers the mandate enacted after January 1, 2009; and

(ii) when offering a health plan under this section, provide coverage for an emergency medical condition as required by Section 31A-22-627 as follows:

(A) within the organization's service area, covered services shall include health care services from nonaffiliated providers when medically necessary to stabilize an emergency medical condition; and

(B) outside the organization's service area, covered services shall include medically necessary health care services for the treatment of an emergency medical condition that are immediately required while the enrollee is outside the geographic limits of the organization's service area.

(3) An insurer that offers a health benefit plan that is not subject to Chapter 8, Health Maintenance Organizations and Limited Health Plans:

[~~(a) notwithstanding Subsection 31A-22-617(2), may offer a health benefit plan that groups providers into the following reimbursement levels:~~]

[~~(i) tier one contracted providers;~~]

[~~(ii) tier two contracted providers who the insurer shall reimburse at least 75% of tier one providers; and~~]

[~~(iii) one or more tiers of non-contracted providers;~~]

[~~(b)~~] (a) notwithstanding Subsection 31A-22-617(9), may offer a health benefit plan that is not subject to Section 31A-22-618;

[~~(c) beginning July 1, 2012, may offer health benefit plans that:~~]

[~~(i) are not subject to Subsection 31A-22-617(2); and~~]

[~~(ii) are subject to the reimbursement requirements in Section 31A-8-501;~~]

[~~(d)~~] (b) when offering a health plan under this Subsection (3), shall provide coverage of emergency care services as required by Section 31A-22-627 [~~by providing coverage at a reimbursement level of at least 75% of the health benefit plan's highest contracted provider category~~]; and

[~~(e) are~~] (c) is not subject to coverage mandates enacted after January 1, 2009 that are not required by federal law, provided that an insurer offers one plan that covers a mandate enacted after January 1, 2009.

(4) Section 31A-8-106 does not prohibit the offer of a health benefit plan under Subsection (2)(b).

(5) (a) Any difference in price between a health benefit plan offered under Subsections (2)(a) and (b) shall be based on actuarially sound data.

(b) Any difference in price between a health benefit plan offered under [~~Subsections~~] Subsection (3)(a) [~~and (b)~~] shall be based on actuarially sound data.

(6) Nothing in this section limits the number of health benefit plans that an insurer may offer.

Section 21. Section **31A-22-722** is amended to read:

31A-22-722. Utah mini-COBRA benefits for employer group coverage.

(1) An insured may extend the employee's coverage under the current employer's group policy for a period of 12 months, except as provided in Subsections (2) and 31A-22-722.5(4). The right to extend coverage includes:

(a) voluntary termination;

(b) involuntary termination;

(c) retirement;

(d) death;

(e) divorce or legal separation;

(f) loss of dependent status;

(g) sabbatical;

(h) a disability;

(i) leave of absence; or

(j) reduction of hours.

(2) (a) Notwithstanding Subsection (1), an employee may not extend coverage under the current employer's group insurance policy if the employee:

(i) fails to pay premiums or contributions in accordance with the terms of the insurance policy;

(ii) acquires other group coverage covering all preexisting conditions including maternity, if the coverage exists;

(iii) performs an act or practice that constitutes fraud in connection with the coverage;

(iv) makes an intentional misrepresentation of material fact under the terms of the

coverage;

(v) is terminated from employment for gross misconduct;

(vi) is not continuously covered under the current employer's group policy for a period of three months immediately before the termination of the insurance policy due to an event set forth in Subsection (1);

(vii) is eligible for an extension of coverage required by federal law;

(viii) establishes residence outside of this state;

(ix) moves out of the insurer's service area;

(x) is eligible for similar coverage under another group insurance policy; or

(xi) has the employee's coverage terminated because the employer's coverage is terminated, except as provided in Subsection (8)[~~; or~~].

[~~(xii) elects alternative coverage under Section 31A-22-724.~~]

(b) The right to extend coverage under Subsection (1) applies to spouse or dependent coverage, including a surviving spouse or dependents whose coverage under the insurance policy terminates by reason of the death of the employee or member.

(3) (a) The employer shall notify the following in writing of the right to extend group coverage and the payment amounts required for extension of coverage, including the manner, place, and time in which the payments shall be made:

(i) a terminated insured;

(ii) an ex-spouse of an insured; or

(iii) if Subsection (2)(b) applies:

(A) a surviving spouse; and

(B) the guardian of surviving dependents, if different from a surviving spouse.

(b) The notification required in Subsection (3)(a) shall be sent first class mail within 30 days after the termination date of the group coverage to:

(i) the terminated insured's home address as shown on the records of the employer;

(ii) the address of the surviving spouse, if different from the insured's address and if shown on the records of the employer;

(iii) the guardian of any dependents address, if different from the insured's address, and if shown on the records of the employer; and

(iv) the address of the ex-spouse, if shown on the records of the employer.

(4) The insurer shall provide the employee, spouse, or any eligible dependent the opportunity to extend the group coverage at the payment amount stated in Subsection (5) if:

(a) the employer policyholder does not provide the terminated insured the written notification required by Subsection (3)(a); and

(b) the employee or other individual eligible for extension contacts the insurer within 60 days of coverage termination.

(5) A premium amount for extended group coverage may not exceed 102% of the group rate in effect for a group member, including an employer's contribution, if any, for a group insurance policy.

(6) Except as provided in this Subsection (6), coverage extends without interruption for 12 months and may not terminate if the terminated insured or, with respect to a minor, the parent or guardian of the terminated insured:

(a) elects to extend group coverage within 60 days of losing group coverage; and

(b) tenders the amount required to the employer or insurer.

(7) The insured's coverage may be terminated before 12 months if the terminated insured:

(a) establishes residence outside of this state;

(b) moves out of the insurer's service area;

(c) fails to pay premiums or contributions in accordance with the terms of the insurance policy, including any timeliness requirements;

(d) performs an act or practice that constitutes fraud in connection with the coverage;

(e) makes an intentional misrepresentation of material fact under the terms of the coverage;

(f) becomes eligible for similar coverage under another group insurance policy; or

(g) has the coverage terminated because the employer's coverage is terminated, except as provided in Subsection (8).

(8) If the current employer coverage is terminated and the employer replaces coverage with similar coverage under another group insurance policy, without interruption, the terminated insured, spouse, or the surviving spouse and guardian of dependents if Subsection (2)(b) applies, may obtain extension of coverage under the replacement group insurance policy:

(a) for the balance of the period the terminated insured would have extended coverage

under the replaced group insurance policy; and

(b) if the terminated insured is otherwise eligible for extension of coverage.

[~~(9) (a) Within 30 days of the insured's exhaustion of extension of coverage, the employer shall provide the terminated insured and the ex-spouse, or, in the case of the death of the insured, the surviving spouse, or guardian of any dependents, written notification of the right to an individual conversion policy under Section 31A-22-723.~~]

[~~(b)~~{ } ~~The notification required by Subsection (9)(a):~~]

[~~(i) shall be sent first class mail to:~~]

[~~(A) the insured's last-known address as shown on the records of the employer;~~]

[~~(B) the address of the surviving spouse, if different from the insured's address, and if shown on the records of the employer;~~]

[~~(C) the guardian of any dependents last known address as shown on the records of the employer, if different from the address of the surviving spouse; and~~]

[~~(D) the address of the ex-spouse as shown on the records of the employer, if applicable; and~~]

[~~(ii) shall contain the name, address, and telephone number of the insurer that will provide the conversion coverage.~~{

~~**31A-23a-504. 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 as to the particular type of insurance to act in Utah as:~~

~~(i) a producer;~~

~~(ii) a limited line producer;~~

~~(iii) a consultant;~~

~~(iv) a managing general agent; or~~

~~(v) a reinsurance intermediary.~~

~~(b) A person may only accept commission compensation or other compensation as a person described in Subsections (1)(a)(i) through (v) that is directly or indirectly the result of an insurance transaction if that person is licensed under this chapter to act as described in Subsection (1)(a).~~

~~(2) (a) Except as provided in Section 31A-23a-501, a consultant may not pay or receive a commission or other compensation that is directly or indirectly the result of an insurance transaction.~~

~~(b) A consultant may share a consultant fee or other compensation received for consulting services performed within Utah only:~~

~~(i) with another consultant licensed under this chapter; and~~

~~(ii) to the extent that the other consultant contributed to the services performed.~~

~~(3) This section does not prohibit:~~

~~(a) 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;~~

~~(b) compensation paid to or received by a person for referral of a potential customer that seeks to purchase or obtain an opinion or advice on an insurance product if:~~

~~(i) the person is not licensed to sell insurance;~~

~~(ii) the person does not sell or provide opinions or advice on the product; and~~

~~(iii) the compensation does not depend on whether the referral results in a purchase or sale; or~~

~~(c) the payment or assignment of a commission, service fee, brokerage, or other valuable consideration to an agency or a person who does not sell, solicit, or negotiate insurance in this state, unless the payment would constitute an inducement or commission rebate under Section 31A-23a-402 or 31A-23a-402.5.~~

~~(4) (a) In selling a policy of title insurance, sharing of commissions under Subsection (1) may not occur if it will result in:~~

~~(i) an unlawful rebate;~~

~~(ii) compensation in connection with controlled business; or~~

~~(iii) payment of a forwarding fee or finder's fee.~~

~~(b) A person may share compensation for the issuance of a title insurance policy only to the extent that the person contributed to the search and examination of the title or other services connected with the title insurance policy.~~

~~(5) This section does not apply to a bail bond producer or bail enforcement agent as defined in Section 31A-35-102.~~

31A-30-115. Actuarial review of health benefit plans.

(1) (a) The department shall conduct an actuarial review of rates submitted by small employer carriers:

(i) prior to the publication of the premium rates on the Health Insurance Exchange;

(ii) except as permitted by Subsection 31A-30-207(2), to determine if the carrier is using the same rating and underwriting practices in both the defined contribution arrangement market in the Health Insurance Exchange and the defined benefit market offered outside the Health Insurance Exchange, in compliance with Subsection 31A-30-202.5(1)(b);

(iii) to verify the validity of the rates, underwriting and risk factors, and premiums of plans both in and outside of the Health Insurance Exchange;

(iv) to verify that insurers are pricing similar health benefit plans and groups the same in and out of the exchange, except as permitted by Subsection 31A-30-207(2); and

(v) as the department determines is necessary to oversee market conduct.

(b) The actuarial review by the department shall be funded from a fee:

(i) established by the department in accordance with Section 63J-1-504; and

(ii) paid by all small employer carriers participating in the defined contribution arrangement market and small employer carriers offering health benefit plans under Part 1, Individual and Small Employer Group.

(c) The department shall:

(i) report aggregate data from the actuarial review to the risk adjuster board created in Section 31A-42-201; and

(ii) contact carriers, if the department determines it is appropriate, to:

(A) inform a carrier of the department's findings regarding the rates of a particular carrier; and

(B) request a carrier to recalculate or verify base rates, rating factors, and premiums.

(d) A carrier shall comply with the department's request under Subsection (1)(c)(ii).

(2) (a) There is created in the General Fund a restricted account known as the "Health Insurance Actuarial Review Restricted Account."

(b) The Health Insurance Actuarial Review Restricted Account shall consist of money received by the commissioner under this section.

(c) The commissioner shall administer the Health Insurance Actuarial Review

~~Restricted Account. Subject to appropriations by the Legislature, the commissioner shall use money deposited into the Health Insurance Actuarial Review Restricted Account to pay for the actuarial review conducted by the department under this section.~~

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

~~(1) An insurer offering a health benefit plan in the defined contribution arrangement market:~~

~~(a) shall allow an employer to enroll in a small employer defined contribution arrangement plan;~~

~~(b) may not impose a surcharge under Section 31A-30-106.7 for a small employer group selecting a defined contribution arrangement health benefit plan on or before January 1, 2012; and~~

~~(c) shall otherwise comply with the requirements of this part, Chapter 42, Defined Contribution Risk Adjuster Act, and Title 63M, Chapter 1, Part 25, Health System Reform Act.~~

~~(2) (a) Except as provided in Subsection 31A-30-202.5(2), in accordance with Subsection (2)(b), on January 1 of each year, an insurer may enter or exit the defined contribution arrangement market.~~

~~(b) An insurer may offer new or modify existing products in the defined contribution arrangement market:~~

~~(i) on January 1 of each year;~~

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

~~(iii) at other times as established by the risk adjuster board created in Section 31A-42-201.~~

~~(c) (i) An insurer shall give the department, the Health Insurance Exchange, and the risk adjuster board 90 days' advance written notice of any event described in Subsection (2)(a) or (b).~~

~~(ii) When an insurer elects to participate in the defined contribution arrangement market, the insurer shall participate in the defined contribution arrangement market for no less than two years.~~

~~**49-20-410. High deductible health plan -- Health savings account -- Contributions.**~~

~~(1) (a) In addition to other employee benefit plans offered under Subsection~~

~~49-20-201(1), the office shall offer at least one federally qualified high deductible health plan with a health savings account as an optional health plan.~~

~~(b) The provisions and limitations of the plan shall be:~~

~~(i) determined by the office in accordance with federal requirements and limitations; and~~

~~(ii) designed to promote appropriate health care utilization by consumers, including preventive health care services.~~

~~(c) A state employee hired on or after July 1, 2011, who is offered a plan under Subsection 49-20-202(1)(a), shall be enrolled in a federally qualified high deductible health plan unless the employee chooses a different health benefit plan during the employee's open enrollment period.~~

~~(2) The office shall:~~

~~(a) administer the high deductible health plan in coordination with a health savings account for medical expenses for each covered individual in the high deductible health plan;~~

~~(b) offer to all employees training regarding all health plans offered to employees;~~

~~(c) prepare online training as an option for the training required by Subsections (2)(b) and (4);~~

~~(d) ensure the training offered under Subsections (2)(b) and (c) includes information on changing coverages to the high deductible plan with a health savings account, including coordination of benefits with other insurances, restrictions on other insurance coverages, and general tax implications; and~~

~~(e) coordinate annual open enrollment with the Department of Human Resource Management to give state employees the opportunity to affirmatively select preferences from among insurance coverage options.~~

~~(3) (a) Contributions to the health savings account may be made by the employer.~~

~~(b) The amount of the employer contributions under Subsection (3)(a) shall be determined annually by the office, after consultation with the Department of Human Resource Management and the Governor's Office of Planning and Budget so that the annual employer contribution amount reflects the difference in the actuarial value between the program's health maintenance organization coverage and the federally qualified high deductible health plan coverage, after taking into account any difference in employee premium contribution.~~

~~(c) The office shall distribute the annual amount determined under Subsection (3)(b) to employees in two equal amounts with a pay date in January and a pay date in July of each plan year.~~

~~(d) An employee may also make contributions to the health savings account.~~

~~(4) The program shall offer a state employee and the employee's eligible dependents the option to continue coverage under the employee's high deductible health plan in place of a conversion policy under Section 31A-22-723 if:~~

~~(a) the employee was covered by the state employee's high deductible health plan for at least the four years before the date of termination of employment;~~

~~(b) the employee or the employee's eligible dependents have exhausted federal COBRA coverage with the same or similar state employee's high deductible health plan; and~~

~~(c) the employee pays the premium group rate determined by the office for the coverage.~~

~~(5) (a) An employer participating in a plan offered under Subsection 49-20-202(1)(a) shall require each employee to complete training on the health plan options available to the employee.~~

~~(b) The training required by Subsection (5)(a):~~

~~(i) shall include materials prepared by the office under Subsection (2);~~

~~(ii) may be completed online; and~~

~~(iii) shall be completed:~~

~~(A) before the end of the 2012 open enrollment period for current enrollees in the program; and~~

~~(B) for employees hired on or after July 1, 2011, before the employee's selection of a plan in the program.~~

~~Section 6. Section **31A-3-304 (Effective 07/01/13)** is amended to read:~~

~~**31A-3-304 (Effective 07/01/13). Annual fees -- Other taxes or fees prohibited -- Captive Insurance Restricted Account.**~~

~~(1) (a) A captive insurance company shall pay an annual fee imposed under this section to obtain or renew a certificate of authority.~~

~~(b) The commissioner shall:~~

~~(i) determine the annual fee pursuant to Section 31A-3-103; and~~

~~(ii) consider whether the annual fee is competitive with fees imposed by other states on captive insurance companies.~~

