1 # INSURANCE RELATED AMENDMENTS

2 2014 GENERAL SESSION

3 STATE OF UTAH

4 **Chief Sponsor: James A. Dunnigan**

5 Senate Sponsor: Curtis S. Bramble

6

7 **LONG TITLE**

8 **Committee Note:**

9 The Business and Labor Interim Committee recommended this bill.

10 **General Description:**

11 This bill modifies Title 31A, Insurance Code, and Title 53, Public Safety Code, to

12 address the regulation of insurance.

13 **Highlighted Provisions:**

14 This bill:

15 ▸ amends definition provisions;

16 ▸ designates insurance fraud investigators as law enforcement officers;

17 ▸ changes the date captive insurance companies are to pay a fee;

18 ▸ addresses what constitutes a qualified insurer;

19 ▸ modifies requirements for plan of orderly withdrawal from writing a line of

20 insurance;

21 ▸ addresses notice requirements related to a request for a hearing;

22 ▸ modifies calculations related to interest payable on life insurance proceeds;

23 ▸ addresses preexisting condition limitations;

24 ▸ addresses preferred provider contract provisions;

25 ▸ addresses coverage of mental health and substance use disorders;

26 ▸ modifies requirements for the uniform application form and the uniform waiver of

27 coverage form;

28 ▸ amends language regarding the health benefit plan on the Health Insurance
29 Exchange;
30 ▸ amends language regarding open enrollment provisions;
31 ▸ modifies language regarding dental and vision policies being offered on the Health
32 Insurance Exchange;
33 ▸ clarifies language related to the designated responsible licensed individual;
34 ▸ clarifies references to the Violent Crime Control and Law Enforcement Act;
35 ▸ modifies references to state of residence to home state;
36 ▸ addresses requirements related to licensing when a person establishes legal
37 residence in the state;
38 ▸ changes requirements related to the commissioner placing a licensee on probation;
39 ▸ repeals language related to a voluntarily surrendered license that is reinstated upon
40 completion of continuing education requirements;
41 ▸ modifies certain exemptions from continuing education requirements;
42 ▸ clarifies training period requirements;
43 ▸ changes a navigator license term to one year;
44 ▸ provides for training periods for a navigator license;
45 ▸ modifies continuing education requirements for a navigator;
46 ▸ repeals the requirement that the commissioner publish a list of professional
47 designations whose continuing education requirements could be used for certain
48 circumstances related to navigators;
49 ▸ modifies provisions related to inducements;
50 ▸ makes navigator licensees subject to unfair marketing practice restrictions;
51 ▸ amends definitions specific to insurance adjusters' chapter;
52 ▸ exempts an applicant for the crop insurance license class from certain requirements;
53 ▸ modifies the definition of receiver;
54 ▸ addresses the provisions related to the receivership court's seizure order;
55 ▸ amends the purpose statement, definition, and applicability and scope provisions for
56 the Individual, Small Employer, and Group Health Insurance Act;
57 ▸ addresses the surcharge for groups changing carriers by modifying rating and
58 underwriting restrictions for certain health plans;

59 ▸ addresses preexisting condition exclusions and condition-specific exclusion riders
60 in the Individual, Small Employer, and Group Health Insurance Act;
61 ▸ addresses eligibility for the small employer and individual market;
62 ▸ modifies the provisions related to appointment of insurance producers and the
63 Health Insurance Exchange;
64 ▸ modifies Health Insurance Exchange disclosure requirements;
65 ▸ requires a captive insurance company, rather than an association captive insurance
66 company or industrial insured group, to file a specified report;
67 ▸ corrects a reference to a covered employee;
68 ▸ changes reference to a multiple coordinated policy to a master policy;
69 ▸ includes reference to the defined contribution arrangement market into the Defined
70 Contribution Risk Adjuster Act;
71 ▸ modifies definitions in the Small Employer Stop-Loss Insurance Act;
72 ▸ addresses stop-loss insurance coverage standards, stop-loss restrictions, filing
73 requirements, and stop-loss insurance disclosure;
74 ▸ modifies commissioner's rulemaking authority under the Small Employer Stop-Loss
75 Insurance Act; and
76 ▸ makes technical and conforming amendments.
77 **Money Appropriated in this Bill:**
78 None
79 **Other Special Clauses:**
80 This bill provides an effective date.
81 This bill provides for retrospective operation.
82 **Utah Code Sections Affected:**
83 AMENDS:
84 **31A-1-301**, as last amended by Laws of Utah 2013, Chapter 319
85 **31A-2-104**, as last amended by Laws of Utah 1999, Chapter 21
86 **31A-3-304** **(Superseded 07/01/15)**, as last amended by Laws of Utah 2011, Chapter
87 284
88 **31A-3-304** **(Effective 07/01/15)**, as last amended by Laws of Utah 2013, Chapter 319
89 **31A-4-102**, as last amended by Laws of Utah 2008, Chapter 345

90 31A-4-115, as last amended by Laws of Utah 2002, Chapter 308
91 31A-8-402.3, as last amended by Laws of Utah 2004, Chapter 329
92 31A-16-103, as last amended by Laws of Utah 2004, Chapter 2
93 31A-17-607, as last amended by Laws of Utah 2001, Chapter 116
94 31A-22-428, as enacted by Laws of Utah 2008, Chapter 345
95 31A-22-605.1, as enacted by Laws of Utah 2005, Chapter 78
96 31A-22-617, as last amended by Laws of Utah 2013, Chapters 104 and 319
97 31A-22-618.5, as last amended by Laws of Utah 2013, Chapter 319
98 31A-22-625, as last amended by Laws of Utah 2012, Chapter 253
99 31A-22-635, as last amended by Laws of Utah 2012, Chapters 253 and 279
100 31A-22-721, as last amended by Laws of Utah 2011, Chapter 284
101 31A-23a-102, as last amended by Laws of Utah 2013, Chapter 319
102 31A-23a-104, as last amended by Laws of Utah 2012, Chapter 253
103 31A-23a-105, as last amended by Laws of Utah 2013, Chapter 319
104 31A-23a-108, as last amended by Laws of Utah 2012, Chapter 253
105 31A-23a-111, as last amended by Laws of Utah 2012, Chapter 253
106 31A-23a-112, as last amended by Laws of Utah 2008, Chapter 382
107 31A-23a-113, as last amended by Laws of Utah 2012, Chapter 253
108 31A-23a-202, as last amended by Laws of Utah 2013, Chapter 319
109 31A-23a-203, as last amended by Laws of Utah 2012, Chapter 253
110 31A-23a-402.5, as last amended by Laws of Utah 2013, Chapter 319
111 31A-23b-102, as enacted by Laws of Utah 2013, Chapter 341
112 31A-23b-202, as enacted by Laws of Utah 2013, Chapter 341
113 31A-23b-205, as enacted by Laws of Utah 2013, Chapter 341
114 31A-23b-206, as enacted by Laws of Utah 2013, Chapter 341
115 31A-23b-301, as enacted by Laws of Utah 2013, Chapter 341
116 31A-23b-401, as enacted by Laws of Utah 2013, Chapter 341
117 31A-23b-402, as enacted by Laws of Utah 2013, Chapter 341
118 31A-25-208, as last amended by Laws of Utah 2011, Chapter 284
119 31A-25-209, as last amended by Laws of Utah 2008, Chapter 382
120 31A-26-102, as last amended by Laws of Utah 2012, Chapter 151

121 **31A-26-206**, as last amended by Laws of Utah 2011, Chapter 284
122 **31A-26-207**, as last amended by Laws of Utah 2001, Chapter 116
123 **31A-26-213**, as last amended by Laws of Utah 2011, Chapter 284
124 **31A-26-214**, as last amended by Laws of Utah 2008, Chapter 382
125 **31A-26-214.5**, as last amended by Laws of Utah 2009, Chapter 349
126 **31A-27a-102**, as last amended by Laws of Utah 2008, Chapter 382
127 **31A-27a-107**, as enacted by Laws of Utah 2007, Chapter 309
128 **31A-27a-201**, as enacted by Laws of Utah 2007, Chapter 309
129 **31A-27a-701**, as last amended by Laws of Utah 2011, Chapter 297
130 **31A-29-106**, as last amended by Laws of Utah 2013, Chapter 319
131 **31A-29-111**, as last amended by Laws of Utah 2012, Chapters 158 and 347
132 **31A-29-115**, as last amended by Laws of Utah 2004, Chapter 2
133 **31A-30-102**, as last amended by Laws of Utah 2009, Chapter 12
134 **31A-30-103**, as last amended by Laws of Utah 2013, Chapter 168
135 **31A-30-104**, as last amended by Laws of Utah 2013, Chapters 168 and 341
136 **31A-30-106**, as last amended by Laws of Utah 2011, Chapter 284
137 **31A-30-106.7**, as last amended by Laws of Utah 2008, Chapter 382
138 **31A-30-107**, as last amended by Laws of Utah 2009, Chapter 12
139 **31A-30-107.5**, as last amended by Laws of Utah 2011, Chapter 297
140 **31A-30-108**, as last amended by Laws of Utah 2011, Chapter 284
141 **31A-30-207**, as last amended by Laws of Utah 2011, Second Special Session, Chapter 5
142 **31A-30-209**, as last amended by Laws of Utah 2011, Chapter 400
143 **31A-30-211**, as last amended by Laws of Utah 2011, Second Special Session, Chapter 5
144 **31A-37-501**, as last amended by Laws of Utah 2008, Chapter 302
145 **31A-40-203**, as enacted by Laws of Utah 2008, Chapter 318
146 **31A-40-209**, as enacted by Laws of Utah 2008, Chapter 318
147 **31A-42-202**, as last amended by Laws of Utah 2011, Chapter 400
148 **31A-43-102**, as enacted by Laws of Utah 2013, Chapter 341
149 **31A-43-301**, as enacted by Laws of Utah 2013, Chapter 341
150 **31A-43-302**, as enacted by Laws of Utah 2013, Chapter 341
151 **31A-43-303**, as enacted by Laws of Utah 2013, Chapter 341

152 **31A-43-304**, as enacted by Laws of Utah 2013, Chapter 341
153 **53-13-103**, as last amended by Laws of Utah 2011, Chapter 58
154 REPEALS:
155 **31A-30-110**, as last amended by Laws of Utah 2011, Chapters 284 and 297
156 **31A-30-111**, as last amended by Laws of Utah 2002, Chapter 308
157

158 *Be it enacted by the Legislature of the state of Utah:*
159 Section 1. Section **31A-1-301** is amended to read:
160 **31A-1-301. Definitions.**
161 As used in this title, unless otherwise specified:
162 (1) (a) "Accident and health insurance" means insurance to provide protection against
163 economic losses resulting from:
164 (i) a medical condition including:
165 (A) a medical care expense; or
166 (B) the risk of disability;
167 (ii) accident; or
168 (iii) sickness.
169 (b) "Accident and health insurance":
170 (i) includes a contract with disability contingencies including:
171 (A) an income replacement contract;
172 (B) a health care contract;
173 (C) an expense reimbursement contract;
174 (D) a credit accident and health contract;
175 (E) a continuing care contract; and
176 (F) a long-term care contract; and
177 (ii) may provide:
178 (A) hospital coverage;
179 (B) surgical coverage;
180 (C) medical coverage;
181 (D) loss of income coverage;
182 (E) prescription drug coverage;

183 (F) dental coverage; or
184 (G) vision coverage.
185 (c) "Accident and health insurance" does not include workers' compensation insurance.
186 (2) "Actuary" is as defined by the commissioner by rule, made in accordance with Title
187 63G, Chapter 3, Utah Administrative Rulemaking Act.
188 (3) "Administrator" is defined in Subsection [~~(163)~~] (164).
189 (4) "Adult" means an individual who has attained the age of at least 18 years.
190 (5) "Affiliate" means a person who controls, is controlled by, or is under common
191 control with, another person. A corporation is an affiliate of another corporation, regardless of
192 ownership, if substantially the same group of individuals manage the corporations.
193 (6) "Agency" means:
194 (a) a person other than an individual, including a sole proprietorship by which an
195 individual does business under an assumed name; and
196 (b) an insurance organization licensed or required to be licensed under Section
197 31A-23a-301, 31A-25-207, or 31A-26-209.
198 (7) "Alien insurer" means an insurer domiciled outside the United States.
199 (8) "Amendment" means an endorsement to an insurance policy or certificate.
200 (9) "Annuity" means an agreement to make periodical payments for a period certain or
201 over the lifetime of one or more individuals if the making or continuance of all or some of the
202 series of the payments, or the amount of the payment, is dependent upon the continuance of
203 human life.
204 (10) "Application" means a document:
205 (a) (i) completed by an applicant to provide information about the risk to be insured;
206 and
207 (ii) that contains information that is used by the insurer to evaluate risk and decide
208 whether to:
209 (A) insure the risk under:
210 (I) the coverage as originally offered; or
211 (II) a modification of the coverage as originally offered; or
212 (B) decline to insure the risk; or
213 (b) used by the insurer to gather information from the applicant before issuance of an

214 annuity contract.
215 (11) "Articles" or "articles of incorporation" means:
216 (a) the original articles;
217 (b) a special law;
218 (c) a charter;
219 (d) an amendment;
220 (e) restated articles;
221 (f) articles of merger or consolidation;
222 (g) a trust instrument;
223 (h) another constitutive document for a trust or other entity that is not a corporation;
224 and
225 (i) an amendment to an item listed in Subsections (11)(a) through (h).
226 (12) "Bail bond insurance" means a guarantee that a person will attend court when
227 required, up to and including surrender of the person in execution of a sentence imposed under
228 Subsection 77-20-7(1), as a condition to the release of that person from confinement.
229 (13) "Binder" is defined in Section 31A-21-102.
230 (14) "Blanket insurance policy" means a group policy covering a defined class of
231 persons:
232 (a) without individual underwriting or application; and
233 (b) that is determined by definition without designating each person covered.
234 (15) "Board," "board of trustees," or "board of directors" means the group of persons
235 with responsibility over, or management of, a corporation, however designated.
236 (16) "Bona fide office" means a physical office in this state:
237 (a) that is open to the public;
238 (b) that is staffed during regular business hours on regular business days; and
239 (c) at which the public may appear in person to obtain services.
240 (17) "Business entity" means:
241 (a) a corporation;
242 (b) an association;
243 (c) a partnership;
244 (d) a limited liability company;

245 (e) a limited liability partnership; or
246 (f) another legal entity.
247 (18) "Business of insurance" is defined in Subsection (88).
248 (19) "Business plan" means the information required to be supplied to the
249 commissioner under Subsections 31A-5-204(2)(i) and (j), including the information required
250 when these subsections apply by reference under:
251 (a) Section 31A-7-201;
252 (b) Section 31A-8-205; or
253 (c) Subsection 31A-9-205(2).
254 (20) (a) "Bylaws" means the rules adopted for the regulation or management of a
255 corporation's affairs, however designated.
256 (b) "Bylaws" includes comparable rules for a trust or other entity that is not a
257 corporation.
258 (21) "Captive insurance company" means:
259 (a) an insurer:
260 (i) owned by another organization; and
261 (ii) whose exclusive purpose is to insure risks of the parent organization and an
262 affiliated company; or
263 (b) in the case of a group or association, an insurer:
264 (i) owned by the insureds; and
265 (ii) whose exclusive purpose is to insure risks of:
266 (A) a member organization;
267 (B) a group member; or
268 (C) an affiliate of:
269 (I) a member organization; or
270 (II) a group member.
271 (22) "Casualty insurance" means liability insurance.
272 (23) "Certificate" means evidence of insurance given to:
273 (a) an insured under a group insurance policy; or
274 (b) a third party.
275 (24) "Certificate of authority" is included within the term "license."

276 (25) "Claim," unless the context otherwise requires, means a request or demand on an
277 insurer for payment of a benefit according to the terms of an insurance policy.
278 (26) "Claims-made coverage" means an insurance contract or provision limiting
279 coverage under a policy insuring against legal liability to claims that are first made against the
280 insured while the policy is in force.
281 (27) (a) "Commissioner" or "commissioner of insurance" means Utah's insurance
282 commissioner.
283 (b) When appropriate, the terms listed in Subsection (27)(a) apply to the equivalent
284 supervisory official of another jurisdiction.
285 (28) (a) "Continuing care insurance" means insurance that:
286 (i) provides board and lodging;
287 (ii) provides one or more of the following:
288 (A) a personal service;
289 (B) a nursing service;
290 (C) a medical service; or
291 (D) any other health-related service; and
292 (iii) provides the coverage described in this Subsection (28)(a) under an agreement
293 effective:
294 (A) for the life of the insured; or
295 (B) for a period in excess of one year.
296 (b) Insurance is continuing care insurance regardless of whether or not the board and
297 lodging are provided at the same location as a service described in Subsection (28)(a)(ii).
298 (29) (a) "Control," "controlling," "controlled," or "under common control" means the
299 direct or indirect possession of the power to direct or cause the direction of the management
300 and policies of a person. This control may be:
301 (i) by contract;
302 (ii) by common management;
303 (iii) through the ownership of voting securities; or
304 (iv) by a means other than those described in Subsections (29)(a)(i) through (iii).
305 (b) There is no presumption that an individual holding an official position with another
306 person controls that person solely by reason of the position.

307 (c) A person having a contract or arrangement giving control is considered to have
308 control despite the illegality or invalidity of the contract or arrangement.
309 (d) There is a rebuttable presumption of control in a person who directly or indirectly
310 owns, controls, holds with the power to vote, or holds proxies to vote 10% or more of the
311 voting securities of another person.
312 (30) "Controlled insurer" means a licensed insurer that is either directly or indirectly
313 controlled by a producer.
314 (31) "Controlling person" means a person that directly or indirectly has the power to
315 direct or cause to be directed, the management, control, or activities of a reinsurance
316 intermediary.
317 (32) "Controlling producer" means a producer who directly or indirectly controls an
318 insurer.
319 (33) (a) "Corporation" means an insurance corporation, except when referring to:
320 (i) a corporation doing business:
321 (A) as:
322 (I) an insurance producer;
323 (II) a surplus lines producer;
324 (III) a limited line producer;
325 (IV) a consultant;
326 (V) a managing general agent;
327 (VI) a reinsurance intermediary;
328 (VII) a third party administrator; or
329 (VIII) an adjuster; and
330 (B) under:
331 (I) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and
332 Reinsurance Intermediaries;
333 (II) Chapter 25, Third Party Administrators; or
334 (III) Chapter 26, Insurance Adjusters; or
335 (ii) a noninsurer that is part of a holding company system under Chapter 16, Insurance
336 Holding Companies.
337 (b) "Stock corporation" means a stock insurance corporation.

338 (c) "Mutual" or "mutual corporation" means a mutual insurance corporation.
339 (34) (a) "Creditable coverage" has the same meaning as provided in federal regulations
340 adopted pursuant to the Health Insurance Portability and Accountability Act.
341 (b) "Creditable coverage" includes coverage that is offered through a public health plan
342 such as:
343 (i) the Primary Care Network Program under a Medicaid primary care network
344 demonstration waiver obtained subject to Section 26-18-3;
345 (ii) the Children's Health Insurance Program under Section 26-40-106; or
346 (iii) the Ryan White Program Comprehensive AIDS Resources Emergency Act, Pub. L.
347 101-381, and Ryan White HIV/AIDS Treatment Modernization Act of 2006, Pub. L. 109-415.
348 (35) "Credit accident and health insurance" means insurance on a debtor to provide
349 indemnity for payments coming due on a specific loan or other credit transaction while the
350 debtor has a disability.
351 (36) (a) "Credit insurance" means insurance offered in connection with an extension of
352 credit that is limited to partially or wholly extinguishing that credit obligation.
353 (b) "Credit insurance" includes:
354 (i) credit accident and health insurance;
355 (ii) credit life insurance;
356 (iii) credit property insurance;
357 (iv) credit unemployment insurance;
358 (v) guaranteed automobile protection insurance;
359 (vi) involuntary unemployment insurance;
360 (vii) mortgage accident and health insurance;
361 (viii) mortgage guaranty insurance; and
362 (ix) mortgage life insurance.
363 (37) "Credit life insurance" means insurance on the life of a debtor in connection with
364 an extension of credit that pays a person if the debtor dies.
365 (38) "Credit property insurance" means insurance:
366 (a) offered in connection with an extension of credit; and
367 (b) that protects the property until the debt is paid.
368 (39) "Credit unemployment insurance" means insurance:

369 (a) offered in connection with an extension of credit; and
370 (b) that provides indemnity if the debtor is unemployed for payments coming due on a:
371 (i) specific loan; or
372 (ii) credit transaction.
373 (40) "Creditor" means a person, including an insured, having a claim, whether:
374 (a) matured;
375 (b) unmatured;
376 (c) liquidated;
377 (d) unliquidated;
378 (e) secured;
379 (f) unsecured;
380 (g) absolute;
381 (h) fixed; or
382 (i) contingent.
383 (41) (a) "Crop insurance" means insurance providing protection against damage to
384 crops from unfavorable weather conditions, fire or lightning, flood, hail, insect infestation,
385 disease, or other yield-reducing conditions or perils that is:
386 (i) provided by the private insurance market; or
387 (ii) subsidized by the Federal Crop Insurance Corporation.
388 (b) "Crop insurance" includes multiperil crop insurance.
389 (42) (a) "Customer service representative" means a person that provides an insurance
390 service and insurance product information:
391 (i) for the customer service representative's:
392 (A) producer;
393 (B) surplus lines producer; or
394 (C) consultant employer; and
395 (ii) to the customer service representative's employer's:
396 (A) customer;
397 (B) client; or
398 (C) organization.
399 (b) A customer service representative may only operate within the scope of authority of

400 the customer service representative's producer, surplus lines producer, or consultant employer.
401 (43) "Deadline" means a final date or time:
402 (a) imposed by:
403 (i) statute;
404 (ii) rule; or
405 (iii) order; and
406 (b) by which a required filing or payment must be received by the department.
407 (44) "Deemer clause" means a provision under this title under which upon the
408 occurrence of a condition precedent, the commissioner is considered to have taken a specific
409 action. If the statute so provides, a condition precedent may be the commissioner's failure to
410 take a specific action.
411 (45) "Degree of relationship" means the number of steps between two persons
412 determined by counting the generations separating one person from a common ancestor and
413 then counting the generations to the other person.
414 (46) "Department" means the Insurance Department.
415 (47) "Director" means a member of the board of directors of a corporation.
416 (48) "Disability" means a physiological or psychological condition that partially or
417 totally limits an individual's ability to:
418 (a) perform the duties of:
419 (i) that individual's occupation; or
420 (ii) [~~any~~] an occupation for which the individual is reasonably suited by education,
421 training, or experience; or
422 (b) perform two or more of the following basic activities of daily living:
423 (i) eating;
424 (ii) toileting;
425 (iii) transferring;
426 (iv) bathing; or
427 (v) dressing.
428 (49) "Disability income insurance" is defined in Subsection (79).
429 (50) "Domestic insurer" means an insurer organized under the laws of this state.
430 (51) "Domiciliary state" means the state in which an insurer:

431 (a) is incorporated;
432 (b) is organized; or
433 (c) in the case of an alien insurer, enters into the United States.
434 (52) (a) "Eligible employee" means:
435 (i) an employee who:
436 (A) works on a full-time basis; and
437 (B) has a normal work week of 30 or more hours; or
438 (ii) a person described in Subsection (52)(b).
439 (b) "Eligible employee" includes, if the individual is included under a health benefit
440 plan of a small employer:
441 (i) a sole proprietor;
442 (ii) a partner in a partnership; or
443 (iii) an independent contractor.
444 (c) "Eligible employee" does not include, unless eligible under Subsection (52)(b):
445 (i) an individual who works on a temporary or substitute basis for a small employer;
446 (ii) an employer's spouse; or
447 (iii) a dependent of an employer.
448 (53) "Employee" means an individual employed by an employer.
449 (54) "Employee benefits" means one or more benefits or services provided to:
450 (a) an employee; or
451 (b) a dependent of an employee.
452 (55) (a) "Employee welfare fund" means a fund:
453 (i) established or maintained, whether directly or through a trustee, by:
454 (A) one or more employers;
455 (B) one or more labor organizations; or
456 (C) a combination of employers and labor organizations; and
457 (ii) that provides employee benefits paid or contracted to be paid, other than income
458 from investments of the fund:
459 (A) by or on behalf of an employer doing business in this state; or
460 (B) for the benefit of a person employed in this state.
461 (b) "Employee welfare fund" includes a plan funded or subsidized by a user fee or tax

462 revenues.