~~(2) A captive insurance company that fails to pay the fee required by this section is subject to the relevant sanctions of this title.~~

~~(3) (a) Except as provided in Subsection (3)(d) and notwithstanding Title 59, Chapter 9, Taxation of Admitted Insurers, the following constitute the sole taxes, fees, or charges under the laws of this state that may be levied or assessed on a captive insurance company:~~

~~(i) a fee under this section;~~

~~(ii) a fee under Chapter 37, Captive Insurance Companies Act; and~~

~~(iii) a fee under Chapter 37a, Special Purpose Financial Captive Insurance Company Act.~~

~~(b) The state or a county, city, or town within the state may not levy or collect an occupation tax or other tax, fee, or charge not described in Subsections (3)(a)(i) through (iii) against a captive insurance company.~~

~~(c) The state may not levy, assess, or collect a withdrawal fee under Section 31A-4-115 against a captive insurance company.~~

~~(d) A captive insurance company is subject to real and personal property taxes.~~

~~(4) A captive insurance company shall pay the fee imposed by this section to the commissioner by June 20 of each year.~~

~~(5) (a) Money received pursuant to a fee described in Subsection (3)(a) shall be deposited into the Captive Insurance Restricted Account.~~

~~(b) There is created in the General Fund a restricted account known as the "Captive Insurance Restricted Account."~~

~~(c) The Captive Insurance Restricted Account shall consist of the fees described in Subsection (3)(a).~~

~~(d) The commissioner shall administer the Captive Insurance Restricted Account. Subject to appropriations by the Legislature, the commissioner shall use the money deposited into the Captive Insurance Restricted Account to:~~

~~(i) administer and enforce:~~

~~(A) Chapter 37, Captive Insurance Companies Act; and~~

~~(B) Chapter 37a, Special Purpose Financial Captive Insurance Company Act; and~~

~~(ii) promote the captive insurance industry in Utah.~~

~~(e) An appropriation from the Captive Insurance Restricted Account is nonlapsing, except that at the end of each fiscal year, money received by the commissioner in excess of [$950,000] $1,250,000 shall be treated as free revenue in the General Fund.~~

~~Section 75. Section **31A-4-117** is enacted to read:~~

~~**31A-4-117. Closing or settlement protection.**~~

~~(1) A title insurer may issue closing or settlement protection in the form of a closing protection letter filed with the department to a person who is a party to a transaction in which a title insurance policy is issued.~~

~~(2) Closing or settlement protection may indemnify a person who is a party to a transaction referred to in Subsection (1) against loss that the title insurer approves for the closing or settlement protection, under the terms and conditions of the closing protection letter issued by the title insurer, because of one or more of the following acts of a title insurance policy issuing individual title insurance producer or agency title insurance producer or other settlement service provider:~~

~~(a) theft or misappropriation of settlement funds in connection with a transaction in which one or more title insurance policies are issued by or on behalf of the title insurer issuing the closing or settlement protection, but only to the extent that the theft or misappropriation relates to the status of the title to that interest in land or to the validity, enforceability, and priority of the lien of the mortgage on that interest in land; or~~

~~(b) failure to comply with the written closing instructions when agreed to by the settlement agent, title agent, or employee of the title insurer, but only to the extent that the failure to follow the written closing instructions relates to the status of the title to that interest in land or the validity, enforceability, and priority of the lien of the mortgage on that interest in land.~~

~~(3) A title insurer may not make the fee charged by a title insurer for each party receiving closing or settlement protection coverage subject to any agreement requiring a division of fees or premiums collected on behalf of the title insurer. The fee charged for a closing or settlement coverage protection letter will be filed by the title insurer with the department 30 days before use.~~

~~(4) A title insurer may not provide any other protection that purports to contractually~~

indemnify against improper acts or omissions of a person who is a party to a transaction referred to in Subsection (1) with regard to settlement or closing services.

Section 8. Section **31A-8-301** is amended to read:

31A-8-301. Requirements for doing business in state.

(1) Only a corporation incorporated and licensed under Part 2, Domestic Organizations, may do business in this state as an organization.

(2) To do business in this state as an organization, a foreign [corporations] corporation doing a similar business in other states shall incorporate a subsidiary and license [if] it under Part 2, Domestic Organizations, for its Utah business. Except as to Chapter 16, Insurance Holding Companies, the laws applicable to a domestic [organizations] organization apply only to the domestic organization and not to its foreign parent corporation.

Section 9. Section **31A-14-211** is amended to read:

31A-14-211. Restrictions on foreign title insurers.

(1) An authorized foreign title insurer may [not] insure property in this state [except]:

(a) through [a] an agency title insurance producer who is a resident in Utah; or

(b) [through] if the authorized foreign title insurer has a bona fide office in Utah:

(i) that is under the direction and control of the authorized foreign title insurer;

(ii) for which the authorized foreign title insurer pays the expenses, including compensation of the employees of the bona fide office;

(iii) at which a person may request information about title services related to a real estate transaction for which the person is a party;

(iv) at which a person may deliver written communications to the authorized foreign title insurer as required by the real estate transaction for which the person is a party; and

(v) at which a person may deliver escrow money related to a real estate transaction for which the person is a party.

(2) This section does not apply to reinsurance.

Section 10. 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 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] 3.0; and~~

~~[(B) a negative trend, determined in accordance with the "trend test calculation" included in the RBC instructions;]~~

~~(B) triggers the trend test determined in accordance with the trend test calculation included in the life or fraternal RBC instructions; or~~

~~(iii) if a property and casualty 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 3.0; and~~

~~(B) triggers the trend test determined in accordance with the trend test calculation included in the property and casualty 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;

(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 11. Section **31A-19a-209** is amended to read:~~

~~**31A-19a-209. Special provisions for title insurance.**~~

~~(1) (a) (i) The Title and Escrow Commission shall adopt rules subject to Section 31A-2-404, establishing rate standards and rating methods for [title agencies and producers]~~ individual title insurance producers and agency title insurance producers~~.~~

~~(ii) The commissioner shall determine compliance with rate standards and rating methods for title insurance insurers[, agencies, and producers]~~, individual title insurance producers, and agency title insurance producers~~.~~

~~(b) In addition to the considerations in determining compliance with rate standards and rating methods as set forth in Sections 31A-19a-201 and 31A-19a-202, including for title insurers, the commissioner and the Title and Escrow Commission shall consider the costs and~~

~~expenses incurred by title insurance insurers[, agencies, and producers]~~, individual title insurance producers, and agency title insurance producers ~~peculiar to the business of title insurance including:~~

~~(i) the maintenance of title plants; and~~

~~(ii) the searching and examining of public records to determine insurability of title to real redevelopment property.~~

~~(2) (a) Every title insurance insurer[,]~~ or ~~agency[, and] title insurance producer~~, and every individual title insurance producer who is not designated by an agency title insurance producer ~~shall file with the commissioner:~~

~~(i) a schedule of the escrow charges that the title insurance insurer[, agency, or]~~, individual title insurance producer, or agency title insurance producer proposes to use in this state for services performed in connection with the issuance of policies of title insurance; and

~~(ii) any changes to the schedule of the escrow charges described in Subsection (2)(a)(i).~~

~~(b) Except for a schedule filed by a title insurance insurer under this Subsection (2), a schedule filed under this Subsection (2) is subject to review by the Title and Escrow Commission.~~

~~(c) (i) The schedule of escrow charges required to be filed by Subsection (2)(a)(i) takes effect on the day on which the schedule of escrow charges is filed.~~

~~(ii) Any changes to the schedule of the escrow charges required to be filed by Subsection (2)(a)(ii) take effect on the day specified in the change to the schedule of escrow charges except that the effective date may not be less than 30 calendar days after the day on which the change to the schedule of escrow charges is filed.~~

~~(3) A title insurance insurer[, agency, or producer]~~, individual title insurance producer, or agency title insurance producer ~~may not file or use any rate or other charge relating to the business of title insurance, including rates or charges filed for escrow that would cause the title insurance company[, agency, or producer]~~, individual title insurance producer, or agency title insurance producer ~~to:~~

~~(a) operate at less than the cost of doing:~~

~~(i) the insurance business; or~~

~~(ii) the escrow business; or~~

~~(b) fail to adequately underwrite a title insurance policy.~~

(4) (a) All or any of the schedule of rates or schedule of charges, including the schedule of escrow charges, may be changed or amended at any time, subject to the limitations in this Subsection (4).

(b) Each change or amendment shall:

(i) be filed with the commissioner, subject to review by the Title and Escrow Commission; and

(ii) state the effective date of the change or amendment, which may not be less than 30 calendar days after the day on which the change or amendment is filed.

(c) Any change or amendment remains in force for a period of at least 90 calendar days from the change or amendment's effective date.

(5) While the schedule of rates and schedule of charges are effective, a copy of each shall be:

(a) retained in each of the offices of:

(i) the title insurance insurer in this state;

(ii) the title insurance insurer's individual title insurance producers or agency title insurance producers in this state; and

(b) upon request, furnished to the public.

(6) Except in accordance with the schedules of rates and charges filed with the commissioner, a title insurance insurer[, agency, or producer], individual title insurance producer, or agency title insurance producer may not make or impose any premium or other charge:

(a) in connection with the issuance of a policy of title insurance; or

(b) for escrow services performed in connection with the issuance of a policy of title insurance.

Section 12. Section **31A-20-110** is amended to read:

31A-20-110. Underwriting rules for title insurance.

(1) [No] A title insurance policy may not be written until the title insurer or its individual title insurance producer or agency title insurance producer has conducted a reasonable search and examination of the title and has made a determination of insurability of title under sound underwriting principles. Evidence of this search and reasonable determination shall be retained in the files of the title insurer or its individual title insurance

producer or agency title insurance producer for not less than 15 years after the policy has been issued, either in its original form or as recorded by any process which can accurately and reliably reproduce the original. This section does not apply to a company assuming liability through a contract of reinsurance, or to a company acting as coinsurer, if another coinsuring company has complied with this section.

(2) [No] A title insurance policy may not be issued except by a title [insurance company or by a] insurer, an individual title insurance producer who is appointed by an insurer, or agency title insurance producer licensed under Section 31A-23a-105.

(3) This section is enforceable only by the commissioner. It does not create, eliminate, or modify any private cause of action or remedy.

Section 13. Section **31A-22-429** is enacted to read:

31A-22-429. Producer's duties related to replacement of life insurance or annuity.

(1) In connection with or as part of each application for life insurance or annuities, the applicant shall complete and the producer shall submit to the insurer the statements required by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act as to:

(a) whether the applicant has existing policies or contracts; and

(b) whether the proposed life insurance or annuity will replace, discontinue, or change an existing policy or contract.

(2) If an applicant for life insurance or an annuity answers "yes" to the question regarding replacement, discontinuance, or change of an existing policy or contract referred to in Subsection (1), the producer shall present to, and leave with, the applicant, not later than at the time of taking the application, the notice regarding replacements in the form adopted by the commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, or other substantially similar document filed with the commissioner. However, a filing is not required when an amendment to the notice is limited to the omission of a reference not applicable to the product being sold or replaced. With respect to an electronically completed application and notice, the producer is not required to leave a copy of the electronically completed notice with the applicant.

(3) (a) The notice described in Subsection (2) shall:

(i) list each existing policy or contract contemplated to be replaced, properly identified by name of insurer, the insured or annuitant, and policy or contract number if available; and

(ii) include a statement as to whether each policy or contract will be replaced or whether a policy will be used as a source of financing for the new policy or contract.

(b) If a policy or contract number has not been issued by the existing insurer, alternative identification, such as an application or receipt number, shall be listed.

(4) In connection with a replacement transaction the producer shall leave with the applicant by no later than at the time of policy or contract delivery the original or a copy of all printed sales material. With respect to electronically presented sales material, it shall be provided to the policy or contract holder in printed form no later than at the time of policy or contract delivery.

(5) Except as provided in rule made by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, in connection with a replacement transaction, the producer shall submit to the insurer to which an application for a policy or contract is presented:

(a) a copy of each document required by this section;

(b) a statement identifying any preprinted or electronically presented company approved sales materials used; and

(c) copies of any individualized sales materials, including any illustrations related to the specific policy or contract purchased.

Section 14. Section **31A-22-519** is amended to read:

31A-22-519. Death pending conversion.

If a person insured under a group life insurance policy, or the insured dependent of that person, dies during the period of eligibility for conversion under Section 31A-22-517 or 31A-22-518 and before the individual policy becomes effective, the amount of life insurance to which [he] the insured would have been entitled to have issued under the individual policy is payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium has been made.

Section 15. 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 78B-3-403 under which the health care providers agree to supply services, at prices specified in the contracts, to persons insured by an insurer.~~

~~(a) (i) 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.~~

~~(ii) In any dispute involving a provider's claim for reimbursement, the same shall be determined in accordance with applicable law, the provider contract, the subscriber contract, and the insurer's written payment policies in effect at the time services were rendered.~~

~~(iii) If the parties are unable to resolve their dispute, the matter shall be subject to binding arbitration by a jointly selected arbitrator. Each party is to bear its own expense except the cost of the jointly selected arbitrator shall be equally shared. This Subsection (1)(a)(iii) does not apply to the claim of a general acute hospital to the extent it is inconsistent with the hospital's provider agreement.~~

~~(iv) An organization may not penalize a provider solely for pursuing a claims dispute or otherwise demanding payment for a sum believed owing.~~

~~(v) If an insurer permits another entity with which it does not share common ownership or control to use or otherwise lease one or more of the organization's networks of participating providers, the organization shall ensure, at a minimum, that the entity pays participating providers in accordance with the same fee schedule and general payment policies as the organization would for that network.~~

~~(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;~~

~~(iv) other copayments; or~~

~~(v) any other reasonable manner.~~

~~(c) If the insurer is a managed care organization, as defined in Subsection 31A-27a-403(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 earlier of:~~

~~(I) 90 days after 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 Subsection 31A-27a-403(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)](e), 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, Utah Health Code and 58, Occupations and Professions]~~ is subject to the reimbursement requirements in Section 31A-8-501 on or after January 1, 2014~~.~~

~~[(b) (i) Until July 1, 2012, 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.]~~

~~[(ii) Notwithstanding Subsection (2)(b)(i), an insurer may offer a health plan that complies with the provisions of Subsection 31A-22-618.5(3).]~~

~~[(iii) The commissioner may adopt a rule dealing with the determination of what constitutes 75% of the average amount paid by the insurer under Subsection (2)(b)(i) for comparable services of preferred health care providers who are members of the same class of health care providers.]~~

~~[(c)]~~ (b) ~~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]~~

~~(c) An~~ insurer using preferred health care provider contracts may impose a deductible on coverage of health care providers not under contract.