463 (56) "Endorsement" means a written agreement attached to a policy or certificate to

464 modify the policy or certificate coverage.

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

466 (a) the first day of coverage; or

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

468 (58) (a) "Escrow" means:

469 (i) a transaction that effects the sale, transfer, encumbering, or leasing of real property,

470 when a person not a party to the transaction, and neither having nor acquiring an interest in the

471 title, performs, in accordance with the written instructions or terms of the written agreement

472 between the parties to the transaction, any of the following actions:

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

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

475 (ii) a settlement or closing involving:

476 (A) a mobile home;

477 (B) a grazing right;

478 (C) a water right; or

479 (D) other personal property authorized by the commissioner.

480 (b) "Escrow" does not include:

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

482 (A) an acknowledgment;

483 (B) a copy certification;

484 (C) jurat; and

485 (D) an oath or affirmation;

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

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

488 (59) "Escrow agent" means an agency title insurance producer meeting the

489 requirements of Sections 31A-4-107, 31A-14-211, and 31A-23a-204, who is acting through an

490 individual title insurance producer licensed with an escrow subline of authority.

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

492 excluded.

493 (b) The items listed in a list using the term "excludes" are representative examples for
494 use in interpretation of this title.
495 (61) "Exclusion" means for the purposes of accident and health insurance that an
496 insurer does not provide insurance coverage, for whatever reason, for one of the following:
497 (a) a specific physical condition;
498 (b) a specific medical procedure;
499 (c) a specific disease or disorder; or
500 (d) a specific prescription drug or class of prescription drugs.
501 (62) "Expense reimbursement insurance" means insurance:
502 (a) written to provide a payment for an expense relating to hospital confinement
503 resulting from illness or injury; and
504 (b) written:
505 (i) as a daily limit for a specific number of days in a hospital; and
506 (ii) to have a one or two day waiting period following a hospitalization.
507 (63) "Fidelity insurance" means insurance guaranteeing the fidelity of a person holding
508 a position of public or private trust.
509 (64) (a) "Filed" means that a filing is:
510 (i) submitted to the department as required by and in accordance with applicable
511 statute, rule, or filing order;
512 (ii) received by the department within the time period provided in applicable statute,
513 rule, or filing order; and
514 (iii) accompanied by the appropriate fee in accordance with:
515 (A) Section 31A-3-103; or
516 (B) rule.
517 (b) "Filed" does not include a filing that is rejected by the department because it is not
518 submitted in accordance with Subsection (64)(a).
519 (65) "Filing," when used as a noun, means an item required to be filed with the
520 department including:
521 (a) a policy;
522 (b) a rate;
523 (c) a form;

524 (d) a document;
525 (e) a plan;
526 (f) a manual;
527 (g) an application;
528 (h) a report;
529 (i) a certificate;
530 (j) an endorsement;
531 (k) an actuarial certification;
532 (l) a licensee annual statement;
533 (m) a licensee renewal application;
534 (n) an advertisement; or
535 (o) an outline of coverage.
536 (66) "First party insurance" means an insurance policy or contract in which the insurer
537 agrees to pay a claim submitted to it by the insured for the insured's losses.
538 (67) "Foreign insurer" means an insurer domiciled outside of this state, including an
539 alien insurer.
540 (68) (a) "Form" means one of the following prepared for general use:
541 (i) a policy;
542 (ii) a certificate;
543 (iii) an application;
544 (iv) an outline of coverage; or
545 (v) an endorsement.
546 (b) "Form" does not include a document specially prepared for use in an individual
547 case.
548 (69) "Franchise insurance" means an individual insurance policy provided through a
549 mass marketing arrangement involving a defined class of persons related in some way other
550 than through the purchase of insurance.
551 (70) "General lines of authority" include:
552 (a) the general lines of insurance in Subsection (71);
553 (b) title insurance under one of the following sublines of authority:
554 (i) search, including authority to act as a title marketing representative;

555 (ii) escrow, including authority to act as a title marketing representative; and
556 (iii) title marketing representative only;
557 (c) surplus lines;
558 (d) workers' compensation; and
559 (e) [~~any other~~] another line of insurance that the commissioner considers necessary to
560 recognize in the public interest.
561 (71) "General lines of insurance" include:
562 (a) accident and health;
563 (b) casualty;
564 (c) life;
565 (d) personal lines;
566 (e) property; and
567 (f) variable contracts, including variable life and annuity.
568 (72) "Group health plan" means an employee welfare benefit plan to the extent that the
569 plan provides medical care:
570 (a) (i) to an employee; or
571 (ii) to a dependent of an employee; and
572 (b) (i) directly;
573 (ii) through insurance reimbursement; or
574 (iii) through another method.
575 (73) (a) "Group insurance policy" means a policy covering a group of persons that is
576 issued:
577 (i) to a policyholder on behalf of the group; and
578 (ii) for the benefit of a member of the group who is selected under a procedure defined
579 in:
580 (A) the policy; or
581 (B) an agreement that is collateral to the policy.
582 (b) A group insurance policy may include a member of the policyholder's family or a
583 dependent.
584 (74) "Guaranteed automobile protection insurance" means insurance offered in
585 connection with an extension of credit that pays the difference in amount between the

586 insurance settlement and the balance of the loan if the insured automobile is a total loss.
587 (75) (a) Except as provided in Subsection (75)(b), "health benefit plan" means a policy
588 or certificate that:
589 (i) provides health care insurance;
590 (ii) provides major medical expense insurance; or
591 (iii) is offered as a substitute for hospital or medical expense insurance, such as:
592 (A) a hospital confinement indemnity; or
593 (B) a limited benefit plan.
594 (b) "Health benefit plan" does not include a policy or certificate that:
595 (i) provides benefits solely for:
596 (A) accident;
597 (B) dental;
598 (C) income replacement;
599 (D) long-term care;
600 (E) a Medicare supplement;
601 (F) a specified disease;
602 (G) vision; or
603 (H) a short-term limited duration; or
604 (ii) is offered and marketed as supplemental health insurance.
605 (76) "Health care" means any of the following intended for use in the diagnosis,
606 treatment, mitigation, or prevention of a human ailment or impairment:
607 (a) a professional service;
608 (b) a personal service;
609 (c) a facility;
610 (d) equipment;
611 (e) a device;
612 (f) supplies; or
613 (g) medicine.
614 (77) (a) "Health care insurance" or "health insurance" means insurance providing:
615 (i) a health care benefit; or
616 (ii) payment of an incurred health care expense.

617 (b) "Health care insurance" or "health insurance" does not include accident and health
618 insurance providing a benefit for:
619 (i) replacement of income;
620 (ii) short-term accident;
621 (iii) fixed indemnity;
622 (iv) credit accident and health;
623 (v) supplements to liability;
624 (vi) workers' compensation;
625 (vii) automobile medical payment;
626 (viii) no-fault automobile;
627 (ix) equivalent self-insurance; or
628 (x) a type of accident and health insurance coverage that is a part of or attached to
629 another type of policy.
630 (78) "Health Insurance Portability and Accountability Act" means the Health Insurance
631 Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936, as amended.
632 (79) "Income replacement insurance" or "disability income insurance" means insurance
633 written to provide payments to replace income lost from accident or sickness.
634 (80) "Indemnity" means the payment of an amount to offset all or part of an insured
635 loss.
636 (81) "Independent adjuster" means an insurance adjuster required to be licensed under
637 Section 31A-26-201 who engages in insurance adjusting as a representative of an insurer.
638 (82) "Independently procured insurance" means insurance procured under Section
639 31A-15-104.
640 (83) "Individual" means a natural person.
641 (84) "Inland marine insurance" includes insurance covering:
642 (a) property in transit on or over land;
643 (b) property in transit over water by means other than boat or ship;
644 (c) bailee liability;
645 (d) fixed transportation property such as bridges, electric transmission systems, radio
646 and television transmission towers and tunnels; and
647 (e) personal and commercial property floaters.

648 (85) "Insolvency" means that:
649 (a) an insurer is unable to pay its debts or meet its obligations as the debts and
650 obligations mature;
651 (b) an insurer's total adjusted capital is less than the insurer's mandatory control level
652 RBC under Subsection 31A-17-601(8)(c); or
653 (c) an insurer is determined to be hazardous under this title.
654 (86) (a) "Insurance" means:
655 (i) an arrangement, contract, or plan for the transfer of a risk or risks from one or more
656 persons to one or more other persons; or
657 (ii) an arrangement, contract, or plan for the distribution of a risk or risks among a
658 group of persons that includes the person seeking to distribute that person's risk.
659 (b) "Insurance" includes:
660 (i) a risk distributing arrangement providing for compensation or replacement for
661 damages or loss through the provision of a service or a benefit in kind;
662 (ii) a contract of guaranty or suretyship entered into by the guarantor or surety as a
663 business and not as merely incidental to a business transaction; and
664 (iii) a plan in which the risk does not rest upon the person who makes an arrangement,
665 but with a class of persons who have agreed to share the risk.
666 (87) "Insurance adjuster" means a person who directs or conducts the investigation,
667 negotiation, or settlement of a claim under an insurance policy other than life insurance or an
668 annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.
669 (88) "Insurance business" or "business of insurance" includes:
670 (a) providing health care insurance by an organization that is or is required to be
671 licensed under this title;
672 (b) providing a benefit to an employee in the event of a contingency not within the
673 control of the employee, in which the employee is entitled to the benefit as a right, which
674 benefit may be provided either:
675 (i) by a single employer or by multiple employer groups; or
676 (ii) through one or more trusts, associations, or other entities;
677 (c) providing an annuity:
678 (i) including an annuity issued in return for a gift; and

679 (ii) except an annuity provided by a person specified in Subsections 31A-22-1305(2)
680 and (3);
681 (d) providing the characteristic services of a motor club as outlined in Subsection
682 (116);
683 (e) providing another person with insurance;
684 (f) making as insurer, guarantor, or surety, or proposing to make as insurer, guarantor,
685 or surety, a contract or policy of title insurance;
686 (g) transacting or proposing to transact any phase of title insurance, including:
687 (i) solicitation;
688 (ii) negotiation preliminary to execution;
689 (iii) execution of a contract of title insurance;
690 (iv) insuring; and
691 (v) transacting matters subsequent to the execution of the contract and arising out of
692 the contract, including reinsurance;
693 (h) transacting or proposing a life settlement; and
694 (i) doing, or proposing to do, any business in substance equivalent to Subsections
695 (88)(a) through (h) in a manner designed to evade this title.
696 (89) "Insurance consultant" or "consultant" means a person who:
697 (a) advises another person about insurance needs and coverages;
698 (b) is compensated by the person advised on a basis not directly related to the insurance
699 placed; and
700 (c) except as provided in Section 31A-23a-501, is not compensated directly or
701 indirectly by an insurer or producer for advice given.
702 (90) "Insurance holding company system" means a group of two or more affiliated
703 persons, at least one of whom is an insurer.
704 (91) (a) "Insurance producer" or "producer" means a person licensed or required to be
705 licensed under the laws of this state to sell, solicit, or negotiate insurance.
706 (b) (i) "Producer for the insurer" means a producer who is compensated directly or
707 indirectly by an insurer for selling, soliciting, or negotiating an insurance product of that
708 insurer.
709 (ii) "Producer for the insurer" may be referred to as an "agent."

710 (c) (i) "Producer for the insured" means a producer who:
711 (A) is compensated directly and only by an insurance customer or an insured; and
712 (B) receives no compensation directly or indirectly from an insurer for selling,
713 soliciting, or negotiating an insurance product of that insurer to an insurance customer or
714 insured.
715 (ii) "Producer for the insured" may be referred to as a "broker."
716 (92) (a) "Insured" means a person to whom or for whose benefit an insurer makes a
717 promise in an insurance policy and includes:
718 (i) a policyholder;
719 (ii) a subscriber;
720 (iii) a member; and
721 (iv) a beneficiary.
722 (b) The definition in Subsection (92)(a):
723 (i) applies only to this title; and
724 (ii) does not define the meaning of this word as used in an insurance policy or
725 certificate.
726 (93) (a) "Insurer" means a person doing an insurance business as a principal including:
727 (i) a fraternal benefit society;
728 (ii) an issuer of a gift annuity other than an annuity specified in Subsections
729 31A-22-1305(2) and (3);
730 (iii) a motor club;
731 (iv) an employee welfare plan; and
732 (v) a person purporting or intending to do an insurance business as a principal on that
733 person's own account.
734 (b) "Insurer" does not include a governmental entity to the extent the governmental
735 entity is engaged in an activity described in Section 31A-12-107.
736 (94) "Interinsurance exchange" is defined in Subsection [~~(146)~~] (147).
737 (95) "Involuntary unemployment insurance" means insurance:
738 (a) offered in connection with an extension of credit; and
739 (b) that provides indemnity if the debtor is involuntarily unemployed for payments
740 coming due on a:

741 (i) specific loan; or
742 (ii) credit transaction.
743 (96) "Large employer," in connection with a health benefit plan, means an employer
744 who, with respect to a calendar year and to a plan year:
745 (a) employed an average of at least 51 eligible employees on each business day during
746 the preceding calendar year; and
747 (b) employs at least two employees on the first day of the plan year.
748 (97) "Late enrollee," with respect to an employer health benefit plan, means an
749 individual whose enrollment is a late enrollment.
750 (98) "Late enrollment," with respect to an employer health benefit plan, means
751 enrollment of an individual other than:
752 (a) on the earliest date on which coverage can become effective for the individual
753 under the terms of the plan; or
754 (b) through special enrollment.
755 (99) (a) Except for a retainer contract or legal assistance described in Section
756 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for a
757 specified legal expense.
758 (b) "Legal expense insurance" includes an arrangement that creates a reasonable
759 expectation of an enforceable right.
760 (c) "Legal expense insurance" does not include the provision of, or reimbursement for,
761 legal services incidental to other insurance coverage.
762 (100) (a) "Liability insurance" means insurance against liability:
763 (i) for death, injury, or disability of a human being, or for damage to property,
764 exclusive of the coverages under:
765 (A) Subsection (110) for medical malpractice insurance;
766 (B) Subsection (138) for professional liability insurance; and
767 (C) Subsection [~~(172)~~] (173) for workers' compensation insurance;
768 (ii) for a medical, hospital, surgical, and funeral benefit to a person other than the
769 insured who is injured, irrespective of legal liability of the insured, when issued with or
770 supplemental to insurance against legal liability for the death, injury, or disability of a human
771 being, exclusive of the coverages under:

772 (A) Subsection (110) for medical malpractice insurance;
773 (B) Subsection (138) for professional liability insurance; and
774 (C) Subsection [(172)] (173) for workers' compensation insurance;
775 (iii) for loss or damage to property resulting from an accident to or explosion of a
776 boiler, pipe, pressure container, machinery, or apparatus;
777 (iv) for loss or damage to property caused by:
778 (A) the breakage or leakage of a sprinkler, water pipe, or water container; or
779 (B) water entering through a leak or opening in a building; or
780 (v) for other loss or damage properly the subject of insurance not within another kind
781 of insurance as defined in this chapter, if the insurance is not contrary to law or public policy.
782 (b) "Liability insurance" includes:
783 (i) vehicle liability insurance;
784 (ii) residential dwelling liability insurance; and
785 (iii) making inspection of, and issuing a certificate of inspection upon, an elevator,
786 boiler, machinery, or apparatus of any kind when done in connection with insurance on the
787 elevator, boiler, machinery, or apparatus.
788 (101) (a) "License" means authorization issued by the commissioner to engage in an
789 activity that is part of or related to the insurance business.
790 (b) "License" includes a certificate of authority issued to an insurer.
791 (102) (a) "Life insurance" means:
792 (i) insurance on a human life; and
793 (ii) insurance pertaining to or connected with human life.
794 (b) The business of life insurance includes:
795 (i) granting a death benefit;
796 (ii) granting an annuity benefit;
797 (iii) granting an endowment benefit;
798 (iv) granting an additional benefit in the event of death by accident;
799 (v) granting an additional benefit to safeguard the policy against lapse; and
800 (vi) providing an optional method of settlement of proceeds.
801 (103) "Limited license" means a license that:
802 (a) is issued for a specific product of insurance; and

803 (b) limits an individual or agency to transact only for that product or insurance.
804 (104) "Limited line credit insurance" includes the following forms of insurance:
805 (a) credit life;
806 (b) credit accident and health;
807 (c) credit property;
808 (d) credit unemployment;
809 (e) involuntary unemployment;
810 (f) mortgage life;
811 (g) mortgage guaranty;
812 (h) mortgage accident and health;
813 (i) guaranteed automobile protection; and
814 (j) another form of insurance offered in connection with an extension of credit that:
815 (i) is limited to partially or wholly extinguishing the credit obligation; and
816 (ii) the commissioner determines by rule should be designated as a form of limited line
817 credit insurance.
818 (105) "Limited line credit insurance producer" means a person who sells, solicits, or
819 negotiates one or more forms of limited line credit insurance coverage to an individual through
820 a master, corporate, group, or individual policy.
821 (106) "Limited line insurance" includes:
822 (a) bail bond;
823 (b) limited line credit insurance;
824 (c) legal expense insurance;
825 (d) motor club insurance;
826 (e) car rental related insurance;
827 (f) travel insurance;
828 (g) crop insurance;
829 (h) self-service storage insurance;
830 (i) guaranteed asset protection waiver;
831 (j) portable electronics insurance; and
832 (k) another form of limited insurance that the commissioner determines by rule should
833 be designated a form of limited line insurance.

834 (107) "Limited lines authority" includes[~~: (a)~~] the lines of insurance listed in
835 Subsection (106)[~~; and~~].
836 [~~(b) a customer service representative.~~]
837 (108) "Limited lines producer" means a person who sells, solicits, or negotiates limited
838 lines insurance.
839 (109) (a) "Long-term care insurance" means an insurance policy or rider advertised,
840 marketed, offered, or designated to provide coverage:
841 (i) in a setting other than an acute care unit of a hospital;
842 (ii) for not less than 12 consecutive months for a covered person on the basis of:
843 (A) expenses incurred;
844 (B) indemnity;
845 (C) prepayment; or
846 (D) another method;
847 (iii) for one or more necessary or medically necessary services that are:
848 (A) diagnostic;
849 (B) preventative;
850 (C) therapeutic;
851 (D) rehabilitative;
852 (E) maintenance; or
853 (F) personal care; and
854 (iv) that may be issued by:
855 (A) an insurer;
856 (B) a fraternal benefit society;
857 (C) (I) a nonprofit health hospital; and
858 (II) a medical service corporation;
859 (D) a prepaid health plan;
860 (E) a health maintenance organization; or
861 (F) an entity similar to the entities described in Subsections (109)(a)(iv)(A) through (E)
862 to the extent that the entity is otherwise authorized to issue life or health care insurance.
863 (b) "Long-term care insurance" includes:
864 (i) any of the following that provide directly or supplement long-term care insurance:

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

896 corporation.
897 (112) "Minimum capital" or "minimum required capital" means the capital that must be
898 constantly maintained by a stock insurance corporation as required by statute.
899 (113) "Mortgage accident and health insurance" means insurance offered in connection
900 with an extension of credit that provides indemnity for payments coming due on a mortgage
901 while the debtor has a disability.
902 (114) "Mortgage guaranty insurance" means surety insurance under which a mortgagee
903 or other creditor is indemnified against losses caused by the default of a debtor.
904 (115) "Mortgage life insurance" means insurance on the life of a debtor in connection
905 with an extension of credit that pays if the debtor dies.
906 (116) "Motor club" means a person:
907 (a) licensed under:
908 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
909 (ii) Chapter 11, Motor Clubs; or
910 (iii) Chapter 14, Foreign Insurers; and
911 (b) that promises for an advance consideration to provide for a stated period of time
912 one or more:
913 (i) legal services under Subsection 31A-11-102(1)(b);
914 (ii) bail services under Subsection 31A-11-102(1)(c); or
915 (iii) (A) trip reimbursement;
916 (B) towing services;
917 (C) emergency road services;
918 (D) stolen automobile services;
919 (E) a combination of the services listed in Subsections (116)(b)(iii)(A) through (D); or
920 (F) other services given in Subsections 31A-11-102(1)(b) through (f).
921 (117) "Mutual" means a mutual insurance corporation.
922 (118) "Network plan" means health care insurance:
923 (a) that is issued by an insurer; and
924 (b) under which the financing and delivery of medical care is provided, in whole or in
925 part, through a defined set of providers under contract with the insurer, including the financing
926 and delivery of an item paid for as medical care.

927 (119) "Nonparticipating" means a plan of insurance under which the insured is not
928 entitled to receive a dividend representing a share of the surplus of the insurer.
929 (120) "Ocean marine insurance" means insurance against loss of or damage to:
930 (a) ships or hulls of ships;
931 (b) goods, freight, cargoes, merchandise, effects, disbursements, profits, money,
932 securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia
933 interests, or other cargoes in or awaiting transit over the oceans or inland waterways;
934 (c) earnings such as freight, passage money, commissions, or profits derived from
935 transporting goods or people upon or across the oceans or inland waterways; or
936 (d) a vessel owner or operator as a result of liability to employees, passengers, bailors,
937 owners of other vessels, owners of fixed objects, customs or other authorities, or other persons
938 in connection with maritime activity.
939 (121) "Order" means an order of the commissioner.
940 (122) "Outline of coverage" means a summary that explains an accident and health
941 insurance policy.
942 (123) "Participating" means a plan of insurance under which the insured is entitled to
943 receive a dividend representing a share of the surplus of the insurer.
944 (124) "Participation," as used in a health benefit plan, means a requirement relating to
945 the minimum percentage of eligible employees that must be enrolled in relation to the total
946 number of eligible employees of an employer reduced by each eligible employee who
947 voluntarily declines coverage under the plan because the employee:
948 (a) has other group health care insurance coverage; or
949 (b) receives:
950 (i) Medicare, under the Health Insurance for the Aged Act, Title XVIII of the Social
951 Security Amendments of 1965; or
952 (ii) another government health benefit.
953 (125) "Person" includes:
954 (a) an individual;
955 (b) a partnership;
956 (c) a corporation;
957 (d) an incorporated or unincorporated association;

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

989 (ii) a service contract provided under Chapter 6a, Service Contracts; and
990 (iii) a corporation licensed under:
991 (A) Chapter 7, Nonprofit Health Service Insurance Corporations; or
992 (B) Chapter 8, Health Maintenance Organizations and Limited Health Plans.
993 (c) "Policy" does not include:
994 (i) a certificate under a group insurance contract; or
995 (ii) a document that does not purport to have legal effect.
996 (130) "Policyholder" means a person who controls a policy, binder, or oral contract by
997 ownership, premium payment, or otherwise.
998 (131) "Policy illustration" means a presentation or depiction that includes
999 nonguaranteed elements of a policy of life insurance over a period of years.
1000 (132) "Policy summary" means a synopsis describing the elements of a life insurance
1001 policy.
1002 (133) "PPACA" means the Patient Protection and Affordable Care Act, Pub. L. No.
1003 111-148 and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, and
1004 related federal regulations and guidance.
1005 (134) "Preexisting condition," with respect to a health benefit plan:
1006 (a) means a condition that was present before the effective date of coverage, whether or
1007 not medical advice, diagnosis, care, or treatment was recommended or received before that day;
1008 and
1009 (b) does not include a condition indicated by genetic information unless an actual
1010 diagnosis of the condition by a physician has been made.
1011 (135) (a) "Premium" means the monetary consideration for an insurance policy.
1012 (b) "Premium" includes, however designated:
1013 (i) an assessment;
1014 (ii) a membership fee;
1015 (iii) a required contribution; or
1016 (iv) monetary consideration.
1017 (c) (i) "Premium" does not include consideration paid to a third party administrator for
1018 the third party administrator's services.
1019 (ii) "Premium" includes an amount paid by a third party administrator to an insurer for

1020 insurance on the risks administered by the third party administrator.
1021 (136) "Principal officers" for a corporation means the officers designated under
1022 Subsection 31A-5-203(3).
1023 (137) "Proceeding" includes an action or special statutory proceeding.
1024 (138) "Professional liability insurance" means insurance against legal liability incident
1025 to the practice of a profession and provision of a professional service.
1026 (139) (a) Except as provided in Subsection (139)(b), "property insurance" means
1027 insurance against loss or damage to real or personal property of every kind and any interest in
1028 that property:
1029 (i) from all hazards or causes; and
1030 (ii) against loss consequential upon the loss or damage including vehicle
1031 comprehensive and vehicle physical damage coverages.
1032 (b) "Property insurance" does not include:
1033 (i) inland marine insurance; and
1034 (ii) ocean marine insurance.
1035 (140) "Qualified long-term care insurance contract" or "federally tax qualified
1036 long-term care insurance contract" means:
1037 (a) an individual or group insurance contract that meets the requirements of Section
1038 7702B(b), Internal Revenue Code; or
1039 (b) the portion of a life insurance contract that provides long-term care insurance:
1040 (i) (A) by rider; or
1041 (B) as a part of the contract; and
1042 (ii) that satisfies the requirements of Sections 7702B(b) and (e), Internal Revenue
1043 Code.
1044 (141) "Qualified United States financial institution" means an institution that:
1045 (a) is:
1046 (i) organized under the laws of the United States or any state; or
1047 (ii) in the case of a United States office of a foreign banking organization, licensed
1048 under the laws of the United States or any state;
1049 (b) is regulated, supervised, and examined by a United States federal or state authority
1050 having regulatory authority over a bank or trust company; and

1051 (c) meets the standards of financial condition and standing that are considered
1052 necessary and appropriate to regulate the quality of a financial institution whose letters of credit
1053 will be acceptable to the commissioner as determined by:
1054 (i) the commissioner by rule; or
1055 (ii) the Securities Valuation Office of the National Association of Insurance
1056 Commissioners.
1057 (142) (a) "Rate" means:
1058 (i) the cost of a given unit of insurance; or
1059 (ii) for property or casualty insurance, that cost of insurance per exposure unit either
1060 expressed as:
1061 (A) a single number; or
1062 (B) a pure premium rate, adjusted before the application of individual risk variations
1063 based on loss or expense considerations to account for the treatment of:
1064 (I) expenses;
1065 (II) profit; and
1066 (III) individual insurer variation in loss experience.
1067 (b) "Rate" does not include a minimum premium.
1068 (143) (a) Except as provided in Subsection (143)(b), "rate service organization" means
1069 a person who assists an insurer in rate making or filing by:
1070 (i) collecting, compiling, and furnishing loss or expense statistics;
1071 (ii) recommending, making, or filing rates or supplementary rate information; or
1072 (iii) advising about rate questions, except as an attorney giving legal advice.
1073 (b) "Rate service organization" does not mean:
1074 (i) an employee of an insurer;
1075 (ii) a single insurer or group of insurers under common control;
1076 (iii) a joint underwriting group; or
1077 (iv) an individual serving as an actuarial or legal consultant.
1078 (144) "Rating manual" means any of the following used to determine initial and
1079 renewal policy premiums:
1080 (a) a manual of rates;
1081 (b) a classification;

1082 (c) a rate-related underwriting rule; and
1083 (d) a rating formula that describes steps, policies, and procedures for determining
1084 initial and renewal policy premiums.
1085 (145) "Rebate" means to refund or return a portion of the premium from the premium
1086 paid, commission paid, or consultant fee paid, directly or indirectly, on the sale or renewal of
1087 an insurance policy.
1088 [~~(145)~~] (146) "Received by the department" means:
1089 (a) the date delivered to and stamped received by the department, if delivered in
1090 person;
1091 (b) the post mark date, if delivered by mail;
1092 (c) the delivery service's post mark or pickup date, if delivered by a delivery service;
1093 (d) the received date recorded on an item delivered, if delivered by:
1094 (i) facsimile;
1095 (ii) email; or
1096 (iii) another electronic method; or
1097 (e) a date specified in:
1098 (i) a statute;
1099 (ii) a rule; or
1100 (iii) an order.
1101 [~~(146)~~] (147) "Reciprocal" or "interinsurance exchange" means an unincorporated
1102 association of persons:
1103 (a) operating through an attorney-in-fact common to all of the persons; and
1104 (b) exchanging insurance contracts with one another that provide insurance coverage
1105 on each other.
1106 [~~(147)~~] (148) "Reinsurance" means an insurance transaction where an insurer, for
1107 consideration, transfers any portion of the risk it has assumed to another insurer. In referring to
1108 reinsurance transactions, this title sometimes refers to:
1109 (a) the insurer transferring the risk as the "ceding insurer"; and
1110 (b) the insurer assuming the risk as the:
1111 (i) "assuming insurer"; or
1112 (ii) "assuming reinsurer."

1113 [~~(148)~~] (149) "Reinsurer" means a person licensed in this state as an insurer with the
1114 authority to assume reinsurance.
1115 [~~(149)~~] (150) "Residential dwelling liability insurance" means insurance against
1116 liability resulting from or incident to the ownership, maintenance, or use of a residential
1117 dwelling that is a detached single family residence or multifamily residence up to four units.
1118 [~~(150)~~] (151) (a) "Retrocession" means reinsurance with another insurer of a liability
1119 assumed under a reinsurance contract.
1120 (b) A reinsurer "retrocedes" when the reinsurer reinsures with another insurer part of a
1121 liability assumed under a reinsurance contract.
1122 [~~(151)~~] (152) "Rider" means an endorsement to:
1123 (a) an insurance policy; or
1124 (b) an insurance certificate.
1125 [~~(152)~~] (153) (a) "Security" means a:
1126 (i) note;
1127 (ii) stock;
1128 (iii) bond;
1129 (iv) debenture;
1130 (v) evidence of indebtedness;
1131 (vi) certificate of interest or participation in a profit-sharing agreement;
1132 (vii) collateral-trust certificate;
1133 (viii) preorganization certificate or subscription;
1134 (ix) transferable share;
1135 (x) investment contract;
1136 (xi) voting trust certificate;
1137 (xii) certificate of deposit for a security;
1138 (xiii) certificate of interest of participation in an oil, gas, or mining title or lease or in
1139 payments out of production under such a title or lease;
1140 (xiv) commodity contract or commodity option;
1141 (xv) certificate of interest or participation in, temporary or interim certificate for,
1142 receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed
1143 in Subsections [~~(152)~~] (153)(a)(i) through (xiv); or

1144 (xvi) another interest or instrument commonly known as a security.
1145 (b) "Security" does not include:
1146 (i) any of the following under which an insurance company promises to pay money in a
1147 specific lump sum or periodically for life or some other specified period:
1148 (A) insurance;
1149 (B) an endowment policy; or
1150 (C) an annuity contract; or
1151 (ii) a burial certificate or burial contract.
1152 [~~(153)~~] (154) "Secondary medical condition" means a complication related to an
1153 exclusion from coverage in accident and health insurance.
1154 [~~(154)~~] (155) (a) "Self-insurance" means an arrangement under which a person
1155 provides for spreading its own risks by a systematic plan.
1156 (b) Except as provided in this Subsection [~~(154)~~] (155), "self-insurance" does not
1157 include an arrangement under which a number of persons spread their risks among themselves.
1158 (c) "Self-insurance" includes:
1159 (i) an arrangement by which a governmental entity undertakes to indemnify an
1160 employee for liability arising out of the employee's employment; and
1161 (ii) an arrangement by which a person with a managed program of self-insurance and
1162 risk management undertakes to indemnify its affiliates, subsidiaries, directors, officers, or
1163 employees for liability or risk that is related to the relationship or employment.
1164 (d) "Self-insurance" does not include an arrangement with an independent contractor.
1165 [~~(155)~~] (156) "Sell" means to exchange a contract of insurance:
1166 (a) by any means;
1167 (b) for money or its equivalent; and
1168 (c) on behalf of an insurance company.
1169 [~~(156)~~] (157) "Short-term care insurance" means an insurance policy or rider
1170 advertised, marketed, offered, or designed to provide coverage that is similar to long-term care
1171 insurance, but that provides coverage for less than 12 consecutive months for each covered
1172 person.
1173 [~~(157)~~] (158) "Significant break in coverage" means a period of 63 consecutive days
1174 during each of which an individual does not have creditable coverage.

1175 [(158)] (159) "Small employer[,]" means, in connection with a health benefit plan[,
1176 means an employer who,] and with respect to a calendar year and to a plan year, an employer
1177 who:
1178 (a) employed [an average of] at least [two employees] one employee but not more than
1179 an average of 50 eligible employees on [each] business [day] days during the preceding
1180 calendar year; and
1181 (b) employs at least [two employees] one employee on the first day of the plan year.
1182 [(159)] (160) "Special enrollment period," in connection with a health benefit plan, has
1183 the same meaning as provided in federal regulations adopted pursuant to the Health Insurance
1184 Portability and Accountability Act.
1185 [(160)] (161) (a) "Subsidiary" of a person means an affiliate controlled by that person
1186 either directly or indirectly through one or more affiliates or intermediaries.
1187 (b) "Wholly owned subsidiary" of a person is a subsidiary of which all of the voting
1188 shares are owned by that person either alone or with its affiliates, except for the minimum
1189 number of shares the law of the subsidiary's domicile requires to be owned by directors or
1190 others.
1191 [(161)] (162) Subject to Subsection (86)(b), "surety insurance" includes:
1192 (a) a guarantee against loss or damage resulting from the failure of a principal to pay or
1193 perform the principal's obligations to a creditor or other obligee;
1194 (b) bail bond insurance; and
1195 (c) fidelity insurance.
1196 [(162)] (163) (a) "Surplus" means the excess of assets over the sum of paid-in capital
1197 and liabilities.
1198 (b) (i) "Permanent surplus" means the surplus of an insurer or organization that is
1199 designated by the insurer or organization as permanent.
1200 (ii) Sections 31A-5-211, 31A-7-201, 31A-8-209, 31A-9-209, and 31A-14-205 require
1201 that insurers or organizations doing business in this state maintain specified minimum levels of
1202 permanent surplus.
1203 (iii) Except for assessable mutuals, the minimum permanent surplus requirement is the
1204 same as the minimum required capital requirement that applies to stock insurers.
1205 (c) "Excess surplus" means:

1206 (i) for a life insurer, accident and health insurer, health organization, or property and
1207 casualty insurer as defined in Section 31A-17-601, the lesser of:
1208 (A) that amount of an insurer's or health organization's total adjusted capital that
1209 exceeds the product of:
1210 (I) 2.5; and
1211 (II) the sum of the insurer's or health organization's minimum capital or permanent
1212 surplus required under Section 31A-5-211, 31A-9-209, or 31A-14-205; or
1213 (B) that amount of an insurer's or health organization's total adjusted capital that
1214 exceeds the product of:
1215 (I) 3.0; and
1216 (II) the authorized control level RBC as defined in Subsection 31A-17-601(8)(a); and
1217 (ii) for a monoline mortgage guaranty insurer, financial guaranty insurer, or title insurer
1218 that amount of an insurer's paid-in-capital and surplus that exceeds the product of:
1219 (A) 1.5; and
1220 (B) the insurer's total adjusted capital required by Subsection 31A-17-609(1).
1221 [~~(163)~~] (164) "Third party administrator" or "administrator" means a person who
1222 collects charges or premiums from, or who, for consideration, adjusts or settles claims of
1223 residents of the state in connection with insurance coverage, annuities, or service insurance
1224 coverage, except:
1225 (a) a union on behalf of its members;
1226 (b) a person administering a:
1227 (i) pension plan subject to the federal Employee Retirement Income Security Act of
1228 1974;
1229 (ii) governmental plan as defined in Section 414(d), Internal Revenue Code; or
1230 (iii) nonelecting church plan as described in Section 410(d), Internal Revenue Code;
1231 (c) an employer on behalf of the employer's employees or the employees of one or
1232 more of the subsidiary or affiliated corporations of the employer;
1233 (d) an insurer licensed under the following, but only for a line of insurance for which
1234 the insurer holds a license in this state:
1235 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
1236 (ii) Chapter 7, Nonprofit Health Service Insurance Corporations;

1237 (iii) Chapter 8, Health Maintenance Organizations and Limited Health Plans;
1238 (iv) Chapter 9, Insurance Fraternals; or
1239 (v) Chapter 14, Foreign Insurers;
1240 (e) a person:
1241 (i) licensed or exempt from licensing under:
1242 (A) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and
1243 Reinsurance Intermediaries; or
1244 (B) Chapter 26, Insurance Adjusters; and
1245 (ii) whose activities are limited to those authorized under the license the person holds
1246 or for which the person is exempt; or
1247 (f) an institution, bank, or financial institution:
1248 (i) that is:
1249 (A) an institution whose deposits and accounts are to any extent insured by a federal
1250 deposit insurance agency, including the Federal Deposit Insurance Corporation or National
1251 Credit Union Administration; or
1252 (B) a bank or other financial institution that is subject to supervision or examination by
1253 a federal or state banking authority; and
1254 (ii) that does not adjust claims without a third party administrator license.
1255 [~~(164)~~] (165) "Title insurance" means the insuring, guaranteeing, or indemnifying of an
1256 owner of real or personal property or the holder of liens or encumbrances on that property, or
1257 others interested in the property against loss or damage suffered by reason of liens or
1258 encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity
1259 or unenforceability of any liens or encumbrances on the property.
1260 [~~(165)~~] (166) "Total adjusted capital" means the sum of an insurer's or health
1261 organization's statutory capital and surplus as determined in accordance with:
1262 (a) the statutory accounting applicable to the annual financial statements required to be
1263 filed under Section 31A-4-113; and
1264 (b) another item provided by the RBC instructions, as RBC instructions is defined in
1265 Section 31A-17-601.
1266 [~~(166)~~] (167) (a) "Trustee" means "director" when referring to the board of directors of
1267 a corporation.

1268 (b) "Trustee," when used in reference to an employee welfare fund, means an
1269 individual, firm, association, organization, joint stock company, or corporation, whether acting
1270 individually or jointly and whether designated by that name or any other, that is charged with
1271 or has the overall management of an employee welfare fund.
1272 [~~(167)~~] (168) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted
1273 insurer" means an insurer:
1274 (i) not holding a valid certificate of authority to do an insurance business in this state;
1275 or
1276 (ii) transacting business not authorized by a valid certificate.
1277 (b) "Admitted insurer" or "authorized insurer" means an insurer:
1278 (i) holding a valid certificate of authority to do an insurance business in this state; and
1279 (ii) transacting business as authorized by a valid certificate.
1280 [~~(168)~~] (169) "Underwrite" means the authority to accept or reject risk on behalf of the
1281 insurer.
1282 [~~(169)~~] (170) "Vehicle liability insurance" means insurance against liability resulting
1283 from or incident to ownership, maintenance, or use of a land vehicle or aircraft, exclusive of a
1284 vehicle comprehensive or vehicle physical damage coverage under Subsection (139).
1285 [~~(170)~~] (171) "Voting security" means a security with voting rights, and includes a
1286 security convertible into a security with a voting right associated with the security.
1287 [~~(171)~~] (172) "Waiting period" for a health benefit plan means the period that must
1288 pass before coverage for an individual, who is otherwise eligible to enroll under the terms of
1289 the health benefit plan, can become effective.
1290 [~~(172)~~] (173) "Workers' compensation insurance" means:
1291 (a) insurance for indemnification of an employer against liability for compensation
1292 based on:
1293 (i) a compensable accidental injury; and
1294 (ii) occupational disease disability;
1295 (b) employer's liability insurance incidental to workers' compensation insurance and
1296 written in connection with workers' compensation insurance; and
1297 (c) insurance assuring to a person entitled to workers' compensation benefits the
1298 compensation provided by law.

1299 Section 2. Section **31A-2-104** is amended to read:

1300 **31A-2-104. Other employees -- Insurance fraud investigators.**

1301 (1) The department shall employ a chief examiner and such other professional,
1302 technical, and clerical employees as necessary to carry out the duties of the department.

1303 (2) An insurance fraud investigator employed pursuant to Subsection (1) may be
1304 designated a [~~special function~~] law enforcement officer, as defined in Section [~~53-13-105~~]
1305 53-13-103, by the commissioner, but is not eligible for retirement benefits under the Public
1306 Safety Employee's Retirement System.

1307 Section 3. Section **31A-3-304 (Superseded 07/01/15)** is amended to read:

1308 **31A-3-304 (Superseded 07/01/15). Annual fees -- Other taxes or fees prohibited --**
1309 **Captive Insurance Restricted Account.**

1310 (1) (a) A captive insurance company shall pay an annual fee imposed under this section
1311 to obtain or renew a certificate of authority.

1312 (b) The commissioner shall:

1313 (i) determine the annual fee pursuant to Section 31A-3-103; and

1314 (ii) consider whether the annual fee is competitive with fees imposed by other states on
1315 captive insurance companies.

1316 (2) A captive insurance company that fails to pay the fee required by this section is
1317 subject to the relevant sanctions of this title.

1318 (3) (a) Except as provided in Subsection (3)(d) and notwithstanding Title 59, Chapter
1319 9, Taxation of Admitted Insurers, the following constitute the sole taxes, fees, or charges under
1320 the laws of this state that may be levied or assessed on a captive insurance company:

1321 (i) a fee under this section;

1322 (ii) a fee under Chapter 37, Captive Insurance Companies Act; and

1323 (iii) a fee under Chapter 37a, Special Purpose Financial Captive Insurance Company
1324 Act.

1325 (b) The state or a county, city, or town within the state may not levy or collect an
1326 occupation tax or other tax, fee, or charge not described in Subsections (3)(a)(i) through (iii)
1327 against a captive insurance company.

1328 (c) The state may not levy, assess, or collect a withdrawal fee under Section 31A-4-115
1329 against a captive insurance company.