~~[(e)]~~ (d) ~~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)]~~ (e) ~~For purposes of this section, unfair discrimination between classes of health care providers [shall include]~~ includes~~:~~

~~(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]~~ used ~~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 adverse benefit determination 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 adverse benefit determinations 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) 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]~~ Except as provided in Subsection 31A-22-618.5(3)(a), 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 16. Section **31A-22-618.5** is amended to read:~~

~~**31A-22-618.5. Health benefit plan offerings.**~~

~~(1) The purpose of this section is to increase the range of health benefit plans available in the small group, small employer group, large group, and individual insurance markets.~~

~~(2) A health maintenance organization that is subject to Chapter 8, Health Maintenance Organizations and Limited Health Plans:~~

~~(a) shall offer to potential purchasers at least one health benefit plan that is subject to~~

~~the requirements of Chapter 8, Health Maintenance Organizations and Limited Health Plans; and~~

~~(b) may offer to a potential purchaser one or more health benefit plans that:~~

~~(i) are not subject to one or more of the following:~~

~~(A) the limitations on insured indemnity benefits in Subsection 31A-8-105(4);~~

~~(B) the limitation on point of service products in Subsections 31A-8-408(3) through (6);~~

~~(C) except as provided in Subsection (2)(b)(ii), basic health care services as defined in Section 31A-8-101; or~~

~~(D) coverage mandates enacted after January 1, 2009 that are not required by federal law, provided that the insurer offers one plan under Subsection (2)(a) that covers the mandate enacted after January 1, 2009; and~~

~~(ii) when offering a health plan under this section, provide coverage for an emergency medical condition as required by Section 31A-22-627 as follows:~~

~~(A) within the organization's service area, covered services shall include health care services from non-affiliated providers when medically necessary to stabilize an emergency medical condition; and~~

~~(B) outside the organization's service area, covered services shall include medically necessary health care services for the treatment of an emergency medical condition that are immediately required while the enrollee is outside the geographic limits of the organization's service area.~~

~~(3) An insurer that offers a health benefit plan that is not subject to Chapter 8, Health Maintenance Organizations and Limited Health Plans:~~

~~[(a) notwithstanding Subsection 31A-22-617(2), may offer a health benefit plan that groups providers into the following reimbursement levels:]~~

~~[(i) tier one contracted providers;]~~

~~[(ii) tier two contracted providers who the insurer shall reimburse at least 75% of tier one providers; and]~~

~~[(iii) one or more tiers of non-contracted providers;]~~

~~[(b)]~~ (a) ~~notwithstanding Subsection 31A-22-617(9),~~ may offer a health benefit plan ~~that is not subject to Section 31A-22-618;~~

~~[(c) beginning July 1, 2012, may offer health benefit plans that:]~~

~~[(i) are not subject to Subsection 31A-22-617(2); and]~~

~~[(ii) are subject to the reimbursement requirements in Section 31A-8-501;]~~

~~[(d)]~~ (b) ~~when offering a health plan under this Subsection (3), shall provide coverage of emergency care services as required by Section 31A-22-627 [by providing coverage at a reimbursement level of at least 75% of the health benefit plan's highest contracted provider category]; and~~

~~[(e) are]~~ (c) is ~~not subject to coverage mandates enacted after January 1, 2009 that are not required by federal law, provided that an insurer offers one plan that covers a mandate enacted after January 1, 2009.~~

~~(4) Section 31A-8-106 does not prohibit the offer of a health benefit plan under Subsection (2)(b).~~

~~(5) (a) Any difference in price between a health benefit plan offered under Subsections (2)(a) and (b) shall be based on actuarially sound data.~~

~~(b) Any difference in price between a health benefit plan offered under [Subsections]~~ Subsection ~~(3)(a) [and (b)] shall be based on actuarially sound data.~~

~~(6) Nothing in this section limits the number of health benefit plans that an insurer may offer.~~

~~Section 17. Section **31A-22-724** is amended to read:~~

~~**31A-22-724. Offer of alternative coverage -- Utah NetCare Plan.**~~

~~(1) For purposes of this section, "alternative coverage" means:~~

~~(a) a high deductible or low deductible Utah NetCare Plan described in Subsection (2) for a conversion health benefit plan policy offered under Section 31A-22-723; and~~

~~(b) a high deductible and low deductible Utah NetCare Plans described in Subsection (2) as an alternative to COBRA and mini-COBRA health benefit plan coverage offered under Section 31A-22-722.~~

~~(2) A Utah NetCare Plan under this section is subject to Section 31A-2-212 and shall, except when prohibited by federal law, include:~~

~~(a) healthy lifestyle and wellness incentives;~~

~~(b) the benefits described in this Subsection (2) or at least the actuarial equivalent of the benefits described in this Subsection (2);~~

~~(c) a lifetime maximum benefit per person of not less than $1,000,000;~~

~~(d) an annual maximum benefit per person of not less than $250,000;~~

~~(e) the following deductibles:~~

~~(i) for a low deductible plan:~~

~~(A) $2,000 for an individual plan;~~

~~(B) $4,000 for a two party plan; and~~

~~(C) $6,000 for a family plan;~~

~~(ii) for a high deductible plan:~~

~~(A) $4,000 for an individual plan;~~

~~(B) $8,000 for a two party plan; and~~

~~(C) $12,000 for a family plan;~~

~~(f) the following out-of-pocket maximum costs, including deductibles, copayments, and coinsurance:~~

~~(i) for a low deductible plan:~~

~~(A) $5,000 for an individual plan;~~

~~(B) $10,000 for a two party plan; and~~

~~(C) $15,000 for a family plan; and~~

~~(ii) for a high deductible plan:~~

~~(A) $10,000 for an individual plan;~~

~~(B) $20,000 for a two party plan; and~~

~~(C) $30,000 for a family plan;~~

~~(g) the following benefits before applying a deductible requirement and in accordance with Section 223, Internal Revenue Code, and 42 U.S.C. Sec. 300gg-13:~~

~~(i) all well child exams and immunizations up to age five, with no annual maximum;~~

~~(ii) preventive care up to a $500 annual maximum;~~

~~(iii) primary care and specialist and urgent care not covered under Subsection (2)(g)(i) or (ii) up to a $300 annual maximum; and~~

~~(iv) supplemental accident coverage up to a $500 annual maximum;~~

~~(h) the following copayments for each exam:~~

~~(i) $15 for preventive care and well child exams;~~

~~(ii) $25 for primary care; and~~

~~(iii) $50 for urgent care and specialist care;~~

~~(i) a $200 copayment for an emergency room visit after applying the deductible;~~

~~(j) no more than a 30% coinsurance after deductible for covered plan benefits for:~~

~~(i) hospital services;~~

~~(ii) maternity;~~

~~(iii) laboratory work;~~

~~(iv) x-rays;~~

~~(v) radiology;~~

~~(vi) outpatient surgery services;~~

~~(vii) injectable medications not otherwise covered under a pharmacy benefit;~~

~~(viii) durable medical equipment;~~

~~(ix) ambulance services;~~

~~(x) in-patient mental health services; and~~

~~(xi) out-patient mental health services; and~~

~~(k) the following cost-sharing features for a prescription drug:~~

~~(i) up to a $15 copayment for a generic drug; and~~

~~(ii) up to a 50% coinsurance for a name brand drug.~~

~~(3) A Utah NetCare Plan may exclude:~~

~~(a) the benefit mandates described in Subsections 31A-22-618.5(2)(b) and (3)[(b)](a);~~ and

~~(b) unless required by federal law, mandated coverage required by the following sections and related administrative rules:~~

~~(i) Section 31A-22-610.1, Adoption indemnity benefit;~~

~~(ii) Section 31A-22-623, Coverage of inborn metabolic errors;~~

~~(iii) Section 31A-22-624, Primary care physician;~~

~~(iv) Section 31A-22-626, Coverage of diabetes;~~

~~(v) Section 31A-22-628, Standing referral to a specialist; and~~

~~(vi) a mandated coverage enacted after January 1, 2009, that is not required by federal law.~~

~~(4) A Utah NetCare Plan may include a formulary or preferred drug list.~~

~~(5) (a) Except as provided in Subsection (6), a person may elect alternative coverage~~

~~under this section if the person is eligible for:~~

~~(i) continuation of employer group health benefit plan coverage under federal COBRA laws;~~

~~(ii) continuation of employer group health benefit plan coverage under state mini-COBRA under Section 31A-22-722; or~~

~~(iii) a conversion to an individual health benefit plan after the exhaustion of benefits under:~~

~~(A) alternative coverage elected in place of federal COBRA; or~~

~~(B) state mini-COBRA under Section 31A-22-722.~~

~~(b) The right to extend coverage under Subsection (5)(a) applies to spouse or dependent coverages, including a surviving spouse or dependent whose coverage under the policy terminates by reason of the death of the employee or member.~~

~~(6) If a person elects federal COBRA or state mini-COBRA health benefit plan coverage under Section 31A-22-722, the person is not eligible to elect alternative coverage under this section until the person is eligible to convert coverage to an individual policy under Section 31A-22-723 and Subsection (1)(a).~~

~~(7) (a) [(i)] If alternative coverage is selected as an alternative to COBRA or mini-COBRA health benefit plan coverage under Section 31A-22-722[,]:~~

~~(i) Section 31A-22-722 applies to the alternative coverage[.];~~

~~(ii) [If an employee of a small employer selects alternative coverage as an alternative to COBRA or mini-COBRA health benefit plan coverage,] the insurer may not use a risk factor greater than the employer's most current risk factor for purposes of Subsection 31A-22-722(5)[.]; and~~

~~(iii) the insurer shall credit to the alternative coverage the current year's deductible and out of pocket amounts satisfied under the employer's plan.~~

~~(b) If alternative coverage is selected as a conversion policy under Section 31A-22-723[,]:~~

~~(i) Section 31A-22-723 applies[.]; and~~

~~(ii) the insurer shall credit to the alternative coverage the current year's deductible and out of pocket amounts satisfied under the employer's plan.~~

~~(8) The commissioner shall adopt administrative rules in accordance with Title 63G,~~

~~Chapter 3, Utah Administrative Rulemaking Act, to develop a model letter for employers to use to notify an employee of the employee's options for alternative coverage.~~

~~Section 18).~~]

Section 22. Section **31A-23a-102** is amended to read:

31A-23a-102. Definitions.

As used in this chapter:

(1) "Bail bond producer" is as defined in Section 31A-35-102.

[~~(2) "Escrow" means a license subline of authority in conjunction with the title insurance line of authority that allows a person to conduct escrow as defined in Section 31A-1-301.~~]

[~~(3)~~] (2) "Home state" means a 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.

[~~(4)~~] (3) "Insurer" is as defined in Section 31A-1-301, except that the following persons or similar persons are not insurers for purposes of Part 7, Producer Controlled Insurers:

(a) a risk retention group 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) Chapter 15, Part 2, Risk Retention Groups Act;

(b) a residual market pool;

(c) a joint underwriting authority or association; and

(d) a captive insurer.

[~~(5)~~] (4) "License" is defined in Section 31A-1-301.

[~~(6)~~] (5) (a) "Managing general agent" means a person 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) 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:

(A) with or without the authority;

(B) separately or together with an affiliate; and

(C) directly or indirectly; and

(iv) (A) adjusts or pays claims in excess of an amount determined by the commissioner; or

(B) negotiates reinsurance on behalf of the insurer.

(b) Notwithstanding Subsection [~~(6)~~] (5)(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 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 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.

[~~(7)~~] (6) "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 a substantive benefit, term, or condition of the contract if the person engaged in that act:

(a) sells insurance; or

(b) obtains insurance from insurers for purchasers.

[~~(8)~~] (7) "Reinsurance intermediary" means:

(a) a reinsurance intermediary-broker; or

(b) a reinsurance intermediary-manager.

[~~(9)~~] (8) "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.

[~~(10)~~] (9) (a) "Reinsurance intermediary-manager" means a person 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 is known as a reinsurance intermediary-manager, manager, or other similar term.

(b) Notwithstanding Subsection [~~(10)~~] (9)(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 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 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.

[~~(11)~~] (10) "Search" means a license subline of authority in conjunction with the title insurance line of authority that allows a person to issue title insurance commitments or policies on behalf of a title insurer.

[~~(12)~~] (11) "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.

[~~(13)~~] (12) "Solicit" means:

(a) attempting to sell insurance;

(b) asking or urging a person to apply for:

(i) a particular kind of insurance; and

(ii) insurance from a particular insurance company;

(c) advertising insurance, including advertising for the purpose of obtaining leads for the sale of insurance; or

(d) holding oneself out as being in the insurance business.

[~~(14)~~] (13) "Terminate" means:

(a) the cancellation of the relationship between:

(i) an individual licensee or agency licensee and a particular insurer; or

(ii) an individual licensee and a particular agency licensee; or

(b) the termination of:

(i) an individual licensee's or agency licensee's authority to transact insurance on behalf of a particular insurance company; or

(ii) an individual licensee's authority to transact insurance on behalf of a particular agency licensee.

[~~(15)~~] (14) "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 services; and

(b) does not have a search or escrow license as provided in Section 31A-23a-106.

[~~(16)~~] (15) "Uniform application" means the version of the National Association of Insurance Commissioners' uniform application for resident and nonresident producer licensing at the time the application is filed.

[~~(17)~~] (16) "Uniform business entity application" means the version of the National Association of Insurance Commissioners' uniform business entity application for resident and nonresident business entities at the time the application is filed.

Section ~~{19}~~23. Section **31A-23a-105** is amended to read:

31A-23a-105. General requirements for individual and agency license issuance and renewal.

(1) (a) The commissioner shall issue or renew a license to a person described in Subsection (1)(b) to act as:

(i) a producer;

(ii) a surplus lines producer;

(iii) a limited line producer;

(iv) a consultant;

(v) a managing general agent; or

(vi) a reinsurance intermediary.

(b) The commissioner shall issue or renew a license under Subsection (1)(a) to a person who, as to the license type and line of authority classification applied for under Section 31A-23a-106:

(i) satisfies the application requirements under Section 31A-23a-104;

(ii) satisfies the character requirements under Section 31A-23a-107;

(iii) satisfies any applicable continuing education requirements under Section 31A-23a-202;

(iv) satisfies any applicable examination requirements under Section 31A-23a-108;

(v) satisfies any applicable training period requirements under Section 31A-23a-203;

(vi) if an applicant for a resident individual producer license, certifies that, to the extent applicable, the applicant:

(A) is in compliance with Section 31A-23a-203.5; and

(B) will maintain compliance with Section 31A-23a-203.5 during the period for which the license is issued or renewed;

(vii) has not committed an act that is a ground for denial, suspension, or revocation as provided in Section 31A-23a-111;

(viii) if a nonresident:

(A) complies with Section 31A-23a-109; and

(B) holds an active similar license in that person's state of residence;

(ix) if an applicant for [~~a~~] an individual title insurance producer or agency title insurance producer license, satisfies the requirements of Section 31A-23a-204;

(x) if an applicant for a license to act as a life settlement provider or life settlement producer, satisfies the requirements of Section 31A-23a-117; and

(xi) pays the applicable fees under Section 31A-3-103.

(2) (a) This Subsection (2) applies to the following persons:

(i) an applicant for a pending:

(A) individual or agency producer license;

(B) surplus lines producer license;

(C) limited line producer license;

(D) consultant license;

(E) managing general agent license; or

(F) reinsurance intermediary license; or

(ii) a licensed:

(A) individual or agency producer;

(B) surplus lines producer;

(C) limited line producer;

(D) consultant;

(E) managing general agent; or

(F) reinsurance intermediary.

(b) A person described in Subsection (2)(a) shall report to the commissioner:

(i) an administrative action taken against the person, including a denial of a new or renewal license application:

(A) in another jurisdiction; or

(B) by another regulatory agency in this state; and

(ii) a 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 an individual or agency license; and

(B) for an action or prosecution that occurs on or after the day on which the person files the application:

(I) for an administrative action, within 30 days of the final disposition of the administrative action; or

(II) for a criminal prosecution, within 30 days of the initial appearance before a court; 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 require a person applying for a license or for consent to

engage in the business of insurance to submit to a criminal background check as a condition of receiving a license or consent.

(b) A person, if required to submit to a criminal background check under Subsection (3)(a), shall:

(i) submit a fingerprint card in a form acceptable to the department; and

(ii) consent to a fingerprint background check by:

(A) the Utah Bureau of Criminal Identification; and

(B) the Federal Bureau of Investigation.

(c) For a person who submits a fingerprint card and consents to a fingerprint background check under Subsection (3)(b), the department may request:

(i) criminal background information maintained pursuant to Title 53, Chapter 10, Part 2, Bureau of Criminal Identification, from the Bureau of Criminal Identification; and

(ii) complete Federal Bureau of Investigation criminal background checks through the national criminal history system.

(d) Information obtained by the department from the review of criminal history records received under this Subsection (3) shall be used by the department for the purposes of:

(i) determining if a person satisfies the character requirements under Section 31A-23a-107 for issuance or renewal of a license;

(ii) determining if a person has failed to maintain the character requirements under Section 31A-23a-107; and

(iii) preventing a person who violates the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033, from engaging in the business of insurance in the state.

(e) 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)(c)(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)(c)(ii); and

(iii) charge the person applying for a license or for consent to engage in the business of insurance a fee equal to the aggregate of Subsections (3)(e)(i) and (ii).

(4) To become a resident licensee in accordance with Section 31A-23a-104 and this section, a person licensed as one of the following in another state who moves to this state shall apply within 90 days of establishing legal residence in this state:

(a) insurance producer;

(b) surplus lines producer;

(c) limited line producer;

(d) consultant;

(e) managing general agent; or

(f) reinsurance intermediary.

(5) (a) The commissioner may deny a license application for a license listed in Subsection (5)(b) if the person applying for the license, as to the license type and line of authority classification applied for under Section 31A-23a-106:

(i) fails to satisfy the requirements as set forth in this section; or

(ii) commits an act that is grounds for denial, suspension, or revocation as set forth in Section 31A-23a-111.