1330 (d) A captive insurance company is subject to real and personal property taxes.
1331 (4) A captive insurance company shall pay the fee imposed by this section to the
1332 commissioner by June [20] 1 of each year.
1333 (5) (a) Money received pursuant to a fee described in Subsection (3)(a) shall be
1334 deposited into the Captive Insurance Restricted Account.
1335 (b) There is created in the General Fund a restricted account known as the "Captive
1336 Insurance Restricted Account."
1337 (c) The Captive Insurance Restricted Account shall consist of the fees described in
1338 Subsection (3)(a).
1339 (d) The commissioner shall administer the Captive Insurance Restricted Account.
1340 Subject to appropriations by the Legislature, the commissioner shall use the money deposited
1341 into the Captive Insurance Restricted Account to:
1342 (i) administer and enforce:
1343 (A) Chapter 37, Captive Insurance Companies Act; and
1344 (B) Chapter 37a, Special Purpose Financial Captive Insurance Company Act; and
1345 (ii) promote the captive insurance industry in Utah.
1346 (e) An appropriation from the Captive Insurance Restricted Account is nonlapsing,
1347 except that at the end of each fiscal year, money received by the commissioner in excess of
1348 $950,000 shall be treated as free revenue in the General Fund.
1349 Section 4. Section **31A-3-304 (Effective 07/01/15)** is amended to read:
1350 **31A-3-304 (Effective 07/01/15). Annual fees -- Other taxes or fees prohibited --**
1351 **Captive Insurance Restricted Account.**
1352 (1) (a) A captive insurance company shall pay an annual fee imposed under this section
1353 to obtain or renew a certificate of authority.
1354 (b) The commissioner shall:
1355 (i) determine the annual fee pursuant to Section 31A-3-103; and
1356 (ii) consider whether the annual fee is competitive with fees imposed by other states on
1357 captive insurance companies.
1358 (2) A captive insurance company that fails to pay the fee required by this section is
1359 subject to the relevant sanctions of this title.
1360 (3) (a) Except as provided in Subsection (3)(d) and notwithstanding Title 59, Chapter

1361 9, Taxation of Admitted Insurers, the following constitute the sole taxes, fees, or charges under
1362 the laws of this state that may be levied or assessed on a captive insurance company:
1363 (i) a fee under this section;
1364 (ii) a fee under Chapter 37, Captive Insurance Companies Act; and
1365 (iii) a fee under Chapter 37a, Special Purpose Financial Captive Insurance Company
1366 Act.
1367 (b) The state or a county, city, or town within the state may not levy or collect an
1368 occupation tax or other tax, fee, or charge not described in Subsections (3)(a)(i) through (iii)
1369 against a captive insurance company.
1370 (c) The state may not levy, assess, or collect a withdrawal fee under Section 31A-4-115
1371 against a captive insurance company.
1372 (d) A captive insurance company is subject to real and personal property taxes.
1373 (4) A captive insurance company shall pay the fee imposed by this section to the
1374 commissioner by June [20] 1 of each year.
1375 (5) (a) Money received pursuant to a fee described in Subsection (3)(a) shall be
1376 deposited into the Captive Insurance Restricted Account.
1377 (b) There is created in the General Fund a restricted account known as the "Captive
1378 Insurance Restricted Account."
1379 (c) The Captive Insurance Restricted Account shall consist of the fees described in
1380 Subsection (3)(a).
1381 (d) The commissioner shall administer the Captive Insurance Restricted Account.
1382 Subject to appropriations by the Legislature, the commissioner shall use the money deposited
1383 into the Captive Insurance Restricted Account to:
1384 (i) administer and enforce:
1385 (A) Chapter 37, Captive Insurance Companies Act; and
1386 (B) Chapter 37a, Special Purpose Financial Captive Insurance Company Act; and
1387 (ii) promote the captive insurance industry in Utah.
1388 (e) An appropriation from the Captive Insurance Restricted Account is nonlapsing,
1389 except that at the end of each fiscal year, money received by the commissioner in excess of
1390 $1,250,000 shall be treated as free revenue in the General Fund.
1391 Section 5. Section **31A-4-102** is amended to read:

1392 **31A-4-102. Qualified insurers.**
1393 (1) A person may not conduct an insurance business in Utah in person, through an
1394 agent, through a broker, through the mail, or through another method of communication,
1395 except:
1396 (a) an insurer:
1397 (i) authorized to do business in Utah under [~~Chapter 5, 7, 8, 9, 10, 11, 13, or 14; and~~]:
1398 (A) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
1399 (B) Chapter 7, Nonprofit Health Service Insurance Corporations;
1400 (C) Chapter 8, Health Maintenance Organizations and Limited Health Plans;
1401 (D) Chapter 9, Insurance Fraternals;
1402 (E) Chapter 10, Annuities;
1403 (F) Chapter 11, Motor Clubs;
1404 (G) Chapter 13, Employee Welfare Funds and Plans;
1405 (H) Chapter 14, Foreign Insurers;
1406 (I) Chapter 37, Captive Insurance Companies Act; or
1407 (J) Chapter 37a, Special Purpose Financial Captive Insurance Company Act; and
1408 (ii) within the limits of its certificate of authority;
1409 (b) a joint underwriting group under Section 31A-2-214 or 31A-20-102;
1410 (c) an insurer doing business under Section 31A-15-103;
1411 (d) a person who submits to the commissioner a certificate from the United States
1412 Department of Labor, or such other evidence as satisfies the commissioner, that the laws of
1413 Utah are preempted with respect to specified activities of that person by Section 514 of the
1414 Employee Retirement Income Security Act of 1974 or other federal law; or
1415 (e) a person exempt from this title under Section 31A-1-103 or another applicable
1416 statute.
1417 (2) As used in this section, "insurer" includes a bail bond surety company, as defined in
1418 Section 31A-35-102.
1419 Section 6. Section **31A-4-115** is amended to read:
1420 **31A-4-115. Plan of orderly withdrawal.**
1421 (1) (a) When an insurer intends to withdraw from writing a line of insurance in this
1422 state or to reduce its total annual premium volume by 75% or more, the insurer shall file with

1423 the commissioner a plan of orderly withdrawal.

1424 (b) For purposes of this section, a discontinuance of a health benefit plan pursuant to

1425 one of the following provisions is a withdrawal from a line of insurance:

1426 (i) Subsection 31A-30-107(3)(e); or

1427 (ii) Subsection 31A-30-107.1(3)(e).

1428 (2) An insurer's plan of orderly withdrawal shall:

1429 (a) indicate the date the insurer intends to begin and complete its withdrawal plan; and

1430 (b) include provisions for:

1431 (i) meeting the insurer's contractual obligations;

1432 (ii) providing services to its Utah policyholders and claimants;

1433 (iii) meeting [~~any~~] applicable statutory obligations; and

1434 (iv) [~~(A)~~] the payment of a withdrawal fee of $50,000 to the [~~Utah Comprehensive~~

1435 ~~Health Insurance Pool if: (I) the insurer is an accident and health insurer; and (II) the insurer's~~

1436 ~~line of business is not assumed or placed with another insurer approved by the commissioner;~~

1437 ~~or (B) the payment of a withdrawal fee of $50,000 to the department if: (I) the insurer is not~~

1438 ~~an accident and health insurer; and (II)~~] department if the insurer's line of business is not

1439 assumed or placed with another insurer approved by the commissioner.

1440 (3) The commissioner shall approve a plan of orderly withdrawal if the plan of orderly

1441 withdrawal adequately demonstrates that the insurer will:

1442 (a) protect the interests of the people of the state;

1443 (b) meet the insurer's contractual obligations;

1444 (c) provide service to the insurer's Utah policyholders and claimants; and

1445 (d) meet [~~any~~] applicable statutory obligations.

1446 (4) Section 31A-2-302 governs the commissioner's approval or disapproval of a plan for

1447 orderly withdrawal.

1448 (5) The commissioner may require an insurer to increase the deposit maintained in

1449 accordance with Section 31A-4-105 or Section 31A-4-105.5 and place the deposit in trust in

1450 the name of the commissioner upon finding, after an adjudicative proceeding that:

1451 (a) there is reasonable cause to conclude that the interests of the people of the state are

1452 best served by such action; and

1453 (b) the insurer:

1454 (i) has filed a plan of orderly withdrawal; or
1455 (ii) intends to:
1456 (A) withdraw from writing a line of insurance in this state; or
1457 (B) reduce the insurer's total annual premium volume by 75% or more.
1458 (6) An insurer is subject to the civil penalties under Section 31A-2-308, if the insurer:
1459 (a) withdraws from writing insurance in this state without receiving the commissioner's
1460 approval of a plan of orderly withdrawal; or
1461 (b) reduces its total annual premium volume by 75% or more in any year without
1462 [~~having submitted a plan or receiving the commissioner's approval~~] receiving the
1463 commissioner's approval of a plan of orderly withdrawal.
1464 (7) An insurer that withdraws from writing all lines of insurance in this state may not
1465 resume writing insurance in this state for five years unless[~~: (a)~~] the commissioner finds that
1466 the prohibition should be waived because the waiver is:
1467 [~~(i)~~] (a) in the public interest to promote competition; or
1468 [~~(ii)~~] (b) to resolve inequity in the marketplace[~~; and~~].
1469 [~~(b) the insurer complies with Subsection 31A-30-108(5), if applicable.~~]
1470 (8) The commissioner shall adopt rules necessary to implement this section.
1471 Section 7. Section **31A-8-402.3** is amended to read:
1472 **31A-8-402.3. Discontinuance, nonrenewal, or changes to group health benefit**
1473 **plans.**
1474 (1) Except as otherwise provided in this section, a group health benefit plan for a plan
1475 sponsor is renewable and continues in force:
1476 (a) with respect to all eligible employees and dependents; and
1477 (b) at the option of the plan sponsor.
1478 (2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed:
1479 (a) for a network plan, if[~~: (i)~~] there is no longer any enrollee under the group health
1480 plan who lives, resides, or works in:
1481 [~~(A)~~] (i) the service area of the insurer; or
1482 [~~(B)~~] (ii) the area for which the insurer is authorized to do business; [~~and~~] or
1483 [~~(ii) in the case of the small employer market, the insurer applies the same criteria the~~
1484 ~~insurer would apply in denying enrollment in the plan under Subsection 31A-30-108(7); or~~]

1485 (b) for coverage made available in the small or large employer market only through an
1486 association, if:
1487 (i) the employer's membership in the association ceases; and
1488 (ii) the coverage is terminated uniformly without regard to any health status-related
1489 factor relating to any covered individual.
1490 (3) A health benefit plan for a plan sponsor may be discontinued if:
1491 (a) a condition described in Subsection (2) exists;
1492 (b) the plan sponsor fails to pay premiums or contributions in accordance with the
1493 terms of the contract;
1494 (c) the plan sponsor:
1495 (i) performs an act or practice that constitutes fraud; or
1496 (ii) makes an intentional misrepresentation of material fact under the terms of the
1497 coverage;
1498 (d) the insurer:
1499 (i) elects to discontinue offering a particular health benefit product delivered or issued
1500 for delivery in this state; and
1501 (ii) (A) provides notice of the discontinuation in writing:
1502 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
1503 (II) at least 90 days before the date the coverage will be discontinued;
1504 (B) provides notice of the discontinuation in writing:
1505 (I) to the commissioner; and
1506 (II) at least three working days prior to the date the notice is sent to the affected plan
1507 sponsors, employees, and dependents of the plan sponsors or employees;
1508 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase:
1509 (I) all other health benefit products currently being offered by the insurer in the market;
1510 or
1511 (II) in the case of a large employer, any other health benefit product currently being
1512 offered in that market; and
1513 (D) in exercising the option to discontinue that product and in offering the option of
1514 coverage in this section, acts uniformly without regard to:
1515 (I) the claims experience of a plan sponsor;

1516 (II) any health status-related factor relating to any covered participant or beneficiary; or
1517 (III) any health status-related factor relating to any new participant or beneficiary who
1518 may become eligible for the coverage; or
1519 (e) the insurer:
1520 (i) elects to discontinue all of the insurer's health benefit plans in:
1521 (A) the small employer market;
1522 (B) the large employer market; or
1523 (C) both the small employer and large employer markets; and
1524 (ii) (A) provides notice of the discontinuation in writing:
1525 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
1526 (II) at least 180 days before the date the coverage will be discontinued;
1527 (B) provides notice of the discontinuation in writing:
1528 (I) to the commissioner in each state in which an affected insured individual is known
1529 to reside; and
1530 (II) at least 30 working days prior to the date the notice is sent to the affected plan
1531 sponsors, employees, and the dependents of the plan sponsors or employees;
1532 (C) discontinues and nonrenews all plans issued or delivered for issuance in the
1533 market; and
1534 (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.
1535 (4) A large employer health benefit plan may be discontinued or nonrenewed:
1536 (a) if a condition described in Subsection (2) exists; or
1537 (b) for noncompliance with the insurer's:
1538 (i) minimum participation requirements; or
1539 (ii) employer contribution requirements.
1540 (5) A small employer health benefit plan may be discontinued or nonrenewed:
1541 (a) if a condition described in Subsection (2) exists; or
1542 (b) for noncompliance with the insurer's employer contribution requirements.
1543 (6) A small employer health benefit plan may be nonrenewed:
1544 (a) if a condition described in Subsection (2) exists; or
1545 (b) for noncompliance with the insurer's minimum participation requirements.
1546 (7) (a) Except as provided in Subsection (7)(d), an eligible employee may be

1547 discontinued if after issuance of coverage the eligible employee:
1548 (i) engages in an act or practice in connection with the coverage that constitutes fraud;
1549 or
1550 (ii) makes an intentional misrepresentation of material fact in connection with the
1551 coverage.
1552 (b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:
1553 (i) 12 months after the date of discontinuance; and
1554 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
1555 to reenroll.
1556 (c) At the time the eligible employee's coverage is discontinued under Subsection
1557 (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is
1558 discontinued.
1559 (d) An eligible employee may not be discontinued under this Subsection (7) because of
1560 a fraud or misrepresentation that relates to health status.
1561 (8) For purposes of this section, a reference to "plan sponsor" includes a reference to
1562 the employer:
1563 (a) with respect to coverage provided to an employer member of the association; and
1564 (b) if the health benefit plan is made available by an insurer in the employer market
1565 only through:
1566 (i) an association;
1567 (ii) a trust; or
1568 (iii) a discretionary group.
1569 (9) An insurer may modify a health benefit plan for a plan sponsor only:
1570 (a) at the time of coverage renewal; and
1571 (b) if the modification is effective uniformly among all plans with that product.
1572 Section 8. Section **31A-16-103** is amended to read:
1573 **31A-16-103. Acquisition of control of or merger with domestic insurer.**
1574 (1) (a) A person may not take the actions described in Subsections (1)(b) or (c) unless,
1575 at the time any offer, request, or invitation is made or any such agreement is entered into, or
1576 prior to the acquisition of securities if no offer or agreement is involved:
1577 (i) the person files with the commissioner a statement containing the information

1578 required by this section;
1579 (ii) the person provides a copy of the statement described in Subsection (1)(a)(i) to the
1580 insurer; and
1581 (iii) the commissioner approves the offer, request, invitation, agreement, or acquisition.
1582 (b) Unless the person complies with Subsection (1)(a), a person other than the issuer
1583 may not make a tender offer for, a request or invitation for tenders of, or enter into any
1584 agreement to exchange securities, or seek to acquire or acquire in the open market or otherwise,
1585 any voting security of a domestic insurer if after the acquisition, the person would directly,
1586 indirectly, by conversion, or by exercise of any right to acquire be in control of the insurer.
1587 (c) Unless the person complies with Subsection (1)(a), a person may not enter into an
1588 agreement to merge with or otherwise to acquire control of:
1589 (i) a domestic insurer; or
1590 (ii) any person controlling a domestic insurer.
1591 (d) (i) For purposes of this section, a domestic insurer includes any person controlling a
1592 domestic insurer unless the person as determined by the commissioner is either directly or
1593 through its affiliates primarily engaged in business other than the business of insurance.
1594 (ii) The controlling person described in Subsection (1)(d)(i) shall file with the
1595 commissioner a preacquisition notification containing the information required in Subsection
1596 (2) 30 calendar days before the proposed effective date of the acquisition.
1597 (iii) For the purposes of this section, "person" does not include any securities broker
1598 that in the usual and customary brokers function holds less than 20% of:
1599 (A) the voting securities of an insurance company; or
1600 (B) any person that controls an insurance company.
1601 (iv) This section applies to all domestic insurers and other entities licensed under
1602 Chapters 5, 7, 8, 9, and 11.
1603 (e) (i) An agreement for acquisition of control or merger as contemplated by this
1604 Subsection (1) is not valid or enforceable unless the agreement:
1605 (A) is in writing; and
1606 (B) includes a provision that the agreement is subject to the approval of the
1607 commissioner upon the filing of any applicable statement required under this chapter.
1608 (ii) A written agreement for acquisition or control that includes the provision described

1609 in Subsection (1)(e)(i) satisfies the requirements of this Subsection (1).
1610 (2) The statement to be filed with the commissioner under Subsection (1) shall be
1611 made under oath or affirmation and shall contain the following information:
1612 (a) the name and address of the "acquiring party," which means each person by whom
1613 or on whose behalf the merger or other acquisition of control referred to in Subsection (1) is to
1614 be effected; and
1615 (i) if the person is an individual:
1616 (A) the person's principal occupation;
1617 (B) a listing of all offices and positions held by the person during the past five years;
1618 and
1619 (C) any conviction of crimes other than minor traffic violations during the past 10
1620 years; and
1621 (ii) if the person is not an individual:
1622 (A) a report of the nature of its business operations during:
1623 (I) the past five years; or
1624 (II) for any lesser period as the person and any of its predecessors has been in
1625 existence;
1626 (B) an informative description of the business intended to be done by the person and
1627 the person's subsidiaries;
1628 (C) a list of all individuals who are or who have been selected to become directors or
1629 executive officers of the person, or individuals who perform, or who will perform functions
1630 appropriate to such positions; and
1631 (D) for each individual described in Subsection (2)(a)(ii)(C), the information required
1632 by Subsection (2)(a)(i) for each individual;
1633 (b) (i) the source, nature, and amount of the consideration used or to be used in
1634 effecting the merger or acquisition of control;
1635 (ii) a description of any transaction in which funds were or are to be obtained for the
1636 purpose of effecting the merger or acquisition of control, including any pledge of:
1637 (A) the insurer's stock; or
1638 (B) the stock of any of the insurer's subsidiaries or controlling affiliates; and
1639 (iii) the identity of persons furnishing the consideration;

1640 (c) (i) fully audited financial information, or other financial information considered
1641 acceptable by the commissioner, of the earnings and financial condition of each acquiring party
1642 for:
1643 (A) the preceding five fiscal years of each acquiring party; or
1644 (B) any lesser period the acquiring party and any of its predecessors shall have been in
1645 existence; and
1646 (ii) unaudited information:
1647 (A) similar to the information described in Subsection (2)(c)(i); and
1648 (B) prepared within the 90 days prior to the filing of the statement;
1649 (d) any plans or proposals which each acquiring party may have to:
1650 (i) liquidate the insurer;
1651 (ii) sell its assets;
1652 (iii) merge or consolidate the insurer with any person; or
1653 (iv) make any other material change in the insurer's:
1654 (A) business;
1655 (B) corporate structure; or
1656 (C) management;
1657 (e) (i) the number of shares of any security referred to in Subsection (1) that each
1658 acquiring party proposes to acquire;
1659 (ii) the terms of the offer, request, invitation, agreement, or acquisition referred to in
1660 Subsection (1); and
1661 (iii) a statement as to the method by which the fairness of the proposal was arrived at;
1662 (f) the amount of each class of any security referred to in Subsection (1) that:
1663 (i) is beneficially owned; or
1664 (ii) concerning which there is a right to acquire beneficial ownership by each acquiring
1665 party;
1666 (g) a full description of any contract, arrangement, or understanding with respect to any
1667 security referred to in Subsection (1) in which any acquiring party is involved, including:
1668 (i) the transfer of any of the securities;
1669 (ii) joint ventures;
1670 (iii) loan or option arrangements;

1671 (iv) puts or calls;
1672 (v) guarantees of loans;
1673 (vi) guarantees against loss or guarantees of profits;
1674 (vii) division of losses or profits; or
1675 (viii) the giving or withholding of proxies;
1676 (h) a description of the purchase by any acquiring party of any security referred to in
1677 Subsection (1) during the 12 calendar months preceding the filing of the statement including:
1678 (i) the dates of purchase;
1679 (ii) the names of the purchasers; and
1680 (iii) the consideration paid or agreed to be paid for the purchase;
1681 (i) a description of:
1682 (i) any recommendations to purchase by any acquiring party any security referred to in
1683 Subsection (1) made during the 12 calendar months preceding the filing of the statement; or
1684 (ii) any recommendations made by anyone based upon interviews or at the suggestion
1685 of the acquiring party;
1686 (j) (i) copies of all tender offers for, requests for, or invitations for tenders of, exchange
1687 offers for, and agreements to acquire or exchange any securities referred to in Subsection (1);
1688 and
1689 (ii) if distributed, copies of additional soliciting material relating to the transactions
1690 described in Subsection (2)(j)(i);
1691 (k) (i) the term of any agreement, contract, or understanding made with, or proposed to
1692 be made with, any broker-dealer as to solicitation of securities referred to in Subsection (1) for
1693 tender; and
1694 (ii) the amount of any fees, commissions, or other compensation to be paid to
1695 broker-dealers with regard to any agreement, contract, or understanding described in
1696 Subsection (2)(k)(i); and
1697 (l) any additional information the commissioner requires by rule, which the
1698 commissioner determines to be:
1699 (i) necessary or appropriate for the protection of policyholders of the insurer; or
1700 (ii) in the public interest.
1701 (3) The department may request:

1702 (a) (i) criminal background information maintained pursuant to Title 53, Chapter 10,
1703 Part 2, Bureau of Criminal Identification, from the Bureau of Criminal Identification; and
1704 (ii) complete Federal Bureau of Investigation criminal background checks through the
1705 national criminal history system.
1706 (b) Information obtained by the department from the review of criminal history records
1707 received under Subsection (3)(a) shall be used by the department for the purpose of:
1708 (i) verifying the information in Subsection (2)(a)(i);
1709 (ii) determining the integrity of persons who would control the operation of an insurer;
1710 and
1711 (iii) preventing persons who violate 18 U.S.C. [~~Sections~~] Sec. 1033 [~~and 1034~~] from
1712 engaging in the business of insurance in the state.
1713 (c) If the department requests the criminal background information, the department
1714 shall:
1715 (i) pay to the Department of Public Safety the costs incurred by the Department of
1716 Public Safety in providing the department criminal background information under Subsection
1717 (3)(a)(i);
1718 (ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau
1719 of Investigation in providing the department criminal background information under
1720 Subsection (3)(a)(ii); and
1721 (iii) charge the person required to file the statement referred to in Subsection (1) a fee
1722 equal to the aggregate of Subsections (3)(c)(i) and (ii).
1723 (4) (a) If the source of the consideration under Subsection (2)(b)(i) is a loan made in
1724 the lender's ordinary course of business, the identity of the lender shall remain confidential, if
1725 the person filing the statement so requests.
1726 (b) (i) Under Subsection (2)(e), the commissioner may require a statement of the
1727 adjusted book value assigned by the acquiring party to each security in arriving at the terms of
1728 the offer.
1729 (ii) For purposes of this Subsection (4)(b), "adjusted book value" means each security's
1730 proportional interest in the capital and surplus of the insurer with adjustments that reflect:
1731 (A) market conditions;
1732 (B) business in force; and

1733 (C) other intangible assets or liabilities of the insurer.
1734 (c) The description required by Subsection (2)(g) shall identify the persons with whom
1735 the contracts, arrangements, or understandings have been entered into.
1736 (5) (a) If the person required to file the statement referred to in Subsection (1) is a
1737 partnership, limited partnership, syndicate, or other group, the commissioner may require that
1738 all the information called for by Subsections (2), (3), or (4) shall be given with respect to each:
1739 (i) partner of the partnership or limited partnership;
1740 (ii) member of the syndicate or group; and
1741 (iii) person who controls the partner or member.
1742 (b) If any partner, member, or person referred to in Subsection (5)(a) is a corporation,
1743 or if the person required to file the statement referred to in Subsection (1) is a corporation, the
1744 commissioner may require that the information called for by Subsection (2) shall be given with
1745 respect to:
1746 (i) the corporation;
1747 (ii) each officer and director of the corporation; and
1748 (iii) each person who is directly or indirectly the beneficial owner of more than 10% of
1749 the outstanding voting securities of the corporation.
1750 (6) If any material change occurs in the facts set forth in the statement filed with the
1751 commissioner and sent to the insurer pursuant to Subsection (2), an amendment setting forth
1752 the change, together with copies of all documents and other material relevant to the change,
1753 shall be filed with the commissioner and sent to the insurer within two business days after the
1754 filing person learns of such change.
1755 (7) If any offer, request, invitation, agreement, or acquisition referred to in Subsection
1756 (1) is proposed to be made by means of a registration statement under the Securities Act of
1757 1933, or under circumstances requiring the disclosure of similar information under the
1758 Securities Exchange Act of 1934, or under a state law requiring similar registration or
1759 disclosure, a person required to file the statement referred to in Subsection (1) may use copies
1760 of any registration or disclosure documents in furnishing the information called for by the
1761 statement.
1762 (8) (a) The commissioner shall approve any merger or other acquisition of control
1763 referred to in Subsection (1) unless, after a public hearing on the merger or acquisition, the

1764 commissioner finds that:
1765 (i) after the change of control, the domestic insurer referred to in Subsection (1) would
1766 not be able to satisfy the requirements for the issuance of a license to write the line or lines of
1767 insurance for which it is presently licensed;
1768 (ii) the effect of the merger or other acquisition of control would:
1769 (A) substantially lessen competition in insurance in this state; or
1770 (B) tend to create a monopoly in insurance;
1771 (iii) the financial condition of any acquiring party might:
1772 (A) jeopardize the financial stability of the insurer; or
1773 (B) prejudice the interest of:
1774 (I) its policyholders; or
1775 (II) any remaining securityholders who are unaffiliated with the acquiring party;
1776 (iv) the terms of the offer, request, invitation, agreement, or acquisition referred to in
1777 Subsection (1) are unfair and unreasonable to the securityholders of the insurer;
1778 (v) the plans or proposals which the acquiring party has to liquidate the insurer, sell its
1779 assets, or consolidate or merge it with any person, or to make any other material change in its
1780 business or corporate structure or management, are:
1781 (A) unfair and unreasonable to policyholders of the insurer; and
1782 (B) not in the public interest; or
1783 (vi) the competence, experience, and integrity of those persons who would control the
1784 operation of the insurer are such that it would not be in the interest of the policyholders of the
1785 insurer and the public to permit the merger or other acquisition of control.
1786 (b) For purposes of Subsection (8)(a)(iv), the offering price for each security may not
1787 be considered unfair if the adjusted book values under Subsection (2)(e):
1788 (i) are disclosed to the securityholders; and
1789 (ii) determined by the commissioner to be reasonable.
1790 (9) (a) The public hearing referred to in Subsection (8) shall be held within 30 days
1791 after the statement required by Subsection (1) is filed.
1792 (b) (i) At least 20 days notice of the hearing shall be given by the commissioner to the
1793 person filing the statement.
1794 (ii) Affected parties may waive the notice required by this Subsection (9)(b).

1795 (iii) Not less than seven days notice of the public hearing shall be given by the person
1796 filing the statement to:
1797 (A) the insurer; and
1798 (B) any person designated by the commissioner.
1799 (c) The commissioner shall make a determination within 30 days after the conclusion
1800 of the hearing.
1801 (d) At the hearing, the person filing the statement, the insurer, any person to whom
1802 notice of hearing was sent, and any other person whose interest may be affected by the hearing
1803 may:
1804 (i) present evidence;
1805 (ii) examine and cross-examine witnesses; and
1806 (iii) offer oral and written arguments.
1807 (e) (i) A person or insurer described in Subsection (9)(d) may conduct discovery
1808 proceedings in the same manner as is presently allowed in the district courts of this state.
1809 (ii) All discovery proceedings shall be concluded not later than three days before the
1810 commencement of the public hearing.
1811 (10) (a) The commissioner may retain technical experts to assist in reviewing all, or a
1812 portion of, information filed in connection with a proposed merger or other acquisition of
1813 control referred to in Subsection (1).
1814 (b) In determining whether any of the conditions in Subsection (8) exist, the
1815 commissioner may consider the findings of technical experts employed to review applicable
1816 filings.
1817 (c) (i) A technical expert employed under Subsection (10)(a) shall present to the
1818 commissioner a statement of all expenses incurred by the technical expert in conjunction with
1819 the technical expert's review of a proposed merger or other acquisition of control.
1820 (ii) At the commissioner's direction the acquiring person shall compensate the technical
1821 expert at customary rates for time and expenses:
1822 (A) necessarily incurred; and
1823 (B) approved by the commissioner.
1824 (iii) The acquiring person shall:
1825 (A) certify the consolidated account of all charges and expenses incurred for the review

1826 by technical experts;
1827 (B) retain a copy of the consolidated account described in Subsection (10)(c)(iii)(A);
1828 and
1829 (C) file with the department as a public record a copy of the consolidated account
1830 described in Subsection (10)(c)(iii)(A).
1831 (11) (a) (i) If a domestic insurer proposes to merge into another insurer, any
1832 securityholder electing to exercise a right of dissent may file with the insurer a written request
1833 for payment of the adjusted book value given in the statement required by Subsection (1) and
1834 approved under Subsection (8), in return for the surrender of the security holder's securities.
1835 (ii) The request described in Subsection (11)(a)(i) shall be filed not later than 10 days
1836 after the day of the securityholders' meeting where the corporate action is approved.
1837 (b) The dissenting securityholder is entitled to and the insurer is required to pay to the
1838 dissenting securityholder the specified value within 60 days of receipt of the dissenting security
1839 holder's security.
1840 (c) Persons electing under this Subsection (11) to receive cash for their securities waive
1841 the dissenting shareholder and appraisal rights otherwise applicable under Title 16, Chapter
1842 10a, Part 13, Dissenters' Rights.
1843 (d) (i) This Subsection (11) provides an elective procedure for dissenting
1844 securityholders to resolve their objections to the plan of merger.
1845 (ii) This section does not restrict the rights of dissenting securityholders under Title 16,
1846 Chapter 10a, Utah Revised Business Corporation Act, unless this election is made under this
1847 Subsection (11).
1848 (12) (a) All statements, amendments, or other material filed under Subsection (1), and
1849 all notices of public hearings held under Subsection (8), shall be mailed by the insurer to its
1850 securityholders within five business days after the insurer has received the statements,
1851 amendments, other material, or notices.
1852 (b) (i) Mailing expenses shall be paid by the person making the filing.
1853 (ii) As security for the payment of mailing expenses, that person shall file with the
1854 commissioner an acceptable bond or other deposit in an amount determined by the
1855 commissioner.
1856 (13) This section does not apply to any offer, request, invitation, agreement, or

1857 acquisition that the commissioner by order exempts from the requirements of this section as:
1858 (a) not having been made or entered into for the purpose of, and not having the effect
1859 of, changing or influencing the control of a domestic insurer; or
1860 (b) as otherwise not comprehended within the purposes of this section.
1861 (14) The following are violations of this section:
1862 (a) the failure to file any statement, amendment, or other material required to be filed
1863 pursuant to Subsections (1), (2), and (5); or
1864 (b) the effectuation, or any attempt to effectuate, an acquisition of control of or merger
1865 with a domestic insurer unless the commissioner has given the commissioner's approval to the
1866 acquisition or merger.
1867 (15) (a) The courts of this state are vested with jurisdiction over:
1868 (i) a person who:
1869 (A) files a statement with the commissioner under this section; and
1870 (B) is not resident, domiciled, or authorized to do business in this state; and
1871 (ii) overall actions involving persons described in Subsection (15)(a)(i) arising out of a
1872 violation of this section.
1873 (b) A person described in Subsection (15)(a) is considered to have performed acts
1874 equivalent to and constituting an appointment of the commissioner by that person, to be that
1875 person's lawful agent upon whom may be served all lawful process in any action, suit, or
1876 proceeding arising out of a violation of this section.
1877 (c) A copy of a lawful process described in Subsection (15)(b) shall be:
1878 (i) served on the commissioner; and
1879 (ii) transmitted by registered or certified mail by the commissioner to the person at that
1880 person's last-known address.
1881 Section 9. Section **31A-17-607** is amended to read:
1882 **31A-17-607. Hearings.**
1883 (1) (a) Following receipt of a notice described in Subsection (2), the insurer or health
1884 organization shall have the right to a confidential departmental hearing at which the insurer or
1885 health organization may challenge [~~any~~] a determination or action by the commissioner.
1886 (b) The insurer or health organization shall notify the commissioner of its request for a
1887 hearing within five days after the notification by the commissioner under [~~Subsections~~

1888 ~~31A-17-604(1), (2), and (3)~~] Subsection (2).
1889 (c) Upon receipt of the insurer's or health organization's request for a hearing, the
1890 commissioner shall set a date for the hearing, which date shall be no less than 10 nor more than
1891 30 days after the date of the insurer's or health organization's request.
1892 (2) An insurer or health organization has the right to a hearing under Subsection (1)
1893 after:
1894 (a) notification to an insurer or health organization by the commissioner of an adjusted
1895 RBC report;
1896 (b) notification to an insurer or health organization by the commissioner that:
1897 (i) the insurer's or health organization's RBC plan or revised RBC plan is
1898 unsatisfactory; and
1899 (ii) the notification constitutes a regulatory action level event with respect to the
1900 insurer or health organization;
1901 (c) notification to any insurer or health organization by the commissioner that the
1902 insurer or health organization has failed to adhere to its RBC plan or revised RBC plan and that
1903 the failure has substantial adverse effect on the ability of the insurer or health organization to
1904 eliminate the company action level event with respect to the insurer or health organization in
1905 accordance with its RBC plan or revised RBC plan; or
1906 (d) notification to an insurer or health organization by the commissioner of a corrective
1907 order with respect to the insurer or health organization.
1908 Section 10. Section **31A-22-428** is amended to read:
1909 **31A-22-428. Interest payable on life insurance proceeds.**
1910 (1) For a life insurance policy delivered or issued for delivery in this state on or after
1911 May 5, 2008, the insurer shall pay interest on the death proceeds payable upon the death of the
1912 insured.
1913 (2) (a) Except as provided in Subsection (4), for the period beginning on the date of
1914 death and ending the day before the day described in Subsection (3)(b), interest under
1915 Subsection (1) shall accrue at a rate no less than the greater of:
1916 (i) the rate applicable to policy funds left on deposit; [~~or~~] and
1917 (ii) [~~if there is no rate described in Subsection (2)(a)(i), at~~] the Two Year Treasury
1918 Constant Maturity Rate as published by the Federal Reserve.

1919 (b) If there is no rate applicable to policy funds on deposit as stated in Subsection
1920 (2)(a)(i), then the Two Year Treasury Constant Maturity Rates as published by the Federal
1921 Reserve applies.
1922 [(b)] (c) The rate described in Subsection (2)(a) or (b) is the rate in effect on the day on
1923 which the death occurs.
1924 [(c)] (d) Interest is payable until the day on which the claim is paid.
1925 (3) (a) Unless the claim is paid and except as provided in Subsection (4), beginning on
1926 the day described in Subsection (3)(b) and ending the day on which the claim is paid, interest
1927 shall accrue at the rate in Subsection (2) plus additional interest at the rate of 10% annually.
1928 (b) Interest accrues under Subsection (3)(a) beginning with the day that is 31 days from
1929 the latest of:
1930 (i) the day on which the insurer receives proof of death;
1931 (ii) the day on which the insurer receives sufficient information to determine:
1932 (A) liability;
1933 (B) the extent of the liability; and
1934 (C) the appropriate payee legally entitled to the proceeds; and
1935 (iii) the day on which:
1936 (A) legal impediments to payment of proceeds that depend on the action of parties
1937 other than the insurer are resolved; and
1938 (B) the insurer receives sufficient evidence of the resolution of the legal impediments
1939 described in Subsection (3)(b)(iii)(A).
1940 (4) A court of competent jurisdiction may require payment of interest from the date of
1941 death to the day on which a claim is paid at a rate equal to the sum of:
1942 (a) the rate specified in Subsection (2); and
1943 (b) the legal rate identified in Subsection 15-1-1(2).
1944 Section 11. Section **31A-22-605.1** is amended to read:
1945 **31A-22-605.1. Preexisting condition limitations.**
1946 (1) [Any] A provision dealing with preexisting conditions shall be consistent with this
1947 section, Section 31A-22-609, and rules adopted by the commissioner.
1948 (2) Except as provided in this section, an insurer that elects to use an application form
1949 without questions concerning the insured's health or medical treatment history shall provide

1950 coverage under the policy for any loss which occurs more than 12 months after the effective
1951 date of coverage due to a preexisting condition which is not specifically excluded from
1952 coverage.
1953 (3) (a) An insurer that issues a specified disease policy may not deny a claim for loss
1954 due to a preexisting condition that occurs more than six months after the effective date of
1955 coverage.
1956 (b) A specified disease policy may impose a preexisting condition exclusion only if the
1957 exclusion relates to a preexisting condition which first manifested itself within six months
1958 [~~prior to~~] before the effective date of coverage or which was diagnosed by a physician at any
1959 time [~~prior to~~] before the effective date of coverage.
1960 (4) (a) Except as provided in this Subsection (4) and Subsection (5), a health benefit
1961 plan, issued or renewed before January 1, 2014, may impose a preexisting condition exclusion
1962 only if:
1963 (i) the exclusion relates to a preexisting condition for which medical advice, diagnosis,
1964 care, or treatment was recommended or received within the six-month period ending on the
1965 enrollment date from an individual licensed or similarly authorized to provide those services
1966 under state law and operating within the scope of practice authorized by state law;
1967 (ii) the exclusion period ends no later than 12 months after the enrollment date, or in
1968 the case of a late enrollee, 18 months after the enrollment date; and
1969 (iii) the exclusion period is reduced by the number of days of creditable coverage the
1970 enrollee has as of the enrollment date, in accordance with Subsection (4)(b).
1971 (b) (i) The amount of creditable coverage allowed under Subsection (4)(a)(iii) is
1972 determined by counting all the days on which the individual has one or more types of creditable
1973 coverage.
1974 (ii) Days of creditable coverage that occur before a significant break in coverage are
1975 not required to be counted.
1976 (A) Days in a waiting period or affiliation period are not taken into account in
1977 determining whether a significant break in coverage has occurred.
1978 (B) For an individual who elects federal COBRA continuation coverage during the
1979 second election period provided under the federal Trade Act of 2002, the days between the date
1980 the individual lost group health plan coverage and the first day of the second COBRA election

1981 period are not taken into account in determining whether a significant break in coverage has
1982 occurred.
1983 (c) A group health benefit plan may not impose a preexisting condition exclusion
1984 relating to pregnancy.
1985 (d) (i) An insurer imposing a preexisting condition exclusion shall provide a written
1986 general notice of preexisting condition exclusion as part of any written application materials.
1987 (ii) The general notice shall include:
1988 (A) a description of the existence and terms of any preexisting condition exclusion
1989 under the plan, including the six-month period ending on the enrollment date, the maximum
1990 preexisting condition exclusion period, and how the insurer will reduce the maximum
1991 preexisting condition exclusion period by creditable coverage;
1992 (B) a description of the rights of individuals:
1993 (I) to demonstrate creditable coverage, including [~~any~~] applicable waiting periods,
1994 through a certificate of creditable coverage or through other means; and
1995 (II) to request a certificate of creditable coverage from a prior plan;
1996 (C) a statement that the current plan will assist in obtaining a certificate of creditable
1997 coverage from [~~any~~] <u>a</u> prior plan or issuer if necessary; and
1998 (D) a person to contact, and an address and telephone number for the person, for
1999 obtaining additional information or assistance regarding the preexisting condition exclusion.
2000 (e) An insurer may not impose [~~any~~] <u>a</u> limit on the amount of time that an individual
2001 has to present a certificate or other evidence of creditable coverage.
2002 (f) This Subsection (4) does not preclude application of [~~any~~] <u>a</u> waiting period
2003 applicable to all new enrollees under the plan.
2004 <u>(5) For a health benefit plan issued or renewed on or after January 1, 2014, an insurer</u>
2005 <u>may not impose a preexisting condition exclusion.</u>
2006 Section 12. Section **31A-22-617** is amended to read:
2007 **31A-22-617. Preferred provider contract provisions.**
2008 Health insurance policies may provide for insureds to receive services or
2009 reimbursement under the policies in accordance with preferred health care provider contracts as
2010 follows:
2011 (1) Subject to restrictions under this section, [~~any~~] <u>an</u> insurer or third party

2012 administrator may enter into contracts with health care providers as defined in Section
2013 78B-3-403 under which the health care providers agree to supply services, at prices specified in
2014 the contracts, to persons insured by an insurer.
2015 (a) (i) A health care provider contract may require the health care provider to accept the
2016 specified payment in this Subsection (1) as payment in full, relinquishing the right to collect
2017 additional amounts from the insured person.
2018 (ii) In [~~any~~] a dispute involving a provider's claim for reimbursement, the same shall be
2019 determined in accordance with applicable law, the provider contract, the subscriber contract,
2020 and the insurer's written payment policies in effect at the time services were rendered.
2021 (iii) If the parties are unable to resolve their dispute, the matter shall be subject to
2022 binding arbitration by a jointly selected arbitrator. Each party is to bear its own expense except
2023 the cost of the jointly selected arbitrator shall be equally shared. This Subsection (1)(a)(iii)
2024 does not apply to the claim of a general acute hospital to the extent it is inconsistent with the
2025 hospital's provider agreement.
2026 (iv) An organization may not penalize a provider solely for pursuing a claims dispute
2027 or otherwise demanding payment for a sum believed owing.
2028 (v) If an insurer permits another entity with which it does not share common ownership
2029 or control to use or otherwise lease one or more of the organization's networks of participating
2030 providers, the organization shall ensure, at a minimum, that the entity pays participating
2031 providers in accordance with the same fee schedule and general payment policies as the
2032 organization would for that network.
2033 (b) The insurance contract may reward the insured for selection of preferred health care
2034 providers by:
2035 (i) reducing premium rates;
2036 (ii) reducing deductibles;
2037 (iii) coinsurance;
2038 (iv) other copayments; or
2039 (v) any other reasonable manner.
2040 (c) If the insurer is a managed care organization, as defined in Subsection
2041 31A-27a-403(1)(f):
2042 (i) the insurance contract and the health care provider contract shall provide that in the

2043 event the managed care organization becomes insolvent, the rehabilitator or liquidator may:
2044 (A) require the health care provider to continue to provide health care services under
2045 the contract until the earlier of:
2046 (I) 90 days after the date of the filing of a petition for rehabilitation or the petition for
2047 liquidation; or
2048 (II) the date the term of the contract ends; and
2049 (B) subject to Subsection (1)(c)(v), reduce the fees the provider is otherwise entitled to
2050 receive from the managed care organization during the time period described in Subsection
2051 (1)(c)(i)(A);
2052 (ii) the provider is required to:
2053 (A) accept the reduced payment under Subsection (1)(c)(i)(B) as payment in full; and
2054 (B) relinquish the right to collect additional amounts from the insolvent managed care
2055 organization's enrollee, as defined in Subsection 31A-27a-403(1)(b);
2056 (iii) if the contract between the health care provider and the managed care organization
2057 has not been reduced to writing, or the contract fails to contain the [~~language required by~~]
2058 <u>requirements described in</u> Subsection (1)(c)(i), the provider may not collect or attempt to
2059 collect from the enrollee:
2060 (A) sums owed by the insolvent managed care organization; or
2061 (B) the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B);
2062 (iv) the following may not bill or maintain [~~any~~] <u>an</u> action at law against an enrollee to
2063 collect sums owed by the insolvent managed care organization or the amount of the regular fee
2064 reduction authorized under Subsection (1)(c)(i)(B):
2065 (A) a provider;
2066 (B) an agent;
2067 (C) a trustee; or
2068 (D) an assignee of a person described in Subsections (1)(c)(iv)(A) through (C); and
2069 (v) notwithstanding Subsection (1)(c)(i):
2070 (A) a rehabilitator or liquidator may not reduce a fee by less than 75% of the provider's
2071 regular fee set forth in the contract; and
2072 (B) the enrollee shall continue to pay the copayments, deductibles, and other payments
2073 for services received from the provider that the enrollee was required to pay before the filing

2074 of:
2075 (I) a petition for rehabilitation; or
2076 (II) a petition for liquidation.
2077 (2) (a) Subject to Subsections (2)(b) through (2)(e), an insurer using preferred health
2078 care provider contracts is subject to the reimbursement requirements in Section 31A-8-501 on
2079 or after January 1, 2014.
2080 (b) When reimbursing for services of health care providers not under contract, the
2081 insurer may make direct payment to the insured.
2082 (c) An insurer using preferred health care provider contracts may impose a deductible
2083 on coverage of health care providers not under contract.
2084 (d) When selecting health care providers with whom to contract under Subsection (1),
2085 an insurer may not unfairly discriminate between classes of health care providers, but may
2086 discriminate within a class of health care providers, subject to Subsection (7).
2087 (e) For purposes of this section, unfair discrimination between classes of health care
2088 providers includes:
2089 (i) refusal to contract with class members in reasonable proportion to the number of
2090 insureds covered by the insurer and the expected demand for services from class members; and
2091 (ii) refusal to cover procedures for one class of providers that are:
2092 (A) commonly used by members of the class of health care providers for the treatment
2093 of illnesses, injuries, or conditions;
2094 (B) otherwise covered by the insurer; and
2095 (C) within the scope of practice of the class of health care providers.
2096 (3) Before the insured consents to the insurance contract, the insurer shall fully disclose
2097 to the insured that it has entered into preferred health care provider contracts. The insurer shall
2098 provide sufficient detail on the preferred health care provider contracts to permit the insured to
2099 agree to the terms of the insurance contract. The insurer shall provide at least the following
2100 information:
2101 (a) a list of the health care providers under contract, and if requested their business
2102 locations and specialties;
2103 (b) a description of the insured benefits, including [~~any~~] deductibles, coinsurance, or
2104 other copayments;

2105 (c) a description of the quality assurance program required under Subsection (4); and
2106 (d) a description of the adverse benefit determination procedures required under
2107 Subsection (5).
2108 (4) (a) An insurer using preferred health care provider contracts shall maintain a quality
2109 assurance program for assuring that the care provided by the health care providers under
2110 contract meets prevailing standards in the state.
2111 (b) The commissioner in consultation with the executive director of the Department of
2112 Health may designate qualified persons to perform an audit of the quality assurance program.
2113 The auditors shall have full access to all records of the organization and its health care
2114 providers, including medical records of individual patients.
2115 (c) The information contained in the medical records of individual patients shall
2116 remain confidential. All information, interviews, reports, statements, memoranda, or other data
2117 furnished for purposes of the audit and any findings or conclusions of the auditors are
2118 privileged. The information is not subject to discovery, use, or receipt in evidence in any legal
2119 proceeding except hearings before the commissioner concerning alleged violations of this
2120 section.
2121 (5) An insurer using preferred health care provider contracts shall provide a reasonable
2122 procedure for resolving complaints and adverse benefit determinations initiated by the insureds
2123 and health care providers.
2124 (6) An insurer may not contract with a health care provider for treatment of illness or
2125 injury unless the health care provider is licensed to perform that treatment.
2126 (7) (a) A health care provider or insurer may not discriminate against a preferred health
2127 care provider for agreeing to a contract under Subsection (1).
2128 (b) [~~Any~~] A health care provider licensed to treat [~~any~~] an illness or injury within the
2129 scope of the health care provider's practice, who is willing and able to meet the terms and
2130 conditions established by the insurer for designation as a preferred health care provider, shall
2131 be able to apply for and receive the designation as a preferred health care provider. Contract
2132 terms and conditions may include reasonable limitations on the number of designated preferred
2133 health care providers based upon substantial objective and economic grounds, or expected use
2134 of particular services based upon prior provider-patient profiles.
2135 (8) Upon the written request of a provider excluded from a provider contract, the

2136 commissioner may hold a hearing to determine if the insurer's exclusion of the provider is
2137 based on the criteria set forth in Subsection (7)(b).
2138 [~~(9) Except as provided in Subsection 31A-22-618.5(3)(a), insurers are subject to~~
2139 ~~Sections 31A-22-613.5, 31A-22-614.5, and 31A-22-618.~~]
2140 [~~(10)~~] (9) Nothing in this section is to be construed as to require an insurer to offer a
2141 certain benefit or service as part of a health benefit plan.
2142 [~~(11)~~] (10) This section does not apply to catastrophic mental health coverage provided
2143 in accordance with Section 31A-22-625.
2144 [~~(12)~~] (11) Notwithstanding [~~the provisions of~~] Subsection (1), Subsection (7)(b), and
2145 Section 31A-22-618, an insurer or third party administrator is not required to, but may, enter
2146 into [~~contracts~~] a contract with a licensed athletic [~~trainers~~] trainer, licensed under Title 58,
2147 Chapter 40a, Athletic Trainer Licensing Act.
2148 Section 13. Section **31A-22-618.5** is amended to read:
2149 **31A-22-618.5. Health benefit plan offerings.**
2150 (1) The purpose of this section is to increase the range of health benefit plans available
2151 in the small group, small employer group, large group, and individual insurance markets.
2152 (2) A health maintenance organization that is subject to Chapter 8, Health Maintenance
2153 Organizations and Limited Health Plans:
2154 (a) shall offer to potential purchasers at least one health benefit plan that is subject to
2155 the requirements of Chapter 8, Health Maintenance Organizations and Limited Health Plans;
2156 and
2157 (b) may offer to a potential purchaser one or more health benefit plans that:
2158 (i) are not subject to one or more of the following:
2159 (A) the limitations on insured indemnity benefits in Subsection 31A-8-105(4);
2160 (B) the limitation on point of service products in Subsections 31A-8-408(3) through
2161 (6);
2162 (C) except as provided in Subsection (2)(b)(ii), basic health care services as defined in
2163 Section 31A-8-101; or
2164 (D) coverage mandates enacted after January 1, 2009 that are not required by federal
2165 law, provided that the insurer offers one plan under Subsection (2)(a) that covers the mandate
2166 enacted after January 1, 2009; and

2167 (ii) when offering a health plan under this section, provide coverage for an emergency
2168 medical condition as required by Section 31A-22-627 as follows:
2169 (A) within the organization's service area, covered services shall include health care
2170 services from nonaffiliated providers when medically necessary to stabilize an emergency
2171 medical condition; and
2172 (B) outside the organization's service area, covered services shall include medically
2173 necessary health care services for the treatment of an emergency medical condition that are
2174 immediately required while the enrollee is outside the geographic limits of the organization's
2175 service area.
2176 (3) An insurer that offers a health benefit plan that is not subject to Chapter 8, Health
2177 Maintenance Organizations and Limited Health Plans:
2178 (a) [~~notwithstanding Subsection 31A-22-617(9),~~] may offer a health benefit plan that is
2179 not subject to Section 31A-22-618;
2180 (b) when offering a health plan under this Subsection (3), shall provide coverage of
2181 emergency care services as required by Section 31A-22-627; and
2182 (c) is not subject to coverage mandates enacted after January 1, 2009 that are not
2183 required by federal law, provided that an insurer offers one plan that covers a mandate enacted
2184 after January 1, 2009.
2185 (4) Section 31A-8-106 does not prohibit the offer of a health benefit plan under
2186 Subsection (2)(b).
2187 (5) (a) Any difference in price between a health benefit plan offered under Subsections
2188 (2)(a) and (b) shall be based on actuarially sound data.
2189 (b) Any difference in price between a health benefit plan offered under Subsection
2190 (3)(a) shall be based on actuarially sound data.
2191 (6) Nothing in this section limits the number of health benefit plans that an insurer may
2192 offer.
2193 Section 14. Section **31A-22-625** is amended to read:
2194 **31A-22-625. Catastrophic coverage of mental health conditions.**
2195 (1) As used in this section:
2196 (a) (i) "Catastrophic mental health coverage" means coverage in a health benefit plan
2197 that does not impose a lifetime limit, annual payment limit, episodic limit, inpatient or

2198 outpatient service limit, or maximum out-of-pocket limit that places a greater financial burden
2199 on an insured for the evaluation and treatment of a mental health condition than for the
2200 evaluation and treatment of a physical health condition.
2201 (ii) "Catastrophic mental health coverage" may include a restriction on cost sharing
2202 factors, such as deductibles, copayments, or coinsurance, before reaching a maximum
2203 out-of-pocket limit.
2204 (iii) "Catastrophic mental health coverage" may include one maximum out-of-pocket
2205 limit for physical health conditions and another maximum out-of-pocket limit for mental health
2206 conditions, except that if separate out-of-pocket limits are established, the out-of-pocket limit
2207 for mental health conditions may not exceed the out-of-pocket limit for physical health
2208 conditions.
2209 (b) (i) "50/50 mental health coverage" means coverage in a health benefit plan that
2210 pays for at least 50% of covered services for the diagnosis and treatment of mental health
2211 conditions.
2212 (ii) "50/50 mental health coverage" may include a restriction on:
2213 (A) episodic limits;
2214 (B) inpatient or outpatient service limits; or
2215 (C) maximum out-of-pocket limits.
2216 (c) "Large employer" is as defined in 42 U.S.C. Sec. 300gg-91.
2217 (d) (i) "Mental health condition" means a condition or disorder involving mental illness
2218 that falls under a diagnostic category listed in the Diagnostic and Statistical Manual, as
2219 periodically revised.
2220 (ii) "Mental health condition" does not include the following when diagnosed as the
2221 primary or substantial reason or need for treatment:
2222 (A) a marital or family problem;
2223 (B) a social, occupational, religious, or other social maladjustment;
2224 (C) a conduct disorder;
2225 (D) a chronic adjustment disorder;
2226 (E) a psychosexual disorder;
2227 (F) a chronic organic brain syndrome;
2228 (G) a personality disorder;

2229 (H) a specific developmental disorder or learning disability; or
2230 (I) an intellectual disability.
2231 (e) "Small employer" is as defined in 42 U.S.C. Sec. 300gg-91.
2232 (2) (a) At the time of purchase and renewal on or before January 1, 2014, an insurer
2233 shall offer to a small employer that it insures or seeks to insure a choice between:
2234 (i) (A) catastrophic mental health coverage; or
2235 (B) federally qualified mental health coverage as described in Subsection (3); and
2236 (ii) 50/50 mental health coverage.
2237 (b) In addition to complying with Subsection (2)(a), an insurer may offer to provide:
2238 (i) catastrophic mental health coverage, 50/50 mental health coverage, or both at levels
2239 that exceed the minimum requirements of this section; or
2240 (ii) coverage that excludes benefits for mental health conditions.
2241 (c) A small employer may, at its option, regardless of the employer's previous coverage
2242 for mental health conditions, choose either:
2243 (i) coverage offered under Subsection (2)(a)(i);
2244 (ii) 50/50 mental health coverage; or
2245 (iii) coverage offered under Subsection (2)(b).
2246 (d) An insurer is exempt from the 30% index rating restriction in Section
2247 31A-30-106.1 and, for the first year only that the employer chooses coverage that meets or
2248 exceeds catastrophic mental health coverage, the 15% annual adjustment restriction in Section
2249 31A-30-106.1, for [~~any~~] a small employer with 20 or less enrolled employees who chooses
2250 coverage that meets or exceeds catastrophic mental health coverage.
2251 (3) (a) An insurer shall offer a large employer mental health and substance use disorder
2252 benefit in compliance with Section 2705 of the Public Health Service Act, 42 U.S.C. Sec.
2253 300gg-26, and federal regulations adopted pursuant to that act.
2254 (b) An insurer shall provide in an individual or small employer health benefit plan,
2255 mental health and substance use disorder benefits in compliance with Section 2705 of the
2256 Public Health Service Act, 42 U.S.C. Sec. 300gg-26, and federal regulations adopted pursuant
2257 to that act.
2258 (4) (a) [~~An~~] For a policy issued or renewed before January 1, 2014, an insurer may
2259 provide catastrophic mental health coverage to a small employer through a managed care

2260 organization or system in a manner consistent with Chapter 8, Health Maintenance
2261 Organizations and Limited Health Plans, regardless of whether the insurance policy uses a
2262 managed care organization or system for the treatment of physical health conditions.
2263 (b) (i) Notwithstanding any other provision of this title, an insurer may:
2264 (A) establish a closed panel of providers for catastrophic mental health coverage; and
2265 (B) refuse to provide a benefit to be paid for services rendered by a nonpanel provider
2266 unless:
2267 (I) the insured is referred to a nonpanel provider with the prior authorization of the
2268 insurer; and
2269 (II) the nonpanel provider agrees to follow the insurer's protocols and treatment
2270 guidelines.
2271 (ii) If an insured receives services from a nonpanel provider in the manner permitted by
2272 Subsection (4)(b)(i)(B), the insurer shall reimburse the insured for not less than 75% of the
2273 average amount paid by the insurer for comparable services of panel providers under a
2274 noncapitated arrangement who are members of the same class of health care providers.
2275 (iii) This Subsection (4)(b) may not be construed as requiring an insurer to authorize a
2276 referral to a nonpanel provider.
2277 (c) To be eligible for catastrophic mental health coverage, a diagnosis or treatment of a
2278 mental health condition shall be rendered:
2279 (i) by a mental health therapist as defined in Section 58-60-102; or
2280 (ii) in a health care facility:
2281 (A) licensed or otherwise authorized to provide mental health services pursuant to:
2282 (I) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or
2283 (II) Title 62A, Chapter 2, Licensure of Programs and Facilities; and
2284 (B) that provides a program for the treatment of a mental health condition pursuant to a
2285 written plan.
2286 (5) The commissioner may prohibit an insurance policy that provides mental health
2287 coverage in a manner that is inconsistent with this section.
2288 (6) The commissioner [~~shall: (a)~~] may adopt rules, in accordance with Title 63G,
2289 Chapter 3, Utah Administrative Rulemaking Act, as necessary to ensure compliance with this
2290 section[~~; and~~].

2291 [(b) provide general figures on the percentage of insurance policies that include:]
2292 [(i) no mental health coverage;]
2293 [(ii) 50/50 mental health coverage;]
2294 [(iii) catastrophic mental health coverage; and]
2295 [(iv) coverage that exceeds the minimum requirements of this section.]
2296 [(7) This section may not be construed as discouraging or otherwise preventing an
2297 insurer from providing mental health coverage in connection with an individual insurance
2298 policy.]
2299 Section 15. Section **31A-22-635** is amended to read:
2300 **31A-22-635. Uniform application -- Uniform waiver of coverage -- Information**
2301 **on Health Insurance Exchange.**
2302 (1) For purposes of this section, "insurer":
2303 (a) is defined in Subsection 31A-22-634(1); and
2304 (b) includes the state employee's risk pool under Section 49-20-202.
2305 (2) (a) Insurers offering a health benefit plan to an individual or small employer shall
2306 use a uniform application form.
2307 (b) The uniform application form:
2308 (i) [except for cancer and transplants,] may not include questions about an applicant's
2309 health history [prior to the previous five years]; and
2310 (ii) shall be shortened and simplified in accordance with rules adopted by the
2311 commissioner.
2312 (c) Insurers offering a health benefit plan to a small employer shall use a uniform
2313 waiver of coverage form, which may not include health status related questions [other than
2314 pregnancy], and is limited to:
2315 (i) information that identifies the employee;
2316 (ii) proof of the employee's insurance coverage; and
2317 (iii) a statement that the employee declines coverage with a particular employer group.
2318 (3) Notwithstanding the requirements of Subsection (2)(a), the uniform application and
2319 uniform waiver of coverage forms may, if the combination or modification is approved by the
2320 commissioner, be combined or modified to facilitate a more efficient and consumer friendly
2321 experience for:

2322 (a) enrollees using the Health Insurance Exchange; or
2323 (b) insurers using electronic applications.
2324 (4) The uniform application form, and uniform waiver form, shall be adopted and
2325 approved by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative
2326 Rulemaking Act.
2327 (5) (a) An insurer who offers a health benefit plan [~~in either the group or individual~~
2328 ~~market~~] on the Health Insurance Exchange created in Section 63M-1-2504, shall:
2329 (i) accept and process an electronic submission of the uniform application or uniform
2330 waiver from the Health Insurance Exchange using the electronic standards adopted pursuant to
2331 Section 63M-1-2506;
2332 (ii) if requested, provide the applicant with a copy of the completed application either
2333 by mail or electronically;
2334 (iii) post all health benefit plans offered by the insurer in the defined contribution
2335 arrangement market on the Health Insurance Exchange; and
2336 (iv) post the information required by Subsection (6) on the Health Insurance Exchange
2337 for every health benefit plan the insurer offers on the Health Insurance Exchange.
2338 (b) Except as provided in Subsection (5)(c), an insurer who posts health benefit plans
2339 on the Health Insurance Exchange may not directly or indirectly offer products on the Health
2340 Insurance Exchange that are not health benefit plans.
2341 (c) Notwithstanding Subsection (5)(b):
2342 (i) an insurer may offer a health savings account on the Health Insurance Exchange;
2343 [~~and~~]
2344 (ii) an insurer may offer dental [~~and vision~~] plans on the Health Insurance Exchange
2345 [~~if:~~]; and
2346 [~~(A) the department determines, after study and consultation with the Health System~~
2347 ~~Reform Task Force, that the department is able to establish standards for dental and vision~~
2348 ~~policies offered on the Health Insurance Exchange, and the department determines whether a~~
2349 ~~risk adjuster mechanism is necessary for a defined contribution vision and dental plan market~~
2350 ~~on the Health Insurance Exchange; and~~]
2351 [~~(B)~~] (iii) the department[~~, in accordance with recommendations from the Health~~
2352 ~~System Reform Task Force, adopts~~] may make administrative rules to regulate the offer of

2353 dental [~~and vision~~] plans on the Health Insurance Exchange.
2354 (6) An insurer shall provide the commissioner and the Health Insurance Exchange with
2355 the following information for each health benefit plan submitted to the Health Insurance
2356 Exchange, in the electronic format required by Subsection 63M-1-2506(1):
2357 (a) plan design, benefits, and options offered by the health benefit plan including state
2358 mandates the plan does not cover;
2359 (b) information and Internet address to online provider networks;
2360 (c) wellness programs and incentives;
2361 (d) descriptions of prescription drug benefits, exclusions, or limitations;
2362 (e) the percentage of claims paid by the insurer within 30 days of the date a claim is
2363 submitted to the insurer for the prior year; and
2364 (f) the claims denial and insurer transparency information developed in accordance
2365 with Subsection 31A-22-613.5(4).
2366 (7) The department shall post on the Health Insurance Exchange the department's
2367 solvency rating for each insurer who posts a health benefit plan on the Health Insurance
2368 Exchange. The solvency rating for each insurer shall be based on methodology established by
2369 the department by administrative rule and shall be updated each calendar year.
2370 (8) (a) The commissioner may request information from an insurer under Section
2371 31A-22-613.5 to verify the data submitted to the department and to the Health Insurance
2372 Exchange.
2373 (b) The commissioner shall regulate [~~any~~] the fees charged by insurers to an enrollee
2374 for a uniform application form or electronic submission of the application forms.
2375 Section 16. Section **31A-22-721** is amended to read:
2376 **31A-22-721. A health benefit plan for a plan sponsor -- Discontinuance and**
2377 **nonrenewal.**
2378 (1) Except as otherwise provided in this section, a health benefit plan for a plan
2379 sponsor is renewable and continues in force:
2380 (a) with respect to all eligible employees and dependents; and
2381 (b) at the option of the plan sponsor.
2382 (2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed:
2383 (a) for a network plan, if[~~: (i)~~] there is no longer any enrollee under the group health

2384 plan who lives, resides, or works in:
2385 [~~(A)~~] (i) the service area of the insurer; or
2386 [~~(B)~~] (ii) the area for which the insurer is authorized to do business; [~~and~~] or
2387 [~~(ii) in the case of the small employer market, the insurer applies the same criteria the~~
2388 ~~insurer would apply in denying enrollment in the plan under Subsection 31A-30-108(7); or~~]
2389 (b) for coverage made available in the small or large employer market only through an
2390 association, if:
2391 (i) the employer's membership in the association ceases; and
2392 (ii) the coverage is terminated uniformly without regard to any health status-related
2393 factor relating to any covered individual.
2394 (3) A health benefit plan for a plan sponsor may be discontinued if:
2395 (a) a condition described in Subsection (2) exists;
2396 (b) the plan sponsor fails to pay premiums or contributions in accordance with the
2397 terms of the contract;
2398 (c) the plan sponsor:
2399 (i) performs an act or practice that constitutes fraud; or
2400 (ii) makes an intentional misrepresentation of material fact under the terms of the
2401 coverage;
2402 (d) the insurer:
2403 (i) elects to discontinue offering a particular health benefit product delivered or issued
2404 for delivery in this state;
2405 (ii) (A) provides notice of the discontinuation in writing:
2406 (I) to each plan sponsor, employee, and dependent of a plan sponsor or employee; and
2407 (II) at least 90 days before the date the coverage will be discontinued;
2408 (B) provides notice of the discontinuation in writing:
2409 (I) to the commissioner; and
2410 (II) at least three working days prior to the date the notice is sent to the affected plan
2411 sponsors, employees, and dependents of plan sponsors or employees;
2412 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase any
2413 other health benefit products currently being offered:
2414 (I) by the insurer in the market; or

2415 (II) in the case of a large employer, any other health benefit plan currently being
2416 offered in that market; and
2417 (D) in exercising the option to discontinue that product and in offering the option of
2418 coverage in this section, the insurer acts uniformly without regard to:
2419 (I) the claims experience of a plan sponsor;
2420 (II) any health status-related factor relating to any covered participant or beneficiary; or
2421 (III) any health status-related factor relating to a new participant or beneficiary who
2422 may become eligible for coverage; or
2423 (e) the insurer:
2424 (i) elects to discontinue all of the insurer's health benefit plans:
2425 (A) in the small employer market; or
2426 (B) the large employer market; or
2427 (C) both the small and large employer markets; and
2428 (ii) (A) provides notice of the discontinuance in writing:
2429 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
2430 (II) at least 180 days before the date the coverage will be discontinued;
2431 (B) provides notice of the discontinuation in writing:
2432 (I) to the commissioner in each state in which an affected insured individual is known
2433 to reside; and
2434 (II) at least 30 business days prior to the date the notice is sent to the affected plan
2435 sponsors, employees, and dependents of a plan sponsor or employee;
2436 (C) discontinues and nonrenews all plans issued or delivered for issuance in the
2437 market; and
2438 (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.
2439 (4) A large employer health benefit plan may be discontinued or nonrenewed:
2440 (a) if a condition described in Subsection (2) exists; or
2441 (b) for noncompliance with the insurer's:
2442 (i) minimum participation requirements; or
2443 (ii) employer contribution requirements.
2444 (5) A small employer health benefit plan may be discontinued or nonrenewed:
2445 (a) if a condition described in Subsection (2) exists; or