(b) This Subsection (5) applies to the following licenses:

(i) producer;

(ii) surplus lines producer;

(iii) limited line producer;

(iv) consultant;

(v) managing general agent; or

(vi) reinsurance intermediary.

(6) Notwithstanding the other provisions of this section, the commissioner may:

(a) issue a license to an applicant for a license for a title insurance line of authority only with the concurrence of the Title and Escrow Commission; and

(b) renew a license for a title insurance line of authority only with the concurrence of the Title and Escrow Commission.

Section ~~{20}~~24. Section **31A-23a-106** is amended to read:

31A-23a-106. License types.

(1) (a) A resident or nonresident license issued under this chapter shall be issued under the license types described under Subsection (2).

(b) A license type and a line of authority pertaining to a license type describe the type of licensee and the lines of business that a licensee may sell, solicit, or negotiate. A license type is intended to describe the matters to be considered under any education, examination, and training required of a license applicant under Sections 31A-23a-108, 31A-23a-202, and 31A-23a-203.

(2) (a) A producer license type includes the following lines of authority:

(i) life insurance, including a nonvariable contract;

(ii) variable contracts, including variable life and annuity, if the producer has the life insurance line of authority;

(iii) accident and health insurance, including a contract issued to a policyholder under Chapter 7, Nonprofit Health Service Insurance Corporations, or Chapter 8, Health Maintenance Organizations and Limited Health Plans;

(iv) property insurance;

(v) casualty insurance, including a surety or other bond;

(vi) title insurance under one or more of the following categories:

(A) search, including authority to act as a title marketing representative;

(B) escrow, including authority to act as a title marketing representative; and

(C) title marketing representative only; and

(vii) personal lines insurance.

(b) A surplus lines producer license type includes the following lines of authority:

(i) property insurance, if the person holds an underlying producer license with the property line of insurance; and

(ii) casualty insurance, if the person holds an underlying producer license with the casualty line of authority.

(c) A limited line producer license type includes the following limited lines of authority:

(i) limited line credit insurance;

(ii) travel insurance;

(iii) motor club insurance;

(iv) car rental related insurance;

(v) legal expense insurance;

(vi) crop insurance;

(vii) self-service storage insurance;

(viii) bail bond producer;

(ix) guaranteed asset protection waiver; and

(x) portable electronics insurance.

(d) A consultant license type includes the following lines of authority:

(i) life insurance, including a nonvariable contract;

(ii) variable contracts, including variable life and annuity, if the consultant has the life insurance line of authority;

(iii) accident and health insurance, including a contract issued to a policyholder under Chapter 7, Nonprofit Health Service Insurance Corporations, or Chapter 8, Health Maintenance Organizations and Limited Health Plans;

(iv) property insurance;

(v) casualty insurance, including a surety or other bond; and

(vi) personal lines insurance.

(e) A managing general agent license type includes the following lines of authority:

(i) life insurance, including a nonvariable contract;

(ii) variable contracts, including variable life and annuity, if the managing general agent has the life insurance line of authority;

(iii) accident and health insurance, including a contract issued to a policyholder under Chapter 7, Nonprofit Health Service Insurance Corporations, or Chapter 8, Health Maintenance Organizations and Limited Health Plans;

(iv) property insurance;

(v) casualty insurance, including a surety or other bond; and

(vi) personal lines insurance.

(f) A reinsurance intermediary license type includes the following lines of authority:

(i) life insurance, including a nonvariable contract;

(ii) variable contracts, including variable life and annuity, if the reinsurance intermediary has the life insurance line of authority;

(iii) accident and health insurance, including a contract issued to a policyholder under Chapter 7, Nonprofit Health Service Insurance Corporations, or Chapter 8, Health Maintenance Organizations and Limited Health Plans;

(iv) property insurance;

(v) casualty insurance, including a surety or other bond; and

(vi) personal lines insurance.

(g) A person who holds a license under Subsection (2)(a) has the qualifications necessary to act as a holder of a license under Subsection (2)(c), except that the person may not act under Subsection (2)(c)(viii) or (ix).

(3) (a) The commissioner may by rule recognize other producer, surplus lines producer, limited line producer, consultant, managing general agent, or reinsurance intermediary lines of authority as to kinds of insurance not listed under Subsections (2)(a) through (f).

(b) Notwithstanding Subsection (3)(a), for purposes of title insurance the Title and Escrow Commission may by rule, with the concurrence of the commissioner and subject to Section 31A-2-404, recognize other categories for [~~a~~] an individual title insurance producer or agency title insurance producer line of authority not listed under Subsection (2)(a)(vi).

(4) The variable contracts line of authority requires:

(a) for a producer, licensure by the Financial Industry Regulatory Authority as a:

(i) registered broker-dealer; or

(ii) broker-dealer agent, with a current registration with a broker-dealer; and

(b) for a consultant, registration with the Securities and Exchange Commission or licensure by the Utah Division of Securities as an:

(i) investment adviser; or

(ii) investment adviser representative, with a current association with an investment adviser.

(5) A surplus lines producer is a producer who has a surplus lines license.

Section ~~{21}~~25. Section ~~{**31A-23a-202**}~~**31A-23a-118** is ~~{amended}~~enacted to read:

31A-23a-118. Car rental related licensing requirements.

(1) Subject to Section 31A-23a-103, a person is required to hold a limited line producer license with a car rental related insurance limited line of authority to sell or offer car rental related insurance coverage under a car rental related insurance policy.

(2) A car rental related insurance limited line license issued pursuant to 31A-23a-103 and 31A-23a-106 authorizes an employee or authorized representative of the licensee to sell or offer coverage under a car rental related insurance policy to a customer at each location at which the licensee engages in car rental related insurance transactions.

(3) An agency holding a car rental related insurance limited line license shall:

(a) be appointed by an insurer underwriting a car rental related insurance policy that the agency sells or offers; and

(b) have a designated responsible licensed individual at each location at which the agency is soliciting, selling, or offering car rental related insurance.

(4) An agency holding a car rental related insurance limited line license may employ a nonlicensed individual employed as a counter sales representative in soliciting, selling, or offering car rental related insurance. The nonlicensed individual shall be:

(a) trained and supervised in the sale of car rental related insurance products; and

(b) responsible to a licensed individual designated by the agency at each location where a car rental related insurance product is sold.

Section 26. Section **31A-23a-202** is amended to read:

31A-23a-202. Continuing education requirements.

(1) Pursuant to this section, the commissioner shall by rule prescribe the continuing education requirements for a producer and a consultant.

(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 hours of insurance-related instruction received.

(c) Insurance-related formal education may be a substitute, in whole or in part, for the hours 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) (i) Except as provided in this section, the continuing education requirements shall require:

(A) that a licensee complete 24 credit hours of continuing education for every two-year

licensing period;

(B) that 3 of the 24 credit hours described in Subsection (3)(b)(i)(A) be ethics courses; and

(C) that the licensee complete at least half of the required hours through classroom hours of insurance-related instruction.

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

(A) classroom attendance;

(B) home study;

(C) watching a video recording;

(D) experience credit; or

(E) another method provided by rule.

(iii) (A) Notwithstanding Subsections (3)(b)(i)(A) and (B), [~~a~~] an individual title insurance producer is required to complete 12 credit hours of continuing education for every two-year licensing period, with 3 of the credit hours being ethics courses unless the individual title insurance producer is licensed in this state as [~~a~~] an individual title insurance producer for 20 or more consecutive years.

(B) If [~~a~~] an individual title insurance producer is licensed in this state as [~~a~~] an individual title insurance producer for 20 or more consecutive years, the individual title insurance producer is required to complete 6 credit hours of continuing education for every two-year licensing period, with 3 of the credit hours being ethics courses.

(C) Notwithstanding Subsection (3)(b)(iii)(A) or (B), [~~a~~] an individual title insurance producer is considered to have met the continuing education requirements imposed under Subsection (3)(b)(iii)(A) or (B) if the individual title insurance producer:

(I) is an active member in good standing with the Utah State Bar;

(II) is in compliance with the continuing education requirements of the Utah State Bar; and

(III) if requested by the department, provides the department evidence that the individual title insurance producer complied with the continuing education requirements of the Utah State Bar.

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

licensing period.

(d) (i) A licensee is exempt from continuing education requirements under this section if:

(A) the licensee was first licensed before April 1, 1978;

(B) the license does not have a continuous lapse for a period of more than one year, except for a license for which the licensee has had an exemption approved before May 11, 2011;

(C) the licensee requests an exemption from the department; and

(D) the department approves the exemption.

(ii) If the department approves the exemption under Subsection (3)(d)(i), the licensee is not required to apply again for the exemption.

(e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, 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)(b);

(ii) authorize a continuing education provider or a state or national professional producer or consultant association to:

(A) offer a qualified program for a license type or line of authority on a geographically accessible basis; and

(B) collect a reasonable fee for funding and administration of a continuing education program, subject to the review and approval of the commissioner; and

(iii) provide that membership by a producer or consultant in a state or national professional producer or consultant association is considered a substitute for the equivalent of two hours for each year during which the producer or consultant is a member of the professional association, except that the commissioner may not give more than two hours of continuing education credit in a year regardless of the number of professional associations of which the producer or consultant is a member.

(f) A fee permitted under Subsection (3)(e)(ii)(B) that is charged for attendance at a professional producer or consultant association program may be less for an association member, on the basis of the member's affiliation expense, but shall preserve the right of a

nonmember to attend without affiliation.

(4) The commissioner shall approve a continuing education provider or continuing education course that satisfies the requirements of this section.

(5) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner shall by rule set the processes and procedures for continuing education provider registration and course approval.

(6) The requirements of this section apply only to a producer or consultant who is an individual.

(7) A nonresident producer or consultant is considered to have satisfied this state's continuing education requirements if the nonresident producer or consultant satisfies the nonresident producer's or consultant's home state's continuing education requirements for a licensed insurance producer or consultant.

(8) A producer or consultant subject to this section shall keep documentation of completing the continuing education requirements of this section for two years after the end of the two-year licensing period to which the continuing education applies.

Section ~~{22}~~27. Section **31A-23a-203.5** is amended to read:

31A-23a-203.5. Errors and omissions coverage requirements.

(1) In accordance with this section, a resident individual producer shall ensure that the resident individual producer is covered:

(a) for the legal liability of the resident individual producer as the result of an erroneous act or failure to act in the resident individual producer's capacity as a producer; and

(b) at all times during the term of the resident individual producer's license.

(2) The coverage required by Subsection (1) shall consist of:

(a) a policy naming the resident individual producer;

(b) a policy naming the agency that designates the resident individual producer in accordance with this chapter; or

(c) a written agreement by an insurer or group of affiliated insurers, on behalf of a resident individual producer who is or will become an exclusive agent of the insurer or group of affiliated insurers, under which the insurer or group of affiliated insurers agrees to assume responsibility, to the benefit of an aggrieved person, for legal liability of the resident individual producer as the result of an erroneous act or failure to act in the resident individual producer's

capacity as a producer for the insurer or group of affiliated insurers.

(3) The commissioner may, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, provide for:

(a) the terms and conditions of the coverage required under Subsection (1); and

(b) if the coverage required by Subsection (1) is terminated during a resident individual producer's license term, requirements to:

(i) provide notice; and

(ii) replace the coverage.

(4) [~~A~~] An individual title insurance producer is considered to be in compliance with this section [~~if the~~] when:

(a) the individual title insurance producer is not designated by an agency title producer and maintains [~~a~~] the individual title insurance producer's own bond, policy, or other financial protection in accordance with Subsection 31A-23a-204(2)[~~.~~]; or

(b) the individual title insurance producer is designated by an agency title insurance producer that maintains a bond, policy, or other financial protection in accordance with Subsection 31A-23a-204(2).

(5) Notwithstanding the other provisions of this section, a resident individual producer is exempt from the requirement to maintain coverage as provided in this section during a period in which the resident individual producer is not either:

(a) appointed by an insurer under this title; or

(b) designated by an agency under this title.

(6) A limited lines producer is exempt from this section.

Section ~~{23}~~28. Section **31A-23a-204** is amended to read:

31A-23a-204. Special requirements for title insurance producers and agencies.

[~~A~~] An individual title insurance producer or agency title insurance producer[~~, including an agency,~~] shall be licensed in accordance with this chapter, with the additional requirements listed in this section.

(1) (a) A person that receives a new license under this title as [~~a~~] an agency title insurance [~~agency.~~] producer~~(,)~~ shall at the time of licensure be owned or managed by at least one individual who is licensed for at least three of the five years immediately preceding the date on which the agency title insurance [~~agency~~] producer applies for a license with both:

(i) a search line of authority; and

(ii) an escrow line of authority.

(b) [~~A~~] An agency title insurance [~~agency~~] producer subject to Subsection (1)(a) may comply with Subsection (1)(a) by having the agency title insurance [~~agency~~] producer owned or managed by:

(i) one or more individuals who are licensed with the search line of authority for the time period provided in Subsection (1)(a); and

(ii) one or more individuals who are licensed with the escrow line of authority for the time period provided in Subsection (1)(a).

(c) A person licensed as [~~a~~] an agency title insurance [~~agency~~] producer shall at all times during the term of licensure be owned or managed by at least one individual who is licensed for at least three years within the preceding five-year period with both:

(i) a search line of authority; and

(ii) an escrow line of authority.

(d) The Title and Escrow Commission may by rule, subject to Section 31A-2-404, exempt an attorney with real estate experience from the experience requirements in Subsection (1)(a).

(e) An individual ~~{that}~~who satisfies the requirements of this Subsection (1) is known as a "qualifying licensee." At any given time, an individual may be a qualifying licensee for not more than two agency title insurance producers.

(2) (a) [~~A~~] An individual title insurance producer or agency title insurance [~~agency or~~] producer appointed by an insurer shall maintain:

(i) a fidelity bond;

(ii) a professional liability insurance policy; or

(iii) a financial protection:

(A) equivalent to that described in Subsection (2)(a)(i) or (ii); and

(B) that the commissioner considers adequate.

(b) The bond, insurance, or financial protection required by this Subsection (2):

(i) shall be supplied under a contract approved by the commissioner to provide protection against the improper performance of any service in conjunction with the issuance of a contract or policy of title insurance; and

(ii) be in a face amount no less than $50,000.

(c) The Title and Escrow Commission may by rule, subject to Section 31A-2-404, exempt individual title insurance producer or agency title insurance producers from the requirements of this Subsection (2) upon a finding that, and only so long as, the required policy or bond is generally unavailable at reasonable rates.

(3) [~~A~~] An individual title insurance producer or agency title insurance [~~agency or~~] producer appointed by an insurer may maintain a reserve fund to the extent money was deposited before July 1, 2008, and not withdrawn to the income of the individual title insurance producer or agency title insurance producer.

(4) An examination for licensure shall include questions regarding the search and examination of title to real property.

(5) [~~A~~] An individual title insurance producer may not perform the functions of escrow unless the individual title insurance producer has been examined on the fiduciary duties and procedures involved in those functions.

(6) The Title and Escrow Commission [~~shall~~] may adopt rules, subject to Section 31A-2-404, after consulting with the [~~department~~] commissioner and the [~~department's~~] commissioner's test administrator, establishing an examination for a license that will satisfy this section.

(7) A license may be issued to [~~a~~] an individual title insurance producer or agency title insurance producer who has qualified:

(a) to perform only searches and examinations of title as specified in Subsection (4);

(b) to handle only escrow arrangements as specified in Subsection (5); or

(c) to act as a title marketing representative.

(8) (a) A person licensed to practice law in Utah is exempt from the requirements of Subsections (2) and (3) if that person issues 12 or less policies in any 12-month period.

(b) In determining the number of policies issued by a person licensed to practice law in Utah for purposes of Subsection (8)(a), if the person licensed to practice law in Utah issues a policy to more than one party to the same closing, the person is considered to have issued only one policy.

(9) A person licensed to practice law in Utah, whether exempt under Subsection (8) or not, shall maintain a trust account separate from a law firm trust account for all title and real

estate escrow transactions.

Section ~~{24}~~29. Section **31A-23a-402** is amended to read:

31A-23a-402. Unfair marketing practices -- Communication -- Unfair discrimination -- Coercion or intimidation -- Restriction on choice.

(1) (a) (i) Any of the following may not make or cause to be made any communication that contains false or misleading information, relating to an insurance product or contract, any insurer, or any 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 producer 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:

(I) filing a report;

(II) making a false entry in a record; or

(III) wilfully refraining from making a proper entry in a record.

(iii) A 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, including the Health Insurance Exchange, also called the "Utah Health Exchange," created in Section 63M-1-2504, the Comprehensive Health Insurance Pool created in Chapter 29, Comprehensive Health Insurance Pool Act, and the Children's Health Insurance Program created in Title 26, Chapter 40, Utah Children's Health Insurance Act:

(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 person 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) A licensee's violation creates a rebuttable presumption that the violation was also committed by the insurer if:

(i) the licensee under this title distributes cards or documents, exhibits a sign, or publishes an advertisement that violates Subsection (1)(a), with reference to a particular insurer:

(A) that the licensee represents; or

(B) for whom the licensee processes claims; and

(ii) the cards, documents, signs, or advertisements are supplied or approved by that insurer.

(2) (a) A title insurer [~~or~~], individual title insurance producer, or agency title insurance producer or any officer or employee of [~~either~~] the title insurer, individual title insurance producer, or agency title insurance producer may not pay, allow, give, or offer to pay, allow, or give, directly or indirectly, as an inducement to obtaining any title insurance business:

(i) any rebate, reduction, or abatement of any rate or charge made incident to the issuance of the title insurance;

(ii) any special favor or advantage not generally available to others; [~~or~~]

(iii) any money or other consideration, except if approved under Section 31A-2-405; or

(iv) material inducement.

(b) "Charge made incident to the issuance of the title insurance" includes escrow charges, and any other services that are prescribed in rule by the Title and Escrow Commission after consultation with the commissioner and subject to Section 31A-2-404.

(c) An insured or any other person connected, directly or indirectly, with the

transaction may not knowingly receive or accept, directly or indirectly, any benefit referred to in Subsection (2)(a), including:

(i) a person licensed under Title 61, Chapter 2c, Utah Residential Mortgage Practices and Licensing Act;

(ii) a person licensed under Title 61, Chapter 2f, Real Estate Licensing and Practices Act;

(iii) a builder;

(iv) an attorney; or

(v) an officer, employee, or agent of a person listed in this Subsection (2)(c)(iii).

(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) This Subsection (4) applies to:

(i) a person who is or should be licensed under this title;

(ii) an employee of that licensee or person who should be licensed;

(iii) a person whose primary interest is as a competitor of a person licensed under this title; and

(iv) one acting on behalf of any person described in Subsections (4)(a)(i) through (iii).

(b) A person described in Subsection (4)(a) may not commit or enter into any agreement to participate in any act of boycott, coercion, or intimidation that:

(i) tends to produce:

(A) an unreasonable restraint of the business of insurance; or

(B) a monopoly in that business; or

(ii) results in an applicant purchasing or replacing an insurance contract.

(5) (a) (i) Subject to Subsection (5)(a)(ii), a person may not restrict in the choice of an insurer or licensee under this chapter, 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.

(ii) A person requiring coverage may 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) A licensee under this title 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-23a-111, or 31A-23a-112 may not refuse or fail to return the license to the commissioner on demand.

(8) (a) A person may not engage in an 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 the method of competition, the act, or the practice:

(i) is misleading;

(ii) is deceptive;

(iii) is unfairly discriminatory;

(iv) provides an unfair inducement; or

(v) unreasonably restrains competition.

(b) Notwithstanding Subsection (8)(a), for purpose of the title insurance industry, the Title and Escrow Commission shall make rules, subject to Section 31A-2-404, that define an unfair method of competition or unfair or deceptive act or practice after a finding that the method of competition, the act, or the practice:

(i) is misleading;

(ii) is deceptive;

(iii) is unfairly discriminatory;

(iv) provides an unfair inducement; or

(v) unreasonably restrains competition.

Section ~~{25}~~30. Section **31A-23a-402.5** is amended to read:

31A-23a-402.5. Inducements.

(1) (a) Except as provided in Subsection (2), a producer, consultant, or other licensee under this title, or an officer or employee of a licensee, may not induce a person to enter into, continue, or terminate an insurance contract by offering a benefit that is not:

(i) specified in the insurance contract; or

(ii) directly related to the insurance contract.

(b) An insurer may not make or knowingly allow an agreement of insurance that is not clearly expressed in the insurance contract to be issued or renewed.

(c) A licensee under this title may not absorb the tax under Section 31A-3-301.

(2) This section does not apply to a title insurer, [~~a title~~] an individual title insurance producer, or agency title insurance producer, or an officer or employee of a title insurer [~~or title~~], an individual title insurance producer, or an agency title insurance producer.

(3) Items not prohibited by Subsection (1) include an insurer:

(a) reducing premiums because of expense savings;

(b) providing to a policyholder or insured one or more incentives, as defined by the commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to participate in a program or activity designed to reduce claims or claim expenses, including:

(i) a premium discount offered to a small or large employer group based on a wellness program if:

(A) the premium discount for the employer group does not exceed 20% of the group premium; and

(B) the premium discount based on the wellness program is offered uniformly by the insurer to all employer groups in the large or small group market;

(ii) a premium discount offered to employees of a small or large employer group in an amount that does not exceed federal limits on wellness program incentives; or

(iii) a combination of premium discounts offered to the employer group and the employees of an employer group, based on a wellness program, if:

(A) the premium discounts for the employer group comply with Subsection (3)(b)(i); and

(B) the premium discounts for the employees of an employer group comply with Subsection (3)(b)(ii); or

(c) receiving premiums under an installment payment plan.

(4) Items not prohibited by Subsection (1) include a producer, consultant, or other licensee, or an officer or employee of a licensee, either directly or through a third party:

(a) engaging in a usual kind of social courtesy if receipt of the social courtesy is not conditioned on a quote or the purchase of a particular insurance product;

(b) extending credit on a premium to the insured:

(i) without interest, for no more than 90 days from the effective date of the insurance contract;

(ii) for interest that is not less than the legal rate under Section 15-1-1, on the unpaid balance after the time period described in Subsection (4)(b)(i); and

(iii) except that an installment or payroll deduction payment of premiums on an insurance contract issued under an insurer's mass marketing program is not considered an extension of credit for purposes of this Subsection (4)(b);

(c) preparing or conducting a survey that:

(i) is directly related to an accident and health insurance policy purchased from the licensee; or

(ii) is used by the licensee to assess the benefit needs and preferences of insureds, employers, or employees directly related to an insurance product sold by the licensee;

(d) providing limited human resource services that are directly related to an insurance product sold by the licensee, including:

(i) answering questions directly related to:

(A) an employee benefit offering or administration, if the insurance product purchased from the licensee is accident and health insurance or health insurance; and

(B) employment practices liability, if the insurance product offered by or purchased from the licensee is property or casualty insurance; and

(ii) providing limited human resource compliance training and education directly pertaining to an insurance product purchased from the licensee;

(e) providing the following types of information or guidance:

(i) providing guidance directly related to compliance with federal and state laws for an insurance product purchased from the licensee;

(ii) providing a workshop or seminar addressing an insurance issue that is directly related to an insurance product purchased from the licensee; or

(iii) providing information regarding:

(A) employee benefit issues;

(B) directly related insurance regulatory and legislative updates; or

(C) similar education about an insurance product sold by the licensee and how the insurance product interacts with tax law;

(f) preparing or providing a form that is directly related to an insurance product purchased from, or offered by, the licensee;

(g) preparing or providing documents directly related to a premium only cafeteria plan within the meaning of Section 125, Internal Revenue Code, or a flexible spending account, but not providing ongoing administration of a flexible spending account;

(h) providing enrollment and billing assistance, including:

(i) providing benefit statements or new hire insurance benefits packages; and

(ii) providing technology services such as an electronic enrollment platform or application system;

(i) communicating coverages in writing and in consultation with the insured and employees;

(j) providing employee communication materials and notifications directly related to an insurance product purchased from a licensee;

(k) providing claims management and resolution to the extent permitted under the licensee's license;

(l) providing underwriting or actuarial analysis or services;

(m) negotiating with an insurer regarding the placement and pricing of an insurance product;

(n) recommending placement and coverage options;

(o) providing a health fair or providing assistance or advice on establishing or operating a wellness program, but not providing any payment for or direct operation of the

wellness program;

(p) providing COBRA and Utah mini-COBRA administration, consultations, and other services directly related to an insurance product purchased from the licensee;

(q) assisting with a summary plan description;

(r) providing information necessary for the preparation of documents directly related to the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001, et seq., as amended;

(s) providing information or services directly related to the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936, as amended, such as services directly related to health care access, portability, and renewability when offered in connection with accident and health insurance sold by a licensee;

(t) sending proof of coverage to a third party with a legitimate interest in coverage;

(u) providing information in a form approved by the commissioner and directly related to determining whether an insurance product sold by the licensee meets the requirements of a third party contract that requires or references insurance coverage;

(v) facilitating risk management services directly related to [~~the~~] property and casualty insurance [~~product~~] products sold or offered for sale by the licensee, including:

(i) risk management;

(ii) claims and loss control services; [~~and~~]

(iii) risk assessment consulting[~~:~~], including analysis of:

(A) employer's job descriptions; or

(B) employer's safety procedures or manuals; and

(iv) providing information and training on best practices;

(w) otherwise providing services that are legitimately part of servicing an insurance product purchased from a licensee; and

(x) providing other directly related services approved by the department.

(5) An inducement prohibited under Subsection (1) includes a producer, consultant, or other licensee, or an officer or employee of a licensee:

(a) (i) providing a premium or commission rebate;

(ii) paying the salary of an employee of a person who purchases an insurance product from the licensee; or

(iii) if the licensee is an insurer, or a third party administrator who contracts with an insurer, paying the salary for an onsite staff member to perform an act prohibited under Subsection (5)(b)(xii); or

(b) engaging in one or more of the following unless a fee is paid in accordance with Subsection [~~(7)~~] (8):

(i) performing background checks of prospective employees;

(ii) providing legal services by a person licensed to practice law;

(iii) performing drug testing that is directly related to an insurance product purchased from the licensee;

(iv) preparing employer or employee handbooks, except that a licensee may:

(A) provide information for a medical benefit section of an employee handbook;

(B) provide information for the section of an employee handbook directly related to an employment practices liability insurance product purchased from the licensee; or

(C) prepare or print an employee benefit enrollment guide;

(v) providing job descriptions, postings, and applications for a person [~~that purchases an employment practices liability insurance product from the licensee~~];

(vi) providing payroll services;

(vii) providing performance reviews or performance review training;

(viii) providing union advice;

(ix) providing accounting services;

(x) providing data analysis information technology programs, except as provided in Subsection (4)(h)(ii);

(xi) providing administration of health reimbursement accounts or health savings accounts; or

(xii) if the licensee is an insurer, or a third party administrator who contracts with an insurer, the insurer issuing an insurance policy that lists in the insurance policy one or more of the following prohibited benefits:

(A) performing background checks of prospective employees;

(B) providing legal services by a person licensed to practice law;

(C) performing drug testing that is directly related to an insurance product purchased from the insurer;

(D) preparing employer or employee handbooks;

(E) providing job descriptions postings, and applications;

(F) providing payroll services;

(G) providing performance reviews or performance review training;

(H) providing union advice;

(I) providing accounting services;

(J) providing discrimination testing; or

(K) providing data analysis information technology programs.

(6) A producer, consultant, or other licensee or an officer or employee of a licensee shall itemize and bill separately from any other insurance product or service offered or provided under Subsection (5)(b).

[~~(6)~~] (7) (a) A de minimis gift or meal not to exceed $25 for each individual receiving the gift or meal is ~~{[}~~presumed to be a social courtesy not~~{]} allowed, whether or not it is}~~ conditioned on [~~the~~] a quote or purchase of a particular insurance product for purposes of Subsection (4)(a).

(b) Notwithstanding Subsection (4)(a), a de minimis gift or meal not to exceed $10 may be conditioned on receipt of a quote of a particular insurance product if the de minimis gift or meal is provided by the insurer and not by a producer or consultant.

[~~(7)~~] (8) If as provided under Subsection (5)(b) a producer, consultant, or other licensee is paid a fee to provide an item listed in Subsection (5)(b), the licensee shall comply with Subsection 31A-23a-501(2) in charging the fee, except that the fee paid for the item shall equal or exceed the fair market value of the item.

Section ~~{26}~~31. Section **31A-23a-406** is amended to read:

31A-23a-406. Title insurance producer's business.

(1) [~~A~~] An individual title insurance producer or agency title insurance producer may do escrow involving real property transactions if all of the following exist:

(a) the individual title insurance producer or agency title insurance producer is licensed with:

(i) the title line of authority; and

(ii) the escrow subline of authority;

(b) the individual title insurance producer or agency title insurance producer is

appointed by a title insurer authorized to do business in the state;

(c) the individual title insurance producer or agency title insurance producer issues one or more of the following as part of the transaction:

(i) an owner's policy of title insurance; or

(ii) a lender's policy of title insurance;

(d) money deposited with the individual title insurance producer or agency title insurance producer in connection with any escrow:

(i) is deposited:

(A) in a federally insured financial institution; and

(B) in a trust account that is separate from all other trust account money that is not related to real estate transactions;

(ii) is the property of the one or more persons entitled to the money under the provisions of the escrow; and

(iii) is segregated escrow by escrow in the records of the individual title insurance producer or agency title insurance producer;

(e) earnings on money held in escrow may be paid out of the escrow account to any person in accordance with the conditions of the escrow;

(f) the escrow does not require the individual title insurance producer or agency title insurance producer to hold:

(i) construction money; or

(ii) money held for exchange under Section 1031, Internal Revenue Code; and

(g) the individual title insurance producer or agency title insurance producer shall maintain a physical office in Utah staffed by a person with an escrow subline of authority who processes the escrow.

(2) Notwithstanding Subsection (1), [~~a~~] an individual title insurance producer or agency title insurance producer may engage in the escrow business if:

(a) the escrow involves:

(i) a mobile home;

(ii) a grazing right;

(iii) a water right; or

(iv) other personal property authorized by the commissioner; and

(b) the individual title insurance producer or agency title insurance producer complies with this section except for Subsection (1)(c).

(3) Money held in escrow:

(a) is not subject to any debts of the individual title insurance producer or agency title insurance producer;

(b) may only be used to fulfill the terms of the individual escrow under which the money is accepted; and

(c) may not be used until the conditions of the escrow are met.

(4) Assets or property other than escrow money received by [~~a~~] an individual title insurance producer or agency title insurance producer in accordance with an escrow shall be maintained in a manner that will:

(a) reasonably preserve and protect the asset or property from loss, theft, or damages; and

(b) otherwise comply with the general duties and responsibilities of a fiduciary or bailee.

(5) (a) A check from the trust account described in Subsection (1)(d) may not be drawn, executed, or dated, or money otherwise disbursed unless the segregated escrow account from which money is to be disbursed contains a sufficient credit balance consisting of collected and cleared money at the time the check is drawn, executed, or dated, or money is otherwise disbursed.

(b) As used in this Subsection (5), money is considered to be "collected and cleared," and may be disbursed as follows:

(i) cash may be disbursed on the same day the cash is deposited;

(ii) a wire transfer may be disbursed on the same day the wire transfer is deposited; and

(iii) the proceeds of one or more of the following financial instruments may be disbursed on the same day the financial instruments are deposited if received from a single party to the real estate transaction and if the aggregate of the financial instruments for the real estate transaction is less than $10,000:

(A) a cashier's check, certified check, or official check that is drawn on an existing account at a federally insured financial institution;

(B) a check drawn on the trust account of a principal broker or associate broker

licensed under Title 61, Chapter 2f, Real Estate Licensing and Practices Act, if the individual title insurance producer or agency title insurance producer has reasonable and prudent grounds to believe sufficient money will be available from the trust account on which the check is drawn at the time of disbursement of proceeds from the individual title insurance producer or agency title insurance producer's escrow account;

(C) a personal check not to exceed $500 per closing; or

(D) a check drawn on the escrow account of another individual title insurance producer or agency title insurance producer, if the individual title insurance producer or agency title insurance producer in the escrow transaction has reasonable and prudent grounds to believe that sufficient money will be available for withdrawal from the account upon which the check is drawn at the time of disbursement of money from the escrow account of the individual title insurance producer or agency title insurance producer in the escrow transaction.