2446 (b) for noncompliance with the insurer's employer contribution requirements.
2447 (6) A small employer health benefit plan may be nonrenewed:
2448 (a) if a condition described in Subsection (2) exists; or
2449 (b) for noncompliance with the insurer's minimum participation requirements.
2450 (7) (a) Except as provided in Subsection (7)(d), an eligible employee may be
2451 discontinued if after issuance of coverage the eligible employee:
2452 (i) engages in an act or practice that constitutes fraud in connection with the coverage;
2453 or
2454 (ii) makes an intentional misrepresentation of material fact in connection with the
2455 coverage.
2456 (b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:
2457 (i) 12 months after the date of discontinuance; and
2458 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
2459 to reenroll.
2460 (c) At the time the eligible employee's coverage is discontinued under Subsection
2461 (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is
2462 discontinued.
2463 (d) An eligible employee may not be discontinued under this Subsection (7) because of
2464 a fraud or misrepresentation that relates to health status.
2465 (8) (a) Except as provided in Subsection (8)(b), an insurer that elects to discontinue
2466 offering a health benefit plan under Subsection (3)(e) shall be prohibited from writing new
2467 business in such market in this state for a period of five years beginning on the date of
2468 discontinuation of the last coverage that is discontinued.
2469 (b) The commissioner may waive the prohibition under Subsection (8)(a) when the
2470 commissioner finds that waiver is in the public interest:
2471 (i) to promote competition; or
2472 (ii) to resolve inequity in the marketplace.
2473 (9) If an insurer is doing business in one established geographic service area of the
2474 state, this section applies only to the insurer's operations in that geographic service area.
2475 (10) An insurer may modify a health benefit plan for a plan sponsor only:
2476 (a) at the time of coverage renewal; and

2477 (b) if the modification is effective uniformly among all plans with a particular product
2478 or service.
2479 (11) For purposes of this section, a reference to "plan sponsor" includes a reference to
2480 the employer:
2481 (a) with respect to coverage provided to an employer member of the association; and
2482 (b) if the health benefit plan is made available by an insurer in the employer market
2483 only through:
2484 (i) an association;
2485 (ii) a trust; or
2486 (iii) a discretionary group.
2487 (12) (a) A small employer that, after purchasing a health benefit plan in the small group
2488 market, employs on average more than 50 eligible employees on each business day in a
2489 calendar year may continue to renew the health benefit plan purchased in the small group
2490 market.
2491 (b) A large employer that, after purchasing a health benefit plan in the large group
2492 market, employs on average less than 51 eligible employees on each business day in a calendar
2493 year may continue to renew the health benefit plan purchased in the large group market.
2494 (13) An insurer offering employer sponsored health benefit plans shall comply with the
2495 Health Insurance Portability and Accountability Act, 42 U.S.C. Sec. 300gg and 300gg-1.
2496 Section 17. Section **31A-23a-102** is amended to read:
2497 **31A-23a-102. Definitions.**
2498 As used in this chapter:
2499 (1) "Bail bond producer" is as defined in Section 31A-35-102.
2500 (2) "Home state" means a state or territory of the United States or the District of
2501 Columbia in which an insurance producer:
2502 (a) maintains the insurance producer's principal:
2503 (i) place of residence; or
2504 (ii) place of business; and
2505 (b) is licensed to act as an insurance producer.
2506 (3) "Insurer" is as defined in Section 31A-1-301, except that the following persons or
2507 similar persons are not insurers for purposes of Part 7, Producer Controlled Insurers:

2508 (a) a risk retention group as defined in:
2509 (i) the Superfund Amendments and Reauthorization Act of 1986, Pub. L. No. 99-499;
2510 (ii) the Risk Retention Act, 15 U.S.C. Sec. 3901 et seq.; and
2511 (iii) Chapter 15, Part 2, Risk Retention Groups Act;
2512 (b) a residual market pool;
2513 (c) a joint underwriting authority or association; and
2514 (d) a captive insurer.
2515 (4) "License" is defined in Section 31A-1-301.
2516 (5) (a) "Managing general agent" means a person that:
2517 (i) manages all or part of the insurance business of an insurer, including the
2518 management of a separate division, department, or underwriting office;
2519 (ii) acts as an agent for the insurer whether it is known as a managing general agent,
2520 manager, or other similar term;
2521 (iii) produces and underwrites an amount of gross direct written premium equal to, or
2522 more than, 5% of[;] the policyholder surplus as reported in the last annual statement of the
2523 insurer in any one quarter or year:
2524 (A) with or without the authority;
2525 (B) separately or together with an affiliate; and
2526 (C) directly or indirectly; and
2527 (iv) (A) adjusts or pays claims in excess of an amount determined by the
2528 commissioner; or
2529 (B) negotiates reinsurance on behalf of the insurer.
2530 (b) Notwithstanding Subsection (5)(a), the following persons may not be considered as
2531 managing general agent for the purposes of this chapter:
2532 (i) an employee of the insurer;
2533 (ii) a United States manager of the United States branch of an alien insurer;
2534 (iii) an underwriting manager that, pursuant to contract:
2535 (A) manages all the insurance operations of the insurer;
2536 (B) is under common control with the insurer;
2537 (C) is subject to Chapter 16, Insurance Holding Companies; and
2538 (D) is not compensated based on the volume of premiums written; and

2539 (iv) the attorney-in-fact authorized by and acting for the subscribers of a reciprocal
2540 insurer or inter-insurance exchange under powers of attorney.
2541 (6) "Negotiate" means the act of conferring directly with or offering advice directly to a
2542 purchaser or prospective purchaser of a particular contract of insurance concerning a
2543 substantive benefit, term, or condition of the contract if the person engaged in that act:
2544 (a) sells insurance; or
2545 (b) obtains insurance from insurers for purchasers.
2546 (7) "Reinsurance intermediary" means:
2547 (a) a reinsurance intermediary-broker; or
2548 (b) a reinsurance intermediary-manager.
2549 (8) "Reinsurance intermediary-broker" means a person other than an officer or
2550 employee of the ceding insurer, firm, association, or corporation who solicits, negotiates, or
2551 places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority
2552 or power to bind reinsurance on behalf of the insurer.
2553 (9) (a) "Reinsurance intermediary-manager" means a person who:
2554 (i) has authority to bind or who manages all or part of the assumed reinsurance
2555 business of a reinsurer, including the management of a separate division, department, or
2556 underwriting office; and
2557 (ii) acts as an agent for the reinsurer whether the person is known as a reinsurance
2558 intermediary-manager, manager, or other similar term.
2559 (b) Notwithstanding Subsection (9)(a), the following persons may not be considered
2560 reinsurance intermediary-managers for the purpose of this chapter with respect to the reinsurer:
2561 (i) an employee of the reinsurer;
2562 (ii) a United States manager of the United States branch of an alien reinsurer;
2563 (iii) an underwriting manager that, pursuant to contract:
2564 (A) manages all the reinsurance operations of the reinsurer;
2565 (B) is under common control with the reinsurer;
2566 (C) is subject to Chapter 16, Insurance Holding Companies; and
2567 (D) is not compensated based on the volume of premiums written; and
2568 (iv) the manager of a group, association, pool, or organization of insurers that:
2569 (A) engage in joint underwriting or joint reinsurance; and

2570 (B) are subject to examination by the insurance commissioner of the state in which the
2571 manager's principal business office is located.
2572 (10) "Resident" is as defined by rule made by the commissioner in accordance with
2573 Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
2574 [~~(10)~~] (11) "Search" means a license subline of authority in conjunction with the title
2575 insurance line of authority that allows a person to issue title insurance commitments or policies
2576 on behalf of a title insurer.
2577 [~~(11)~~] (12) "Sell" means to exchange a contract of insurance:
2578 (a) by any means;
2579 (b) for money or its equivalent; and
2580 (c) on behalf of an insurance company.
2581 [~~(12)~~] (13) "Solicit" means:
2582 (a) attempting to sell insurance;
2583 (b) asking or urging a person to apply for:
2584 (i) a particular kind of insurance; and
2585 (ii) insurance from a particular insurance company;
2586 (c) advertising insurance, including advertising for the purpose of obtaining leads for
2587 the sale of insurance; or
2588 (d) holding oneself out as being in the insurance business.
2589 [~~(13)~~] (14) "Terminate" means:
2590 (a) the cancellation of the relationship between:
2591 (i) an individual licensee or agency licensee and a particular insurer; or
2592 (ii) an individual licensee and a particular agency licensee; or
2593 (b) the termination of:
2594 (i) an individual licensee's or agency licensee's authority to transact insurance on behalf
2595 of a particular insurance company; or
2596 (ii) an individual licensee's authority to transact insurance on behalf of a particular
2597 agency licensee.
2598 [~~(14)~~] (15) "Title marketing representative" means a person who:
2599 (a) represents a title insurer in soliciting, requesting, or negotiating the placing of:
2600 (i) title insurance; or

2601 (ii) escrow services; and
2602 (b) does not have a search or escrow license as provided in Section 31A-23a-106.
2603 [~~(15)~~] (16) "Uniform application" means the version of the National Association of
2604 Insurance Commissioners' uniform application for resident and nonresident producer licensing
2605 at the time the application is filed.
2606 [~~(16)~~] (17) "Uniform business entity application" means the version of the National
2607 Association of Insurance Commissioners' uniform business entity application for resident and
2608 nonresident business entities at the time the application is filed.
2609 Section 18. Section **31A-23a-104** is amended to read:
2610 **31A-23a-104. Application for individual license -- Application for agency license.**
2611 (1) This section applies to an initial or renewal license as a:
2612 (a) producer;
2613 (b) surplus lines producer;
2614 (c) limited line producer;
2615 (d) consultant;
2616 (e) managing general agent; or
2617 (f) reinsurance intermediary.
2618 (2) (a) Subject to Subsection (2)(b), to obtain or renew an individual license, an
2619 individual shall:
2620 (i) file an application for an initial or renewal individual license with the commissioner
2621 on forms and in a manner the commissioner prescribes; and
2622 (ii) pay a license fee that is not refunded if the application:
2623 (A) is denied; or
2624 (B) is incomplete when filed and is never completed by the applicant.
2625 (b) An application described in this Subsection (2) shall provide:
2626 (i) information about the applicant's identity;
2627 (ii) the applicant's Social Security number;
2628 (iii) the applicant's personal history, experience, education, and business record;
2629 (iv) whether the applicant is 18 years of age or older;
2630 (v) whether the applicant has committed an act that is a ground for denial, suspension,
2631 or revocation as set forth in Section 31A-23a-105 or 31A-23a-111;

2632 (vi) if the application is for a resident individual producer license, certification that the
2633 applicant complies with Section 31A-23a-203.5; and
2634 (vii) any other information the commissioner reasonably requires.
2635 (3) The commissioner may require a document reasonably necessary to verify the
2636 information contained in an application filed under this section.
2637 (4) An applicant's Social Security number contained in an application filed under this
2638 section is a private record under Section 63G-2-302.
2639 (5) (a) Subject to Subsection (5)(b), to obtain or renew an agency license, a person
2640 shall:
2641 (i) file an application for an initial or renewal agency license with the commissioner on
2642 forms and in a manner the commissioner prescribes; and
2643 (ii) pay a license fee that is not refunded if the application:
2644 (A) is denied; or
2645 (B) is incomplete when filed and is never completed by the applicant.
2646 (b) An application described in Subsection (5)(a) shall provide:
2647 (i) information about the applicant's identity;
2648 (ii) the applicant's federal employer identification number;
2649 (iii) the designated responsible licensed [~~producer~~] individual;
2650 (iv) the identity of the owners, partners, officers, and directors;
2651 (v) whether the applicant has committed an act that is a ground for denial, suspension,
2652 or revocation as set forth in Section 31A-23a-105 or 31A-23a-111; and
2653 (vi) any other information the commissioner reasonably requires.
2654 Section 19. Section **31A-23a-105** is amended to read:
2655 **31A-23a-105. General requirements for individual and agency license issuance**
2656 **and renewal.**
2657 (1) (a) The commissioner shall issue or renew a license to a person described in
2658 Subsection (1)(b) to act as:
2659 (i) a producer;
2660 (ii) a surplus lines producer;
2661 (iii) a limited line producer;
2662 (iv) a consultant;

2663 (v) a managing general agent; or
2664 (vi) a reinsurance intermediary.
2665 (b) The commissioner shall issue or renew a license under Subsection (1)(a) to a
2666 person who, as to the license type and line of authority classification applied for under Section
2667 31A-23a-106:
2668 (i) satisfies the application requirements under Section 31A-23a-104;
2669 (ii) satisfies the character requirements under Section 31A-23a-107;
2670 (iii) satisfies [~~any~~] applicable continuing education requirements under Section
2671 31A-23a-202;
2672 (iv) satisfies [~~any~~] applicable examination requirements under Section 31A-23a-108;
2673 (v) satisfies [~~any~~] applicable training period requirements under Section 31A-23a-203;
2674 (vi) if an applicant for a resident individual producer license, certifies that, to the extent
2675 applicable, the applicant:
2676 (A) is in compliance with Section 31A-23a-203.5; and
2677 (B) will maintain compliance with Section 31A-23a-203.5 during the period for which
2678 the license is issued or renewed;
2679 (vii) has not committed an act that is a ground for denial, suspension, or revocation as
2680 provided in Section 31A-23a-111;
2681 (viii) if a nonresident:
2682 (A) complies with Section 31A-23a-109; and
2683 (B) holds an active similar license in that person's home state [~~of residence~~];
2684 (ix) if an applicant for an individual title insurance producer or agency title insurance
2685 producer license, satisfies the requirements of Section 31A-23a-204;
2686 (x) if an applicant for a license to act as a life settlement provider or life settlement
2687 producer, satisfies the requirements of Section 31A-23a-117; and
2688 (xi) pays the applicable fees under Section 31A-3-103.
2689 (2) (a) This Subsection (2) applies to the following persons:
2690 (i) an applicant for a pending:
2691 (A) individual or agency producer license;
2692 (B) surplus lines producer license;
2693 (C) limited line producer license;

2694 (D) consultant license;
2695 (E) managing general agent license; or
2696 (F) reinsurance intermediary license; or
2697 (ii) a licensed:
2698 (A) individual or agency producer;
2699 (B) surplus lines producer;
2700 (C) limited line producer;
2701 (D) consultant;
2702 (E) managing general agent; or
2703 (F) reinsurance intermediary.
2704 (b) A person described in Subsection (2)(a) shall report to the commissioner:
2705 (i) an administrative action taken against the person, including a denial of a new or
2706 renewal license application:
2707 (A) in another jurisdiction; or
2708 (B) by another regulatory agency in this state; and
2709 (ii) a criminal prosecution taken against the person in any jurisdiction.
2710 (c) The report required by Subsection (2)(b) shall:
2711 (i) be filed:
2712 (A) at the time the person files the application for an individual or agency license; and
2713 (B) for an action or prosecution that occurs on or after the day on which the person
2714 files the application:
2715 (I) for an administrative action, within 30 days of the final disposition of the
2716 administrative action; or
2717 (II) for a criminal prosecution, within 30 days of the initial appearance before a court;
2718 and
2719 (ii) include a copy of the complaint or other relevant legal documents related to the
2720 action or prosecution described in Subsection (2)(b).
2721 (3) (a) The department may require a person applying for a license or for consent to
2722 engage in the business of insurance to submit to a criminal background check as a condition of
2723 receiving a license or consent.
2724 (b) A person, if required to submit to a criminal background check under Subsection

2725 (3)(a), shall:
2726 (i) submit a fingerprint card in a form acceptable to the department; and
2727 (ii) consent to a fingerprint background check by:
2728 (A) the Utah Bureau of Criminal Identification; and
2729 (B) the Federal Bureau of Investigation.
2730 (c) For a person who submits a fingerprint card and consents to a fingerprint
2731 background check under Subsection (3)(b), the department may request:
2732 (i) criminal background information maintained pursuant to Title 53, Chapter 10, Part
2733 2, Bureau of Criminal Identification, from the Bureau of Criminal Identification; and
2734 (ii) complete Federal Bureau of Investigation criminal background checks through the
2735 national criminal history system.
2736 (d) Information obtained by the department from the review of criminal history records
2737 received under this Subsection (3) shall be used by the department for the purposes of:
2738 (i) determining if a person satisfies the character requirements under Section
2739 31A-23a-107 for issuance or renewal of a license;
2740 (ii) determining if a person has failed to maintain the character requirements under
2741 Section 31A-23a-107; and
2742 (iii) preventing a person who violates the federal Violent Crime Control and Law
2743 Enforcement Act of 1994, 18 U.S.C. Sec. 1033, from engaging in the business of insurance in
2744 the state.
2745 (e) If the department requests the criminal background information, the department
2746 shall:
2747 (i) pay to the Department of Public Safety the costs incurred by the Department of
2748 Public Safety in providing the department criminal background information under Subsection
2749 (3)(c)(i);
2750 (ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau
2751 of Investigation in providing the department criminal background information under
2752 Subsection (3)(c)(ii); and
2753 (iii) charge the person applying for a license or for consent to engage in the business of
2754 insurance a fee equal to the aggregate of Subsections (3)(e)(i) and (ii).
2755 (4) To become a resident licensee in accordance with Section 31A-23a-104 and this

2756 section, a person licensed as one of the following in another state who moves to this state shall
2757 apply within 90 days of establishing legal residence in this state:
2758 (a) insurance producer;
2759 (b) surplus lines producer;
2760 (c) limited line producer;
2761 (d) consultant;
2762 (e) managing general agent; or
2763 (f) reinsurance intermediary.
2764 (5) (a) The commissioner may deny a license application for a license listed in
2765 Subsection (5)(b) if the person applying for the license, as to the license type and line of
2766 authority classification applied for under Section 31A-23a-106:
2767 (i) fails to satisfy the requirements as set forth in this section; or
2768 (ii) commits an act that is grounds for denial, suspension, or revocation as set forth in
2769 Section 31A-23a-111.
2770 (b) This Subsection (5) applies to the following licenses:
2771 (i) producer;
2772 (ii) surplus lines producer;
2773 (iii) limited line producer;
2774 (iv) consultant;
2775 (v) managing general agent; or
2776 (vi) reinsurance intermediary.
2777 (6) Notwithstanding the other provisions of this section, the commissioner may:
2778 (a) issue a license to an applicant for a license for a title insurance line of authority only
2779 with the concurrence of the Title and Escrow Commission; and
2780 (b) renew a license for a title insurance line of authority only with the concurrence of
2781 the Title and Escrow Commission.
2782 Section 20. Section **31A-23a-108** is amended to read:
2783 **31A-23a-108. Examination requirements.**
2784 (1) (a) The commissioner may require [~~applicants~~] an applicant for [~~any~~] a particular
2785 license type under Section 31A-23a-106 to pass a line of authority examination as a
2786 requirement for a license, except that an examination may not be required of [~~applicants~~] an

2787 applicant for:
2788 (i) [licenses] a license under Subsection 31A-23a-106(2)(c); or
2789 (ii) [other] another limited line license [lines] line of authority recognized by the
2790 commissioner or the Title and Escrow Commission by rule as provided in Subsection
2791 31A-23a-106(3).
2792 (b) The examination described in Subsection (1)(a):
2793 (i) shall reasonably relate to the line of authority for which it is prescribed; and
2794 (ii) may be administered by the commissioner or as otherwise specified by rule.
2795 (2) The commissioner shall waive the requirement of an examination for a nonresident
2796 applicant who:
2797 (a) applies for an insurance producer license in this state within 90 days of establishing
2798 legal residence in this state;
2799 (b) has been licensed for the same line of authority in another state; and
2800 (c) (i) is licensed in the state described in Subsection (2)(b) at the time the applicant
2801 applies for an insurance producer license in this state; or
2802 (ii) if the application is received within 90 days of the cancellation of the applicant's
2803 previous license:
2804 (A) the prior state certifies that at the time of cancellation, the applicant was in good
2805 standing in that state; or
2806 (B) the state's producer database records maintained by the National Association of
2807 Insurance Commissioners or the National Association of Insurance Commissioner's affiliates or
2808 subsidiaries, indicates that the producer is or was licensed in good standing for the line of
2809 authority requested.
2810 [(3) A nonresident producer licensee who moves to this state and applies for a resident
2811 license within 90 days of establishing legal residence in this state shall be exempt from any line
2812 of authority examination that the producer was authorized on the producer's nonresident
2813 producer license, except where the commissioner determines otherwise by rule.]
2814 [(4)] (3) This section's requirement may only be applied to [applicants who are natural
2815 persons] an applicant who is a natural person.
2816 Section 21. Section **31A-23a-111** is amended to read:
2817 **31A-23a-111. Revocation, suspension, surrender, lapsing, limiting, or otherwise**

2818 **terminating a license -- Rulemaking for renewal or reinstatement.**
2819 (1) A license type issued under this chapter remains in force until:
2820 (a) revoked or suspended under Subsection (5);
2821 (b) surrendered to the commissioner and accepted by the commissioner in lieu of
2822 administrative action;
2823 (c) the licensee dies or is adjudicated incompetent as defined under:
2824 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
2825 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and
2826 Minors;
2827 (d) lapsed under Section 31A-23a-113; or
2828 (e) voluntarily surrendered.
2829 (2) The following may be reinstated within one year after the day on which the license
2830 is no longer in force:
2831 (a) a lapsed license; or
2832 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may
2833 not be reinstated after the license period in which the license is voluntarily surrendered.
2834 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a
2835 license, submission and acceptance of a voluntary surrender of a license does not prevent the
2836 department from pursuing additional disciplinary or other action authorized under:
2837 (a) this title; or
2838 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah
2839 Administrative Rulemaking Act.
2840 (4) A line of authority issued under this chapter remains in force until:
2841 (a) the qualifications pertaining to a line of authority are no longer met by the licensee;
2842 or
2843 (b) the supporting license type:
2844 (i) is revoked or suspended under Subsection (5);
2845 (ii) is surrendered to the commissioner and accepted by the commissioner in lieu of
2846 administrative action;
2847 (iii) lapses under Section 31A-23a-113; or
2848 (iv) is voluntarily surrendered; or