(c) A check or deposit not described in Subsection (5)(b) may be disbursed:

(i) within the time limits provided under the Expedited Funds Availability Act, 12 U.S.C. Sec. 4001 et seq., as amended, and related regulations of the Federal Reserve System; or

(ii) upon notification from the financial institution to which the money has been deposited that final settlement has occurred on the deposited financial instrument.

(6) [~~A~~] An individual title insurance producer or agency title insurance producer shall maintain a record of a receipt or disbursement of escrow money.

(7) [~~A~~] An individual title insurance producer or agency title insurance producer shall comply with:

(a) Section 31A-23a-409;

(b) Title 46, Chapter 1, Notaries Public Reform Act; and

(c) any rules adopted by the Title and Escrow Commission, subject to Section 31A-2-404, that govern escrows.

(8) If [~~a~~] an individual title insurance producer or agency title insurance producer conducts a search for real estate located in the state, the individual title insurance producer or agency title insurance producer shall conduct a [~~minimum mandatory search, as defined by rule made by the Title and Escrow Commission, subject to Section 31A-2-404~~] reasonable search of the public records.

Section ~~{27}~~32. Section **31A-23a-406.5** is enacted to read:

31A-23a-406.5. Conduct of escrow.

(1) Only an escrow agent or a title insurer in compliance with Subsection 31A-4-107(1)(a) and Section 31A-14-211 shall conduct escrow.

(2) Subsection (1) does not apply to:

(a) a person defined as an escrow agent in Section 7-22-101; or

(b) a person licensed to practice law in Utah, if that person meets the requirements of Section 31A-23a-204.

Section ~~{28}~~33. Section **31A-23a-407** is amended to read:

31A-23a-407. Liability of title insurers for acts of title insurance producers.

Any title company, represented by one or more individual title insurance producers appointed by an insurer or agency title insurance producers, is directly and primarily liable to others dealing with the individual title insurance producers or agency title insurance producers for the receipt and disbursement of funds deposited in escrows with the individual title insurance producers appointed by an insurer or agency title insurance producers in all those transactions where a commitment or binder for or policy or contract of title insurance of that title [~~insurance company~~] insurer has been ordered, or a preliminary report of the title [~~insurance company~~] insurer has been issued or distributed. This liability does not modify, mitigate, impair, or affect the contractual obligations between the individual title insurance producers or agency title insurance producers and the title [~~insurance company~~] insurer.

Section ~~{29}~~34. Section **31A-23a-413** is amended to read:

31A-23a-413. Title insurance producer's annual report.

[~~Every~~] An agency title insurance producer and an individual title insurance producer who has not been designated by an agency title insurance producer shall annually file with the commissioner, by a date and in a form the commissioner specifies by rule, a verified statement of the agency title insurance producer's or individual title insurance producer's financial condition, transactions, and affairs as of the end of the preceding calendar year.

Section ~~{30}~~35. Section **31A-23a-415** is amended to read:

31A-23a-415. Assessment on agency title insurance producers or title insurers -- Account created.

(1) For purposes of this section:

(a) "Premium" is as defined in Subsection 59-9-101(3).

(b) "Title insurer" means a person:

(i) making any contract or policy of title insurance as:

(A) insurer;

(B) guarantor; or

(C) surety;

(ii) proposing to make any contract or policy of title insurance as:

(A) insurer;

(B) guarantor; or

(C) surety; or

(iii) transacting or proposing to transact any phase of title insurance, including:

(A) soliciting;

(B) negotiating preliminary to execution;

(C) executing of a contract of title insurance;

(D) insuring; and

(E) transacting matters subsequent to the execution of the contract and arising out of the contract.

(c) "Utah risks" means insuring, guaranteeing, or indemnifying with regard to real or personal property located in Utah, an owner of real or personal property, the holders of liens or encumbrances on that property, or others interested in the property against loss or damage suffered by reason of:

(i) liens or encumbrances upon, defects in, or the unmarketability of the title to the property; or

(ii) invalidity or unenforceability of any liens or encumbrances on the property.

(2) (a) The commissioner may assess each title insurer, each individual title insurance producer, who is not designated by an agency title insurance producer, and each agency title insurance [~~agency~~] producer an annual assessment:

(i) determined by the Title and Escrow Commission:

(A) after consultation with the commissioner; and

(B) in accordance with this Subsection (2); and

(ii) to be used for the purposes described in Subsection (3).

(b) [~~A~~] An agency title insurance [~~agency~~] producer and individual title insurance

producer who is not designated by an agency title insurance producer shall be assessed up to:

(i) $250 for the first office in each county in which the agency title insurance [~~agency~~] producer or individual title insurance producer maintains an office; and

(ii) $150 for each additional office the agency title insurance [~~agency~~] producer or individual title insurance producer maintains in the county described in Subsection (2)(b)(i).

(c) A title insurer shall be assessed up to:

(i) $250 for the first office in each county in which the title insurer maintains an office;

(ii) $150 for each additional office the title insurer maintains in the county described in Subsection (2)(c)(i); and

(iii) an amount calculated by:

(A) aggregating the assessments imposed on:

(I) agency title insurance [~~agencies~~] producers and individual title insurance producers under Subsection (2)(b); and

(II) title insurers under Subsections (2)(c)(i) and (2)(c)(ii);

(B) subtracting the amount determined under Subsection (2)(c)(iii)(A) from the total costs and expenses determined under Subsection (2)(d); and

(C) multiplying:

(I) the amount calculated under Subsection (2)(c)(iii)(B); and

(II) the percentage of total premiums for title insurance on Utah risk that are premiums of the title insurer.

(d) Notwithstanding Section 31A-3-103 and subject to Section 31A-2-404, the Title and Escrow Commission by rule shall establish the amount of costs and expenses described under Subsection (3) that will be covered by the assessment, except the costs or expenses to be covered by the assessment may not exceed $80,000 annually.

(3) (a) Money received by the state under this section shall be deposited into the Title Licensee Enforcement Restricted Account.

(b) There is created in the General Fund a restricted account known as the "Title Licensee Enforcement Restricted Account."

(c) The Title Licensee Enforcement Restricted Account shall consist of the money received by the state under this section.

(d) The commissioner shall administer the Title Licensee Enforcement Restricted

Account. Subject to appropriations by the Legislature, the commissioner shall use the money deposited into the Title Licensee Enforcement Restricted Account only to pay for a cost or expense incurred by the department in the administration, investigation, and enforcement of this part and Part 5, Compensation of Producers and Consultants, related to:

(i) the marketing of title insurance; and

(ii) audits of [~~agencies~~] agency title insurance producers.

(e) An appropriation from the Title Licensee Enforcement Restricted Account is nonlapsing.

(4) The assessment imposed by this section shall be in addition to any premium assessment imposed under Subsection 59-9-101(3).

Section ~~{31}~~36. Section **31A-23a-503** is amended to read:

31A-23a-503. Controlled business in title insurance.

(1) As used in this section:

(a) "Associate" means any:

(i) business organized for profit in which a person who refers title business is a director, officer, partner, or employee;

(ii) spouse or relative within the second degree by blood or marriage of a person who refers title business, who is a natural person;

(iii) employee of a person who refers title business; or

(iv) person with whom a person who refers title business or any associate of that title insurer, individual title insurance producer, or agency title insurance producer has any agreement, arrangement, or understanding, or pursues any course of conduct, designed to avoid the provisions of this chapter.

(b) "Controlled business" means that portion of the title insurance business of a title insurer [~~or~~], individual title insurance producer, or agency title insurance producer in this state that is referred to it by all those producers of title business who have a financial interest in the title insurer [~~or~~], individual title insurance producer, or agency title insurance producer and by all associates of those producers. Business is referred if there is influence over the selection of the person with whom the business is placed.

(c) "A person who refers title business" includes any person engaged in this state in a business of:

(i) buying or selling interests in real property;

(ii) making loans secured by interests in real property; or

(iii) acting as a representative or employee of a person who buys or sells any interest in real property or who lends or borrows money with interest as security, other than acting as a licensed title insurer [~~or~~], individual title insurance producer, or agency title insurance producer doing the business of title insurance.

(d) "Financial interest" means any legal or beneficial interest that together with other interests entitles the holder to more than 1% of the net profits or net worth of the business in which the interest is held.

(2) A title insurer [~~or~~], individual title insurance producer, or agency title insurance producer or person having a financial interest in a title insurer [~~or~~], individual title insurance producer, or agency title insurance producer may not knowingly be a party to or knowingly permit to continue in any arrangement in which the title insurer, individual title insurance producer or agency title insurance producer, or person knows or has reason to believe that any person who refers title business has or will have, directly or indirectly, a financial interest in the title insurer [~~or~~], individual title insurance producer, or agency title insurance producer, if it reasonably appears that a substantial factor in the person who refers title business owning or acquiring the financial interest is the expected realization of financial profit or gain derived in whole or in part from controlled business.

(3) A title insurer may not appoint or knowingly continue its authorization of any individual title insurance producer or agency title insurance producer in which the company knows or has reason to believe that any person who refers title business has or will have, directly or indirectly, a financial interest, if it reasonably appears that a substantial factor in the person who refers title business owning or acquiring the financial interest is the person's expected realization of financial profit or gain derived in whole or part from controlled business.

(4) (a) If for any calendar quarter, the gross operating revenues of a title insurer [~~or~~], individual title insurance producer, or agency title insurance producer derived from all sources of controlled business in this state amount to more than 1/3 of its gross operating revenues from all other sources of its business of title insurance in this state, it is presumed that the expected realization of financial profit or gain derived in whole or in part from controlled

business was a substantial factor in the ownership of financial interest in the title insurer [~~or~~], individual title insurance producer, or agency title insurance producer.

(b) The title insurer [~~or~~], individual title insurance producer, or agency title insurance producer has the burden of overcoming the presumption described in Subsection (4)(a).

(c) This Subsection (4) does not authorize any controlled business if a violation of the standards set forth in Subsection (2) or (3) exists.

(5) A title insurer [~~or~~], individual title insurance producer, or agency title insurance producer may not accept any order for the business of title insurance that it knows or has reason to believe constitutes controlled business, unless it records and maintains in its permanent records on forms prescribed by the commissioner the facts relating to the transactions.

(6) An applicant for qualification as a title insurer [~~or~~], individual title insurance producer, or agency title insurance producer may not be granted a license if it reasonably appears that the expected realization of financial profit or gain to be derived in whole or in part from controlled business is or will be a substantial factor in the applicant's plan of operation or in the ownership or acquisition of financial interests in the applicant by any person who refers title business.

(7) Each title insurer [~~and~~], individual title insurance producer, and agency title insurance producer shall maintain permanent records relating to its controlled business on forms prescribed by the commissioner.

(8) (a) Each title insurer and agency title insurance producer shall file annually with the commissioner, on forms prescribed by the commissioner, reports setting forth:

(i) the names and addresses of any persons owning a financial interest in the title insurer or agency title insurance producer as of the last day of the calendar year, who are known or reasonably believed by the title insurer or agency title insurance producer to be a person who refers title business; and

(ii) a summary compiled from the title insurer's or agency title insurance producer's records of the controlled business, sufficient to inform the commissioner and the Title and Escrow Commission as to the proportion of the title insurer's or agency title insurance producer's gross operating revenues attributable to controlled business during the preceding calendar year.

(b) The reports shall be filed with the reports required under Section 31A-23a-413 and

shall contain the certification of an officer of the title insurer or agency title insurance producer that the information contained in them is true to the best of the officer's knowledge, information, and belief. Upon filing, the reports are public records.

(c) A report filed pursuant to Subsection (8)(a) is subject to review by the Title and Escrow Commission.

(9) An attorney who is also a licensed individual title insurance producer and who issues as producer a policy of title insurance to a client on behalf of whom the attorney is also acting as an attorney and who, in so doing, acts consistently with the applicable ethical standards of the Utah State Bar pertaining to the billing and receipt of legal fees and the receipt of a commission on a policy of title insurance is not, without more, considered to be engaged in controlled business.

Section ~~{32}~~37. Section ~~{**31A-27a-104**}~~**31A-23a-504** is amended to read:

~~{**31A-27a-104. Persons covered.**~~

~~(1) This chapter applies to:~~

~~(a) an insurer who:~~

~~(i) is doing, or has done, an insurance business in this state; and~~

~~(ii) against whom a claim arising from that business may exist;~~

~~(b) a person subject to examination by the commissioner;~~

~~(c) an insurer who purports to do an insurance business in this state;~~

~~(d) an insurer who has an insured who is resident in this state; and~~

~~(e) in addition to Subsections (1)(a) through (d), a person doing business as follows:~~

~~(i) under Chapter 6a, Service Contracts;~~

~~(ii) under Chapter 7, Nonprofit Health Service Insurance Corporations;~~

~~(iii) under Chapter 8a, Health Discount Program Consumer Protection Act;~~

~~(iv) under Chapter 9, Insurance Fraternals;~~

~~(v) under Chapter 11, Motor Clubs;~~

~~(vi) under Chapter 13, Employee Welfare Funds and Plans;~~

~~(vii) under Chapter 15, Unauthorized Insurers, Surplus Lines, and Risk Retention Groups;~~

~~(viii) as a bail bond surety company under Chapter 35, Bail Bond Act;~~

~~(ix) under Chapter 37, Captive Insurance Companies Act;~~

~~(x) a title insurance company;~~

~~(xi) a prepaid health care delivery plan; and~~

~~(xii) a person not described};~~**31A-23a-504. Sharing commissions.**

(1) (a) Except as provided in ~~{Subsections (1)(c)(i) through (xi) that is organized or doing insurance business, or in the process of organizing with the intent to do insurance business in this state.~~

~~(2) Notwithstanding Sections 31A-1-301 and 31A-27a-102, this chapter does not apply to a person licensed by the insurance commissioner as one or more of the following in this state unless the person engages in the business of insurance as an insurer:~~

~~(a) an insurance agency;~~

~~(b) an insurance producer;~~

~~(c);~~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 as to the particular type of insurance to act in Utah as:

(i) a producer;

(ii) a limited line producer;

(~~{d)~~iii) ~~{an insurance}~~a consultant;

(~~{e)~~iv) a managing general agent; or

(~~{f)~~v) a reinsurance intermediary~~{;}~~.

(~~{g) [a] an individual}~~b) A person may only accept commission compensation or other compensation as a person described in Subsections (1)(a)(i) through (v) that is directly or indirectly the result of an insurance transaction if that person is licensed under this chapter to act as described in Subsection (1)(a).

(2) (a) Except as provided in Section 31A-23a-501, a consultant may not pay or receive a commission or other compensation that is directly or indirectly the result of an insurance transaction.

(b) A consultant may share a consultant fee or other compensation received for consulting services performed within Utah only:

(i) with another consultant licensed under this chapter; and

(ii) to the extent that the other consultant contributed to the services performed.

(3) This section does not prohibit:

(a) 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;

(b) compensation paid to or received by a person for referral of a potential customer that seeks to purchase or obtain an opinion or advice on an insurance product if:

(i) the person is not licensed to sell insurance;

(ii) the person does not sell or provide opinions or advice on the product; and

(iii) the compensation does not depend on whether the referral results in a purchase or sale; or

(c) the payment or assignment of a commission, service fee, brokerage, or other valuable consideration to an agency or a person who does not sell, solicit, or negotiate insurance in this state, unless the payment would constitute an inducement or commission rebate under Section 31A-23a-402 or 31A-23a-402.5.

(4) (a) In selling a policy of title insurance, sharing of commissions under Subsection (1) may not occur if it will result in:

(i) an unlawful rebate;

(ii) compensation in connection with controlled business; or

(iii) payment of a forwarding fee or finder's fee.

(b) A person may share compensation for the issuance of a title insurance ~~{producer or agency}~~policy only to the extent that the person contributed to the search and examination of the title or other services connected with the title insurance ~~{producer;~~

~~(h) a third party administrator;~~

~~(i) an insurance adjustor;~~

~~(j) a life settlement provider; or~~

~~(k) a life settlement producer.~~

~~Section 33}~~policy.

(5) This section does not apply to a bail bond producer or bail enforcement agent as defined in Section 31A-35-102[~~.~~] and as described in Subsection 31A-23a-106(2)(c); or

(b) a nonlicensed individual employee or authorized representative of a licensed limited line producer who holds one or more of the following limited lines of authority as described in Subsection 31A-23a-106(2)(c):

(i) car rental related insurance;

(ii) self-service storage insurance; or

(iii) portable electronics insurance.

Section 38. Section ~~{**31A-29-106**}~~**31A-27a-104** is amended to read:

~~{**31A-29-106**}~~**31A-27a-104**. ~~{**Powers of board.**~~

~~(1) The board shall have the general powers and authority granted under the laws of this state to insurance companies licensed to transact health care}~~**Persons covered.**

(1) This chapter applies to:

(a) an insurer who:

(i) is doing, or has done, an insurance business~~{. In addition, the board shall have the specific authority to:~~

~~(a) enter into contracts to carry out the provisions and purposes of this chapter, including, with the approval of}~~ in this state; and

(ii) against whom a claim arising from that business may exist;

(b) a person subject to examination by the commissioner~~{, contracts with:~~

~~(i) similar pools of other states for the joint performance of common administrative functions; or~~

~~(ii) persons or other organizations for the performance of administrative functions;~~

~~(b) sue or be sued, including taking such legal action necessary to avoid the payment of improper claims against the pool or the coverage provided through the pool;~~

~~(c) establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas, and any other actuarial function appropriate to the operation of the pool;~~

~~(d) issue policies of insurance in accordance with the requirements of this chapter;~~

~~(e) retain an executive director and appropriate legal, actuarial, and other personnel as necessary to provide technical assistance in the operations of the pool;~~

~~(f) establish rules, conditions, and procedures for reinsuring risks under this chapter;~~

~~(g) cause the pool to have an annual audit of its operations by the state auditor;~~

~~(h) coordinate with the Department of Health in seeking to obtain from the Centers for Medicare and Medicaid Services, or other appropriate office or agency of government, all appropriate waivers, authority, and permission needed to coordinate the coverage available~~

~~from the pool with coverage available under Medicaid, either before or after Medicaid coverage, or as a conversion option upon completion of Medicaid eligibility, without the necessity for requalification by the enrollee;~~

~~(i) provide for and employ cost containment measures and requirements including preadmission certification, concurrent inpatient review, and individual case management for the purpose of making the pool more cost-effective;~~

~~(j) offer pool coverage through contracts with health maintenance organizations, preferred provider organizations, and other managed care systems that will manage costs while maintaining quality care;~~

~~(k) establish annual limits on benefits payable under the pool to or on behalf of any enrollee;~~

~~(l) exclude from coverage under the pool specific benefits, medical conditions, and procedures for the purpose of protecting the financial viability of the pool;~~

~~(m) administer the Pool Fund;~~

~~(n) make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement this chapter; [and]~~

~~(o) adopt, trademark, and copyright a trade name for the pool for use in marketing and publicizing the pool and its products[.]; and~~

(p) transition health care coverage for all individuals covered under the pool as part of the conversion to health insurance coverage, regardless of preexisting conditions, under PPACA.

~~(2) (a) The board shall prepare and submit an annual report to the Legislature which shall include:~~

~~(i) the net premiums anticipated;~~

~~(ii) actuarial projections of payments required of the pool;~~

~~(iii) the expenses of administration; and~~

~~(iv) the anticipated reserves or losses of the pool.~~

~~(b) The budget for operation of the pool is subject to the approval of the board.~~

~~(c) The administrative budget of the board and the commissioner under this chapter shall comply with the requirements of Title 63J, Chapter 1, Budgetary Procedures Act, and is subject to review and approval by the Legislature.~~

~~(3) (a) The board shall on or before September 1, 2004, require the plan administrator or an independent actuarial consultant retained by the plan administrator to redetermine the reasonable equivalent of the criteria for uninsurability required under Subsection 31A-30-106(1)(h) that is used by the board to determine eligibility for coverage in the pool.~~

~~(b) The board shall redetermine the criteria established in Subsection (3)(a) at least every five years thereafter.~~

~~Section 34);~~

(c) an insurer who purports to do an insurance business in this state;

(d) an insurer who has an insured who is resident in this state; and

(e) in addition to Subsections (1)(a) through (d), a person doing business as follows:

(i) under Chapter 6a, Service Contracts;

(ii) under Chapter 7, Nonprofit Health Service Insurance Corporations;

(iii) under Chapter 8a, Health Discount Program Consumer Protection Act;

(iv) under Chapter 9, Insurance Fraternals;

(v) under Chapter 11, Motor Clubs;

(vi) under Chapter 13, Employee Welfare Funds and Plans;

(vii) under Chapter 15, Unauthorized Insurers, Surplus Lines, and Risk Retention Groups;

(viii) as a bail bond surety company under Chapter 35, Bail Bond Act;

(ix) under Chapter 37, Captive Insurance Companies Act;

(x) a title insurance company;

(xi) a prepaid health care delivery plan; and

(xii) a person not described in Subsections (1)(e)(i) through (xi) that is organized or doing insurance business, or in the process of organizing with the intent to do insurance business in this state.

(2) Notwithstanding Sections 31A-1-301 and 31A-27a-102, this chapter does not apply to a person licensed by the insurance commissioner as one or more of the following in this state unless the person engages in the business of insurance as an insurer:

(a) an insurance agency;

(b) an insurance producer;

(c) a limited line producer;

(d) an insurance consultant;

(e) a managing general agent;

(f) reinsurance intermediary;

(g) [~~a~~] an individual title insurance producer or agency title insurance producer;

(h) a third party administrator;

(i) an insurance adjustor;

(j) a life settlement provider; or

(k) a life settlement producer.

Section 39. Section ~~{~~**~~31A-29-113~~**~~}~~**31A-29-106** is amended to read:

~~{~~**~~31A-29-113. Benefits -- Additional types of pool insurance -- Preexisting conditions -- Waiver -- Maximum benefits.~~**

~~(1) (a) The pool policy shall pay for eligible medical expenses rendered or furnished for the diagnoses or treatment of illness or injury that:~~

~~(i) exceed the deductible and copayment amounts applicable under Section 31A-29-114; and~~

~~(ii) are not otherwise limited or excluded.~~

~~(b) Eligible medical expenses are the allowed charges established by the board for the health care services and items rendered during times for which benefits are extended under the pool policy.~~

~~(2) The coverage to be issued by the pool, its schedule of benefits, exclusions, and other limitations shall be established by the board.~~

~~(3) The commissioner shall approve the benefit package developed by the board to ensure its compliance with this chapter.~~

~~(4) The pool shall offer at least one benefit plan through a managed care program as authorized under Section 31A-29-106.~~

~~(5) This chapter may not be construed to prohibit the pool from issuing additional types of pool policies with different types of benefits which in the opinion of the board may be of benefit to the citizens of Utah.~~

~~(6) (a)~~**31A-29-106. Powers of board.**

(1) The board shall ~~{design and require an administrator to}~~have the general powers and authority granted under the laws of this state to insurance companies licensed to transact

health care insurance business. In addition, the board shall have the specific authority to:

(a) enter into contracts to carry out the provisions and purposes of this chapter, including, with the approval of the commissioner, contracts with:

(i) similar pools of other states for the joint performance of common administrative functions; or

(ii) persons or other organizations for the performance of administrative functions;

(b) sue or be sued, including taking such legal action necessary to avoid the payment of improper claims against the pool or the coverage provided through the pool;

(c) establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas, and any other actuarial function appropriate to the operation of the pool;

(d) issue policies of insurance in accordance with the requirements of this chapter;

(e) retain an executive director and appropriate legal, actuarial, and other personnel as necessary to provide technical assistance in the operations of the pool;

(f) establish rules, conditions, and procedures for reinsuring risks under this chapter;

(g) cause the pool to have an annual audit of its operations by the state auditor;

(h) coordinate with the Department of Health in seeking to obtain from the Centers for Medicare and Medicaid Services, or other appropriate office or agency of government, all appropriate waivers, authority, and permission needed to coordinate the coverage available from the pool with coverage available under Medicaid, either before or after Medicaid coverage, or as a conversion option upon completion of Medicaid eligibility, without the necessity for requalification by the enrollee;

(i) provide for and employ cost containment measures and requirements including preadmission certification~~{ and}~~, concurrent inpatient review, and individual case management for the purpose of making the pool more ~~{cost effective.}~~cost-effective;

(~~{b}~~j) ~~{Sections 31A-22-617 and 31A-22-618 do not apply to coverage issued under this chapter.~~

~~(7) (a) A pool policy may contain provisions under which coverage for a preexisting condition is excluded if:~~

~~(i) the exclusion relates to a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received, from an~~

~~individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by state law, within the six-month period ending on the effective date of plan coverage; and~~

~~(ii) except as provided in Subsection (8), the exclusion extends for a period no longer than the six-month period following the effective date of plan coverage for a given individual.~~

~~(b) Subsection (7)(a) does not apply to a HIPAA eligible individual.~~

~~(8) (a) A pool policy may contain provisions under which coverage for a preexisting pregnancy is excluded during a ten-month period following the effective date of plan coverage for a given individual.~~

~~(b) Subsection (8)(a) does not apply to a HIPAA eligible individual.~~

~~(9) (a) The pool will waive the preexisting condition exclusion described in Subsections (7)(a) and (8)(a) for an individual that is changing health coverage to the pool, to the extent to which similar exclusions have been satisfied under any prior}~~offer pool coverage through contracts with health maintenance organizations, preferred provider organizations, and other managed care systems that will manage costs while maintaining quality care;

(k) establish annual limits on benefits payable under the pool to or on behalf of any enrollee;

(l) exclude from coverage under the pool specific benefits, medical conditions, and procedures for the purpose of protecting the financial viability of the pool;

(m) administer the Pool Fund;

(n) make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement this chapter; [~~and~~]

(o) adopt, trademark, and copyright a trade name for the pool for use in marketing and publicizing the pool and its products[:]; and

(p) transition health care coverage for all individuals covered under the pool as part of the conversion to health insurance coverage~~{ if the individual applies not later than 63 days following the date of involuntary termination, other than for nonpayment of premiums, from health coverage.~~

~~(b) If this Subsection (9) applies,}~~, regardless of preexisting conditions, under PPACA.

(2) (a) The board shall prepare and submit an annual report to the Legislature which shall include:

(i) the net premiums anticipated;

(ii) actuarial projections of payments required of the pool;

(iii) the expenses of administration; and

(iv) the anticipated reserves or losses of the pool.

(b) The budget for operation of the pool is subject to the approval of the board.

(c) The administrative budget of the board and the commissioner under this chapter shall comply with the requirements of Title 63J, Chapter 1, Budgetary Procedures Act, and is subject to review and approval by the Legislature.

(3) (a) The board shall on or before September 1, 2004, require the plan administrator or an independent actuarial consultant retained by the plan administrator to redetermine the reasonable equivalent of the criteria for uninsurability required under Subsection 31A-30-106(1)(h) that is used by the board to determine eligibility for coverage in the pool.

(b) The board shall ~~{be effective from the date on which the prior coverage was terminated.~~

~~(10) Covered benefits available from the pool may not exceed a [$1,500,000] $1,800,000 lifetime maximum, which includes a per enrollee calendar year maximum established by the board.~~

~~Section 35}~~redetermine the criteria established in Subsection (3)(a) at least every five years thereafter.

Section 40. Section ~~{**31A-31-108**}~~**31A-29-113** is amended to read:

~~{**31A-31-108**}~~**31A-29-113**. ~~{**Assessment of insurers.**~~

~~**(1) For purposes of this section:**~~

~~**(a) The commissioner shall by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, define:**~~

~~**(i) "annuity consideration";**~~

~~**(ii) "membership fees";**~~

~~**(iii) "other fees";**~~

~~**(iv) "deposit-type contract funds"; and**~~

~~**(v) "other considerations in Utah."**~~

~~**(b) "Insurance fraud provisions" means:**~~

~~**(i) this chapter;**~~

~~(ii) Section 34A-2-110; and~~

~~(iii) Section 76-6-521.~~

~~(c) "Utah consideration" means:~~

~~(i) the total premiums written for Utah risks;~~

~~(ii) annuity consideration;~~

~~(iii) membership fees collected by the insurer;~~

~~(iv) other fees collected by the insurer;~~

~~(v) deposit-type contract funds; and~~

~~(vi) other considerations in Utah.~~

~~(d) "Utah risks" means insurance coverage on the lives, health, or against the liability of persons residing in Utah, or on property located in Utah, other than property temporarily in transit through Utah.~~

~~(2) To implement insurance fraud provisions, the commissioner may assess an admitted insurer and a nonadmitted insurer transacting insurance under Chapter 15, Parts 1, Unauthorized Insurers and Surplus Lines, and 2, Risk Retention Groups Act, an annual fee as follows:~~

~~(a) $200 for an insurer for which the sum of the Utah consideration is less than or equal to $1,000,000;~~

~~(b) $450 for an insurer for which the sum of the Utah consideration is greater than $1,000,000 but is less than or equal to $2,500,000;~~

~~(c) $800 for an insurer for which the sum of the Utah consideration is greater than $2,500,000 but is less than or equal to $5,000,000;~~

~~(d) $1,600 for an insurer for which the sum of the Utah consideration is greater than $5,000,000 but less than or equal to $10,000,000;~~

~~(e) $6,100 for an insurer for which the sum of the Utah consideration is greater than $10,000,000 but less than $50,000,000; and~~

~~(f) $15,000 for an insurer for which the sum of the Utah consideration equals or exceeds $50,000,000.~~

~~(3) Money received by the state under this section shall be deposited into the Insurance Fraud Investigation Restricted Account created in Subsection (4).~~

~~(4) (a) There is created in the General Fund a restricted account known as the~~

~~"Insurance Fraud Investigation Restricted Account."~~

~~(b) The Insurance Fraud Investigation Restricted Account shall consist of the money received by the commissioner under this section and [Section 31A-31-109.] Subsections 31A-31-109(1)(a)(ii), (1)(b), (2)(b)(i), (2)(c), and (3)(a). Money ordered paid under Subsections 31A-31-109(1)(a)(i) and (2)(a) shall be deposited in the Insurance Fraud Victim Restitution Fund pursuant to Section 31A-31-108.5.~~

~~(c)~~**Benefits -- Additional types of pool insurance -- Preexisting conditions -- Waiver -- Maximum benefits.**

(1) (a) The pool policy shall pay for eligible medical expenses rendered or furnished for the diagnoses or treatment of illness or injury that:

(i) exceed the deductible and copayment amounts applicable under Section 31A-29-114; and

(ii) are not otherwise limited or excluded.

(b) Eligible medical expenses are the allowed charges established by the board for the health care services and items rendered during times for which benefits are extended under the pool policy.

(2) The coverage to be issued by the pool, its schedule of benefits, exclusions, and other limitations shall be established by the board.

(3) The commissioner shall ~~{administer the Insurance Fraud Investigation Restricted Account. Subject to appropriations by the Legislature, the commissioner shall use the money deposited into the Insurance Fraud Investigation Restricted Account to pay for a cost or expense incurred by the commissioner in the administration, investigation, and enforcement of insurance fraud provisions.~~

~~Section 36}~~approve the benefit package developed by the board to ensure its compliance with this chapter.

(4) The pool shall offer at least one benefit plan through a managed care program as authorized under Section 31A-29-106.

(5) This chapter may not be construed to prohibit the pool from issuing additional types of pool policies with different types of benefits which in the opinion of the board may be of benefit to the citizens of Utah.

(6) (a) The board shall design and require an administrator to employ cost containment

measures and requirements including preadmission certification and concurrent inpatient review for the purpose of making the pool more cost effective.

(b) Sections 31A-22-617 and 31A-22-618 do not apply to coverage issued under this chapter.

(7) (a) A pool policy may contain provisions under which coverage for a preexisting condition is excluded if:

(i) the exclusion relates to a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received, from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by state law, within the six-month period ending on the effective date of plan coverage; and

(ii) except as provided in Subsection (8), the exclusion extends for a period no longer than the six-month period following the effective date of plan coverage for a given individual.

(b) Subsection (7)(a) does not apply to a HIPAA eligible individual.

(8) (a) A pool policy may contain provisions under which coverage for a preexisting pregnancy is excluded during a ten-month period following the effective date of plan coverage for a given individual.

(b) Subsection (8)(a) does not apply to a HIPAA eligible individual.

(9) (a) The pool will waive the preexisting condition exclusion described in Subsections (7)(a) and (8)(a) for an individual that is changing health coverage to the pool, to the extent to which similar exclusions have been satisfied under any prior health insurance coverage if the individual applies not later than 63 days following the date of involuntary termination, other than for nonpayment of premiums, from health coverage.

(b) If this Subsection (9) applies, coverage in the pool shall be effective from the date on which the prior coverage was terminated.

(10) Covered benefits available from the pool may not exceed a [~~$1,500,000~~] $1,800,000 lifetime maximum, which includes a per enrollee calendar year maximum established by the board.

Section 41. Section ~~{31A-31-108.5}~~**31A-30-115** is ~~{enacted}~~amended to read:

~~{~~ **~~31A-31-108.}~~31A-30-115.~~{ Insurance Fraud Victim Restitution Fund.~~**

~~(1)~~ **Actuarial review of health benefit plans.**

(1) (a) The department shall conduct an actuarial review of rates submitted by small employer carriers:

(i) prior to the publication of the premium rates on the Health Insurance Exchange;

(ii) except as permitted by Subsection 31A-30-207(2), to determine if the carrier is using the same rating and underwriting practices in both the defined contribution arrangement market in the Health Insurance Exchange and the defined benefit market offered outside the Health Insurance Exchange[~~, in compliance with Subsection 31A-30-202.5(1)(b)~~];

(iii) to verify the validity of the rates, underwriting and risk factors, and premiums of plans both in and outside of the Health Insurance Exchange;

(iv) to verify that insurers are pricing similar health benefit plans and groups the same in and out of the exchange, except as permitted by Subsection 31A-30-207(2); and

(v) as the department determines is necessary to oversee market conduct.

(b) The actuarial review by the department shall be funded from a fee:

(i) established by the department in accordance with Section 63J-1-504; and

(ii) paid by all small employer carriers participating in the defined contribution arrangement market and small employer carriers offering health benefit plans under Part 1, Individual and Small Employer Group.

(c) The department shall:

(i) report aggregate data from the actuarial review to the risk adjuster board created in Section 31A-42-201; and

(ii) contact carriers, if the department determines it is appropriate, to:

(A) inform a carrier of the department's findings regarding the rates of a particular carrier; and

(B) request a carrier to recalculate or verify base rates, rating factors, and premiums.

(d) A carrier shall comply with the department's request under Subsection (1)(c)(ii).

(2) (a) There is created ~~{a restricted special revenue fund known as the "Insurance Fraud Victim Restitution Fund."~~

~~(2) The Insurance Fraud Victim Restitution Fund}~~in the General Fund a restricted account known as the "Health Insurance Actuarial Review Restricted Account."

(b) The Health Insurance Actuarial Review Restricted Account shall consist of money ~~{ordered paid}~~received by the commissioner under ~~{Subsections 31A-31-109(1)(a)(i) and~~

~~(2)(a)}~~this section.

~~{~~(~~{3}~~c) The commissioner shall administer the Health Insurance ~~{Fraud Victim Restitution Fund for the sole benefit of insurance fraud victims.~~

~~Section 37}~~Actuarial Review Restricted Account. Subject to appropriations by the Legislature, the commissioner shall use money deposited into the Health Insurance Actuarial Review Restricted Account to pay for the actuarial review conducted by the department under this section.

Section 42. Section ~~{**31A-41-102**}~~**31A-30-208** is amended to read:

~~{**31A-41-102. Definitions.**~~

~~As used in this chapter:~~

~~(1) "Commission" means the Title and Escrow Commission created in Section 31A-2-403.~~

~~(2) "Fund" means the Title Insurance Recovery, Education, and Research Fund}~~**31A-30-208. Enrollment for defined contribution arrangements.**

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

(a) shall allow an employer to enroll in a small employer defined contribution arrangement plan;

(b) may not impose a surcharge under Section 31A-30-106.7 for a small employer group selecting a defined contribution arrangement health benefit plan on or before January 1, 2012; and

(c) shall otherwise comply with the requirements of this part, Chapter 42, Defined Contribution Risk Adjuster Act, and Title 63M, Chapter 1, Part 25, Health System Reform Act.

(2) (a) [~~Except as provided in Subsection 31A-30-202.5(2), in~~] In accordance with Subsection (2)(b), on January 1 of each year, an insurer may enter or exit the defined contribution arrangement market.

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

(i) on January 1 of each year;

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

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

~~{31A-41-201}~~31A-42-201.

(~~{~~(3) ~~"Title insurance licensee" means:~~

~~(a) [a]~~ an agency ~~title insurance [agency]~~ producer~~; or~~

~~(b) [a]~~ an individual ~~title insurance producer.~~

~~Section 38}~~c) (i) An insurer shall give the department, the Health Insurance Exchange, and the risk adjuster board 90 days' advance written notice of any event described in Subsection (2)(a) or (b).

(ii) When an insurer elects to participate in the defined contribution arrangement market, the insurer shall participate in the defined contribution arrangement market for no less than two years.

Section 43. Section ~~**{31A-41-201}**~~**31A-31-108** is amended to read:

~~**{31A-41-201. Creation of Title Insurance Recovery, Education, and Research Fund.**~~

~~(1) There is created a restricted special revenue fund to be known as the "Title Insurance Recovery, Education, and Research Fund."~~

~~(2) The fund shall consist of:~~

~~(a) assessments on~~ individual title insurance producers and agency ~~title insurance producers made under}~~**31A-31-108. Assessment of insurers.**

(1) For purposes of this section:

(a) The commissioner shall by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, define:

(i) "annuity consideration";

(ii) "membership fees";

(iii) "other fees";

(iv) "deposit-type contract funds"; and

(v) "other considerations in Utah."

(b) "Insurance fraud provisions" means:

(i) this chapter;

(~~{~~(b) ~~amounts collected under Section 31A-41-305; and~~

~~(c) interest earned on the fund.~~

~~(3) Interest on fund money}~~ii) Section 34A-2-110; and

(iii) Section 76-6-521.

(c) "Utah consideration" means:

(i) the total premiums written for Utah risks;

(ii) annuity consideration;

(iii) membership fees collected by the insurer;

(iv) other fees collected by the insurer;

(v) deposit-type contract funds; and

(vi) other considerations in Utah.

(d) "Utah risks" means insurance coverage on the lives, health, or against the liability of persons residing in Utah, or on property located in Utah, other than property temporarily in transit through Utah.

(2) To implement insurance fraud provisions, the commissioner may assess an admitted insurer and a nonadmitted insurer transacting insurance under Chapter 15, Parts 1, Unauthorized Insurers and Surplus Lines, and 2, Risk Retention Groups Act, an annual fee as follows:

(a) $200 for an insurer for which the sum of the Utah consideration is less than or equal to $1,000,000;

(b) $450 for an insurer for which the sum of the Utah consideration is greater than $1,000,000 but is less than or equal to $2,500,000;

(c) $800 for an insurer for which the sum of the Utah consideration is greater than $2,500,000 but is less than or equal to $5,000,000;

(d) $1,600 for an insurer for which the sum of the Utah consideration is greater than $5,000,000 but less than or equal to $10,000,000;

(e) $6,100 for an insurer for which the sum of the Utah consideration is greater than $10,000,000 but less than $50,000,000; and

(f) $15,000 for an insurer for which the sum of the Utah consideration equals or exceeds $50,000,000.

(3) Money received by the state under this section shall be deposited into the ~~{fund.~~

~~(4) The department}~~Insurance Fraud Investigation Restricted Account created in Subsection (4).

(4) (a) There is created in the General Fund a restricted account known as the

"Insurance Fraud Investigation Restricted Account."

(b) The Insurance Fraud Investigation Restricted Account shall consist of the money received by the commissioner under this section and [~~Section 31A-31-109.~~] Subsections 31A-31-109(1)(a)(ii), (1)(b), (2)(b)(i), (2)(c), and (3)(a). Money ordered paid under Subsections 31A-31-109(1)(a)(i) and (2)(a) shall be deposited in the Insurance Fraud Victim Restitution Fund pursuant to Section 31A-31-108.5.

(c) The commissioner shall administer the ~~{fund. Section 39}~~Insurance Fraud Investigation Restricted Account. Subject to appropriations by the Legislature, the commissioner shall use the money deposited into the Insurance Fraud Investigation Restricted Account to pay for a cost or expense incurred by the commissioner in the administration, investigation, and enforcement of insurance fraud provisions.

Section 44. Section ~~{**31A-41-202**}~~**31A-31-108.5** is ~~{amended to read: }~~enacted to read:

31A-31-108.5. Insurance Fraud Victim Restitution Fund.

(1) There is created a restricted special revenue fund known as the "Insurance Fraud Victim Restitution Fund."

(2) The Insurance Fraud Victim Restitution Fund shall consist of money ordered paid under Subsections 31A-31-109(1)(a)(i) and (2)(a).

(3) The commissioner shall administer the Insurance Fraud Victim Restitution Fund for the sole benefit of insurance fraud victims.

Section 45. Section **31A-41-102** is amended to read:

31A-41-102. Definitions.

As used in this chapter:

(1) "Commission" means the Title and Escrow Commission created in Section 31A-2-403.

(2) "Fund" means the Title Insurance Recovery, Education, and Research Fund created in Section 31A-41-201.

(3) "Title insurance licensee" means:

(a) [~~a~~] an agency title insurance [~~agency~~] producer; or

(b) [~~a~~] an individual title insurance producer.

Section 46. Section **31A-41-201** is amended to read:

31A-41-201. Creation of Title Insurance Recovery, Education, and Research Fund.

(1) There is created a restricted special revenue fund to be known as the "Title Insurance Recovery, Education, and Research Fund."

(2) The fund shall consist of:

(a) assessments on individual title insurance producers and agency title insurance producers made under this chapter;

(b) amounts collected under Section 31A-41-305; and

(c) interest earned on the fund.

(3) Interest on fund money shall be deposited into the fund.

(4) The department shall administer the fund.

Section 47. Section **31A-41-202** is amended to read:

31A-41-202. Assessments.

(1) Beginning January 1, 2009, [~~a~~] an agency title insurance [~~agency~~] producer licensed under this title shall pay an annual assessment determined by the commission by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, except that the annual assessment:

(a) may not exceed $1,000; and

(b) shall be determined on the basis of title insurance premium volume.

(2) Beginning January 1, 2009, an individual who applies for a license or renewal of a license as [~~a~~] an individual title insurance producer, shall pay in addition to any other fee required by this title, an assessment not to exceed $20, as determined by the commission by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, except that if the individual holds more than one license, the total of all assessments under this Subsection (2) may not exceed $20 in a fiscal year.

(3) (a) To be licensed as [~~a~~] an agency title insurance [~~agency~~] producer on or after July 1, 2008, a person shall pay to the department an assessment of $1,000 before the day on which the person is licensed as a title insurance agency.

(b) (i) By no later than July 15, 2008, the department shall assess on [~~a~~] an agency title insurance [~~agency~~] producer licensed as of June 30, 2008, an amount equal to the greater of:

(A) $1,000; or

(B) subject to Subsection (3)(b)(ii), 2% of the balance as of December 31, 2007, in the agency title insurance [~~agency's~~] producer's reserve account [~~required under~~] described in Subsection 31A-23a-204(3).

(ii) The department may assess on [~~a~~] an agency title insurance [~~agency~~] producer an amount less than 2% of the balance described in Subsection (3)(b)(i)(B) if:

(A) before issuing the assessments under this Subsection (3)(b) the department determines that the total of all assessments under Subsection (3)(b)(i) will exceed $250,000;

(B) the amount assessed on the agency title insurance [~~agency~~] producer is not less than $1,000; and

(C) the department reduces the assessment in a proportionate amount for agency title insurance [~~agencies~~] producers assessed on the basis of the 2% of the balance described in Subsection (3)(b)(i)(B).

(iii) [~~A~~] An agency title insurance [~~agency~~] producer assessed under this Subsection (3)(b) shall pay the assessment by no later than August 1, 2008.

(4) The department may not assess a title insurance licensee an assessment for purposes of the fund if that assessment is not expressly provided for in this section.

Section ~~{40}~~48. Section **49-20-410** is amended to read:

49-20-410. High deductible health plan -- Health savings account -- Contributions.

(1) (a) In addition to other employee benefit plans offered under Subsection 49-20-201(1), the office shall offer at least one federally qualified high deductible health plan with a health savings account as an optional health plan.

(b) The provisions and limitations of the plan shall be:

(i) determined by the office in accordance with federal requirements and limitations; and

(ii) designed to promote appropriate health care utilization by consumers, including preventive health care services.

(c) A state employee hired on or after July 1, 2011, who is offered a plan under Subsection 49-20-202(1)(a), shall be enrolled in a federally qualified high deductible health plan unless the employee chooses a different health benefit plan during the employee's open

enrollment period.

(2) The office shall:

(a) administer the high deductible health plan in coordination with a health savings account for medical expenses for each covered individual in the high deductible health plan;

(b) offer to all employees training regarding all health plans offered to employees;

(c) prepare online training as an option for the training required by Subsections (2)(b) and (4);

(d) ensure the training offered under Subsections (2)(b) and (c) includes information on changing coverages to the high deductible plan with a health savings account, including coordination of benefits with other insurances, restrictions on other insurance coverages, and general tax implications; and

(e) coordinate annual open enrollment with the Department of Human Resource Management to give state employees the opportunity to affirmatively select preferences from among insurance coverage options.

(3) (a) Contributions to the health savings account may be made by the employer.

(b) The amount of the employer contributions under Subsection (3)(a) shall be determined annually by the office, after consultation with the Department of Human Resource Management and the Governor's Office of Planning and Budget so that the annual employer contribution amount reflects the difference in the actuarial value between the program's health maintenance organization coverage and the federally qualified high deductible health plan coverage, after taking into account any difference in employee premium contribution.

(c) The office shall distribute the annual amount determined under Subsection (3)(b) to employees in two equal amounts with a pay date in January and a pay date in July of each plan year.

(d) An employee may also make contributions to the health savings account.

~~[(4) The program shall offer a state employee and the employee's eligible dependents the option to continue coverage under the employee's high deductible health plan in place of a conversion policy under Section 31A-22-723 if:]~~

~~[(a) the employee was covered by the state employee's high deductible health plan for at least the four years before the date of termination of employment;]~~

~~[(b) the employee or the employee's eligible dependents have exhausted federal~~

~~COBRA coverage with the same or similar state employee's high deductible health plan; and]~~

~~[(c) the employee pays the premium group rate determined by the office for the coverage.]~~

[~~(5)~~] (4) (a) An employer participating in a plan offered under Subsection 49-20-202(1)(a) shall require each employee to complete training on the health plan options available to the employee.

(b) The training required by Subsection [~~(5)~~] (4)(a):

(i) shall include materials prepared by the office under Subsection (2);

(ii) may be completed online; and

(iii) shall be completed:

(A) before the end of the 2012 open enrollment period for current enrollees in the program; and

(B) for employees hired on or after July 1, 2011, before the employee's selection of a plan in the program.

Section 49. **Repealer.**

This bill repeals:

Section **31A-22-723, Conversion from group coverage.**

Section **31A-22-724, Offer of alternative coverage -- Utah NetCare Plan.**

Section **31A-30-109, Health benefit plan choices.**

Section **31A-30-202.5, Insurer participation in defined contribution arrangement market.**

Section **31A-30-205, Health benefit plans offered in the defined contribution market.**

Section 50. **Effective date.**

(1) If approved by two-thirds of all the members elected to each house, Section 31A-4-117 takes effect upon approval by the governor, or the day following the constitutional time limit of Utah Constitution Article VII, Section 8, without the governor's signature, or in the case of a veto, the date of veto override.

(2) Except as provided in ~~{Subsection}~~Subsections (1), (3) and ~~{Subsection }~~(~~{3}~~4), this bill takes effect on May 14, 2013.

(3) The actions affecting the following take effect on January 1, 2014:

(a) Section 31A-2-201.2;

(b) Section 31A-21-503;

(c) Section 31A-22-612;

(d) Section 31A-22-722;

(e) Section 31A-22-723;

(f) Section 31A-30-109;

(g) Section 31A-30-115;

(h) Section 31A-30-202.5;

(i) Section 31A-30-205;

(j) Section 31A-30-208;

(k) Section 49-20-410;

(~~{3}~~4) The ~~{action to}~~actions affecting Section ~~{31A-3-3-4}~~31A-3-304 (Effective 07/01/13) ~~{takes}~~take effect on July 1, 2015.