2849 (c) the licensee dies or is adjudicated incompetent as defined under:
2850 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
2851 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and
2852 Minors.
2853 (5) (a) If the commissioner makes a finding under Subsection (5)(b), as part of an
2854 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the
2855 commissioner may:
2856 (i) revoke:
2857 (A) a license; or
2858 (B) a line of authority;
2859 (ii) suspend for a specified period of 12 months or less:
2860 (A) a license; or
2861 (B) a line of authority;
2862 (iii) limit in whole or in part:
2863 (A) a license; or
2864 (B) a line of authority; or
2865 (iv) deny a license application.
2866 (b) The commissioner may take an action described in Subsection (5)(a) if the
2867 commissioner finds that the licensee:
2868 (i) is unqualified for a license or line of authority under Section 31A-23a-104,
2869 31A-23a-105, or 31A-23a-107;
2870 (ii) violates:
2871 (A) an insurance statute;
2872 (B) a rule that is valid under Subsection 31A-2-201(3); or
2873 (C) an order that is valid under Subsection 31A-2-201(4);
2874 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other
2875 delinquency proceedings in any state;
2876 (iv) fails to pay a final judgment rendered against the person in this state within 60
2877 days after the day on which the judgment became final;
2878 (v) fails to meet the same good faith obligations in claims settlement that is required of
2879 admitted insurers;

2880 (vi) is affiliated with and under the same general management or interlocking
2881 directorate or ownership as another insurance producer that transacts business in this state
2882 without a license;
2883 (vii) refuses:
2884 (A) to be examined; or
2885 (B) to produce its accounts, records, and files for examination;
2886 (viii) has an officer who refuses to:
2887 (A) give information with respect to the insurance producer's affairs; or
2888 (B) perform any other legal obligation as to an examination;
2889 (ix) provides information in the license application that is:
2890 (A) incorrect;
2891 (B) misleading;
2892 (C) incomplete; or
2893 (D) materially untrue;
2894 (x) violates an insurance law, valid rule, or valid order of another state's insurance
2895 department;
2896 (xi) obtains or attempts to obtain a license through misrepresentation or fraud;
2897 (xii) improperly withholds, misappropriates, or converts money or properties received
2898 in the course of doing insurance business;
2899 (xiii) intentionally misrepresents the terms of an actual or proposed:
2900 (A) insurance contract;
2901 (B) application for insurance; or
2902 (C) life settlement;
2903 (xiv) is convicted of a felony;
2904 (xv) admits or is found to have committed an insurance unfair trade practice or fraud;
2905 (xvi) in the conduct of business in this state or elsewhere:
2906 (A) uses fraudulent, coercive, or dishonest practices; or
2907 (B) demonstrates incompetence, untrustworthiness, or financial irresponsibility;
2908 (xvii) has an insurance license, or its equivalent, denied, suspended, or revoked in
2909 another state, province, district, or territory;
2910 (xviii) forges another's name to:

2911 (A) an application for insurance; or
2912 (B) a document related to an insurance transaction;
2913 (xix) improperly uses notes or another reference material to complete an examination
2914 for an insurance license;
2915 (xx) knowingly accepts insurance business from an individual who is not licensed;
2916 (xxi) fails to comply with an administrative or court order imposing a child support
2917 obligation;
2918 (xxii) fails to:
2919 (A) pay state income tax; or
2920 (B) comply with an administrative or court order directing payment of state income
2921 tax;
2922 (xxiii) violates or permits others to violate the federal Violent Crime Control and Law
2923 Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and therefore under 18 U.S.C. Sec. [~~1033~~] 1034
2924 is prohibited from engaging in the business of insurance; or
2925 (xxiv) engages in a method or practice in the conduct of business that endangers the
2926 legitimate interests of customers and the public.
2927 (c) For purposes of this section, if a license is held by an agency, both the agency itself
2928 and any individual designated under the license are considered to be the holders of the license.
2929 (d) If an individual designated under the agency license commits an act or fails to
2930 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,
2931 the commissioner may suspend, revoke, or limit the license of:
2932 (i) the individual;
2933 (ii) the agency, if the agency:
2934 (A) is reckless or negligent in its supervision of the individual; or
2935 (B) knowingly participates in the act or failure to act that is the ground for suspending,
2936 revoking, or limiting the license; or
2937 (iii) (A) the individual; and
2938 (B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).
2939 (6) A licensee under this chapter is subject to the penalties for acting as a licensee
2940 without a license if:
2941 (a) the licensee's license is:

2942 (i) revoked;
2943 (ii) suspended;
2944 (iii) limited;
2945 (iv) surrendered in lieu of administrative action;
2946 (v) lapsed; or
2947 (vi) voluntarily surrendered; and
2948 (b) the licensee:
2949 (i) continues to act as a licensee; or
2950 (ii) violates the terms of the license limitation.
2951 (7) A licensee under this chapter shall immediately report to the commissioner:
2952 (a) a revocation, suspension, or limitation of the person's license in another state, the
2953 District of Columbia, or a territory of the United States;
2954 (b) the imposition of a disciplinary sanction imposed on that person by another state,
2955 the District of Columbia, or a territory of the United States; or
2956 (c) a judgment or injunction entered against that person on the basis of conduct
2957 involving:
2958 (i) fraud;
2959 (ii) deceit;
2960 (iii) misrepresentation; or
2961 (iv) a violation of an insurance law or rule.
2962 (8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a
2963 license in lieu of administrative action may specify a time, not to exceed five years, within
2964 which the former licensee may not apply for a new license.
2965 (b) If no time is specified in an order or agreement described in Subsection (8)(a), the
2966 former licensee may not apply for a new license for five years from the day on which the order
2967 or agreement is made without the express approval by the commissioner.
2968 (9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of
2969 a license issued under this part if so ordered by a court.
2970 (10) The commissioner shall by rule prescribe the license renewal and reinstatement
2971 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
2972 Section 22. Section **31A-23a-112** is amended to read:

2973 **31A-23a-112. Probation -- Grounds for revocation.**
2974 (1) The commissioner may place a licensee on probation for a period not to exceed 24
2975 months as follows:
2976 (a) after an adjudicative proceeding under Title 63G, Chapter 4, Administrative
2977 Procedures Act, for [~~any~~] circumstances that would justify a suspension under Section
2978 31A-23a-111; or
2979 (b) at the issuance or renewal of a [~~new~~] license:
2980 (i) with an admitted violation under 18 U.S.C. [~~Sections~~] Sec. 1033 [~~and 1034~~]; or
2981 (ii) with a response to background information questions on a new or renewal license
2982 application [~~indicating that~~] or information received from a background check conducted in
2983 connection with a new or renewal license application that indicates:
2984 (A) the person has been convicted of a crime, that is listed by rule made in accordance
2985 with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is grounds for
2986 probation;
2987 (B) the person is currently charged with a crime, that is listed by rule made in
2988 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is
2989 grounds for probation regardless of whether adjudication is withheld;
2990 (C) the person has been involved in an administrative proceeding regarding [~~any~~] a
2991 professional or occupational license; or
2992 (D) [~~any~~] a business in which the person is or was an owner, partner, officer, or
2993 director has been involved in an administrative proceeding regarding [~~any~~] a professional or
2994 occupational license.
2995 (2) The commissioner may place a licensee on probation for a specified period no
2996 longer than 24 months if the licensee has admitted to a violation under 18 U.S.C. [~~Sections~~]
2997 Sec. 1033 [~~and 1034~~].
2998 (3) The probation order shall state the conditions for retention of the license, which
2999 shall be reasonable.
3000 (4) [~~Any~~] A violation of the probation is grounds for revocation pursuant to [~~any~~] a
3001 proceeding authorized under Title 63G, Chapter 4, Administrative Procedures Act.
3002 Section 23. Section **31A-23a-113** is amended to read:
3003 **31A-23a-113. License lapse and voluntary surrender.**

3004 (1) (a) A license issued under this chapter shall lapse if the licensee fails to:
3005 (i) pay when due a fee under Section 31A-3-103;
3006 (ii) complete continuing education requirements under Section 31A-23a-202 before
3007 submitting the license renewal application;
3008 (iii) submit a completed renewal application as required by Section 31A-23a-104;
3009 (iv) submit additional documentation required to complete the licensing process as
3010 related to a specific license type or line of authority; or
3011 (v) maintain an active license in a [~~resident~~] licensee's home state if the licensee is a
3012 nonresident licensee.
3013 (b) (i) A licensee whose license lapses due to the following may request an action
3014 described in Subsection (1)(b)(ii):
3015 (A) military service;
3016 (B) voluntary service for a period of time designated by the person for whom the
3017 licensee provides voluntary service; or
3018 (C) some other extenuating circumstances, such as long-term medical disability.
3019 (ii) A licensee described in Subsection (1)(b)(i) may request:
3020 (A) reinstatement of the license no later than one year after the day on which the
3021 license lapses; and
3022 (B) waiver of any of the following imposed for failure to comply with renewal
3023 procedures:
3024 (I) an examination requirement;
3025 (II) reinstatement fees set under Section 31A-3-103;
3026 (III) continuing education requirements; or
3027 (IV) other sanction imposed for failure to comply with renewal procedures.
3028 (2) If a license issued under this chapter is voluntarily surrendered, the license or line
3029 of authority may be reinstated:
3030 (a) during the license period in which the license is voluntarily surrendered; and
3031 (b) no later than one year after the day on which the license is voluntarily surrendered.
3032 [~~(3) A voluntarily surrendered license that is reinstated during the license period set~~
3033 ~~forth in Subsection (2) may not be reinstated until the person who voluntarily surrendered the~~
3034 ~~license complies with any applicable continuing education requirements for the period during~~

3035 ~~which the license was voluntarily surrendered.~~]

3036 Section 24. Section **31A-23a-202** is amended to read:

3037 **31A-23a-202. Continuing education requirements.**

3038 (1) Pursuant to this section, the commissioner shall by rule prescribe the continuing
3039 education requirements for a producer and a consultant.

3040 (2) (a) The commissioner may not state a continuing education requirement in terms of
3041 formal education.

3042 (b) The commissioner may state a continuing education requirement in terms of hours
3043 of insurance-related instruction received.

3044 (c) Insurance-related formal education may be a substitute, in whole or in part, for the
3045 hours required under Subsection (2)(b).

3046 (3) (a) The commissioner shall impose continuing education requirements in
3047 accordance with a two-year licensing period in which the licensee meets the requirements of
3048 this Subsection (3).

3049 (b) (i) Except as provided in this section, the continuing education requirements shall
3050 require:

3051 (A) that a licensee complete 24 credit hours of continuing education for every two-year
3052 licensing period;

3053 (B) that 3 of the 24 credit hours described in Subsection (3)(b)(i)(A) be ethics courses;
3054 and

3055 (C) that the licensee complete at least half of the required hours through classroom
3056 hours of insurance-related instruction.

3057 (ii) An hour of continuing education in accordance with Subsection (3)(b)(i) may be
3058 obtained through:

3059 (A) classroom attendance;

3060 (B) home study;

3061 (C) watching a video recording;

3062 (D) experience credit; or

3063 (E) another method provided by rule.

3064 (iii) (A) Notwithstanding Subsections (3)(b)(i)(A) and (B), an individual title insurance
3065 producer is required to complete 12 credit hours of continuing education for every two-year

3066 licensing period, with 3 of the credit hours being ethics courses unless the individual title
3067 insurance producer is licensed in this state as an individual title insurance producer for 20 or
3068 more consecutive years.
3069 (B) If an individual title insurance producer is licensed in this state as an individual
3070 title insurance producer for 20 or more consecutive years, the individual title insurance
3071 producer is required to complete 6 credit hours of continuing education for every two-year
3072 licensing period, with 3 of the credit hours being ethics courses.
3073 (C) Notwithstanding Subsection (3)(b)(iii)(A) or (B), an individual title insurance
3074 producer is considered to have met the continuing education requirements imposed under
3075 Subsection (3)(b)(iii)(A) or (B) if the individual title insurance producer:
3076 (I) is an active member in good standing with the Utah State Bar;
3077 (II) is in compliance with the continuing education requirements of the Utah State Bar;
3078 and
3079 (III) if requested by the department, provides the department evidence that the
3080 individual title insurance producer complied with the continuing education requirements of the
3081 Utah State Bar.
3082 (c) A licensee may obtain continuing education hours at any time during the two-year
3083 licensing period.
3084 (d) (i) A licensee is exempt from continuing education requirements under this section
3085 if:
3086 (A) the licensee was first licensed before [~~April 1, 1978~~] December 31, 1982;
3087 (B) the license does not have a continuous lapse for a period of more than one year,
3088 except for a license for which the licensee has had an exemption approved before May 11,
3089 2011;
3090 (C) the licensee requests an exemption from the department; and
3091 (D) the department approves the exemption.
3092 (ii) If the department approves the exemption under Subsection (3)(d)(i), the licensee is
3093 not required to apply again for the exemption.
3094 (e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the
3095 commissioner shall, by rule:
3096 (i) publish a list of insurance professional designations whose continuing education

3097 requirements can be used to meet the requirements for continuing education under Subsection
3098 (3)(b);
3099 (ii) authorize a continuing education provider or a state or national professional
3100 producer or consultant association to:
3101 (A) offer a qualified program for a license type or line of authority on a geographically
3102 accessible basis; and
3103 (B) collect a reasonable fee for funding and administration of a continuing education
3104 program, subject to the review and approval of the commissioner; and
3105 (iii) provide that membership by a producer or consultant in a state or national
3106 professional producer or consultant association is considered a substitute for the equivalent of
3107 two hours for each year during which the producer or consultant is a member of the
3108 professional association, except that the commissioner may not give more than two hours of
3109 continuing education credit in a year regardless of the number of professional associations of
3110 which the producer or consultant is a member.
3111 (f) A fee permitted under Subsection (3)(e)(ii)(B) that is charged for attendance at a
3112 professional producer or consultant association program may be less for an association
3113 member, on the basis of the member's affiliation expense, but shall preserve the right of a
3114 nonmember to attend without affiliation.
3115 (4) The commissioner shall approve a continuing education provider or continuing
3116 education course that satisfies the requirements of this section.
3117 (5) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the
3118 commissioner shall by rule set the processes and procedures for continuing education provider
3119 registration and course approval.
3120 (6) The requirements of this section apply only to a producer or consultant who is an
3121 individual.
3122 (7) A nonresident producer or consultant is considered to have satisfied this state's
3123 continuing education requirements if the nonresident producer or consultant satisfies the
3124 nonresident producer's or consultant's home state's continuing education requirements for a
3125 licensed insurance producer or consultant.
3126 (8) A producer or consultant subject to this section shall keep documentation of
3127 completing the continuing education requirements of this section for two years after the end of

3128 the two-year licensing period to which the continuing education applies.

3129 Section 25. Section **31A-23a-203** is amended to read:

3130 **31A-23a-203. Training period requirements.**

3131 (1) A producer is eligible to become a surplus lines producer only if the producer:

3132 (a) has passed the applicable surplus lines producer examination;

3133 (b) has been a producer with property [~~and~~] or casualty or both lines of authority for at

3134 least three years during the four years immediately preceding the date of application; and

3135 (c) has paid the applicable fee under Section 31A-3-103.

3136 (2) A person is eligible to become a consultant only if the person has acted in a

3137 capacity that would provide the person with preparation to act as an insurance consultant for a

3138 period aggregating not less than three years during the four years immediately preceding the

3139 date of application.

3140 (3) (a) A resident producer with an accident and health line of authority may only sell

3141 long-term care insurance if the producer:

3142 (i) initially completes a minimum of three hours of long-term care training before

3143 selling long-term care coverage; and

3144 (ii) after completing the training required by Subsection (3)(a)(i), completes a

3145 minimum of three hours of long-term care training during each subsequent two-year licensing

3146 period.

3147 (b) A course taken to satisfy a long-term care training requirement may be used toward

3148 satisfying a producer continuing education requirement.

3149 (c) Long-term care training is not a continuing education requirement to renew a

3150 producer license.

3151 (d) An insurer that issues long-term care insurance shall demonstrate to the

3152 commissioner, upon request, that a producer who is appointed by the insurer and who sells

3153 long-term care insurance coverage is in compliance with this Subsection (3).

3154 (4) The training periods required under this section apply only to an individual

3155 applying for a license under this chapter.

3156 Section 26. Section **31A-23a-402.5** is amended to read:

3157 **31A-23a-402.5. Inducements.**

3158 (1) (a) Except as provided in Subsection (2), a producer, consultant, or other licensee

3159 under this title, or an officer or employee of a licensee, may not induce a person to enter into,
3160 continue, or terminate an insurance contract by offering a benefit that is not:
3161 (i) specified in the insurance contract; or
3162 (ii) directly related to the insurance contract.
3163 (b) An insurer may not make or knowingly allow an agreement of insurance that is not
3164 clearly expressed in the insurance contract to be issued or renewed.
3165 (c) A licensee under this title may not absorb the tax under Section 31A-3-301.
3166 (2) This section does not apply to a title insurer, an individual title insurance producer,
3167 or agency title insurance producer, or an officer or employee of a title insurer, an individual
3168 title insurance producer, or an agency title insurance producer.
3169 (3) Items not prohibited by Subsection (1) include an insurer:
3170 (a) reducing premiums because of expense savings;
3171 (b) providing to a policyholder or insured one or more incentives, as defined by the
3172 commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative
3173 Rulemaking Act, to participate in a program or activity designed to reduce claims or claim
3174 expenses, including:
3175 (i) a premium discount offered to a small or large employer group based on a wellness
3176 program if:
3177 (A) the premium discount for the employer group does not exceed 20% of the group
3178 premium; and
3179 (B) the premium discount based on the wellness program is offered uniformly by the
3180 insurer to all employer groups in the large or small group market;
3181 (ii) a premium discount offered to employees of a small or large employer group in an
3182 amount that does not exceed federal limits on wellness program incentives; or
3183 (iii) a combination of premium discounts offered to the employer group and the
3184 employees of an employer group, based on a wellness program, if:
3185 (A) the premium discounts for the employer group comply with Subsection (3)(b)(i);
3186 and
3187 (B) the premium discounts for the employees of an employer group comply with
3188 Subsection (3)(b)(ii); or
3189 (c) receiving premiums under an installment payment plan.

3190 (4) Items not prohibited by Subsection (1) include a producer, consultant, or other
3191 licensee, or an officer or employee of a licensee, either directly or through a third party:
3192 (a) engaging in a usual kind of social courtesy if receipt of the social courtesy is not
3193 conditioned on a quote or the purchase of a particular insurance product;
3194 (b) extending credit on a premium to the insured:
3195 (i) without interest, for no more than 90 days from the effective date of the insurance
3196 contract;
3197 (ii) for interest that is not less than the legal rate under Section 15-1-1, on the unpaid
3198 balance after the time period described in Subsection (4)(b)(i); and
3199 (iii) except that an installment or payroll deduction payment of premiums on an
3200 insurance contract issued under an insurer's mass marketing program is not considered an
3201 extension of credit for purposes of this Subsection (4)(b);
3202 (c) preparing or conducting a survey that:
3203 (i) is directly related to an accident and health insurance policy purchased from the
3204 licensee; or
3205 (ii) is used by the licensee to assess the benefit needs and preferences of insureds,
3206 employers, or employees directly related to an insurance product sold by the licensee;
3207 (d) providing limited human resource services that are directly related to an insurance
3208 product sold by the licensee, including:
3209 (i) answering questions directly related to:
3210 (A) an employee benefit offering or administration, if the insurance product purchased
3211 from the licensee is accident and health insurance or health insurance; and
3212 (B) employment practices liability, if the insurance product offered by or purchased
3213 from the licensee is property or casualty insurance; and
3214 (ii) providing limited human resource compliance training and education directly
3215 pertaining to an insurance product purchased from the licensee;
3216 (e) providing the following types of information or guidance:
3217 (i) providing guidance directly related to compliance with federal and state laws for an
3218 insurance product purchased from the licensee;
3219 (ii) providing a workshop or seminar addressing an insurance issue that is directly
3220 related to an insurance product purchased from the licensee; or

3221 (iii) providing information regarding:
3222 (A) employee benefit issues;
3223 (B) directly related insurance regulatory and legislative updates; or
3224 (C) similar education about an insurance product sold by the licensee and how the
3225 insurance product interacts with tax law;
3226 (f) preparing or providing a form that is directly related to an insurance product
3227 purchased from, or offered by, the licensee;
3228 (g) preparing or providing documents directly related to a premium only cafeteria plan
3229 within the meaning of Section 125, Internal Revenue Code, or a flexible spending account, but
3230 not providing ongoing administration of a flexible spending account;
3231 (h) providing enrollment and billing assistance, including:
3232 (i) providing benefit statements or new hire insurance benefits packages; and
3233 (ii) providing technology services such as an electronic enrollment platform or
3234 application system;
3235 (i) communicating coverages in writing and in consultation with the insured and
3236 employees;
3237 (j) providing employee communication materials and notifications directly related to an
3238 insurance product purchased from a licensee;
3239 (k) providing claims management and resolution to the extent permitted under the
3240 licensee's license;
3241 (l) providing underwriting or actuarial analysis or services;
3242 (m) negotiating with an insurer regarding the placement and pricing of an insurance
3243 product;
3244 (n) recommending placement and coverage options;
3245 (o) providing a health fair or providing assistance or advice on establishing or
3246 operating a wellness program, but not providing any payment for or direct operation of the
3247 wellness program;
3248 (p) providing COBRA and Utah mini-COBRA administration, consultations, and other
3249 services directly related to an insurance product purchased from the licensee;
3250 (q) assisting with a summary plan description, including providing a summary plan
3251 description wraparound;

3252 (r) providing information necessary for the preparation of documents directly related to
3253 the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001, et seq., as
3254 amended;
3255 (s) providing information or services directly related to the Health Insurance Portability
3256 and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936, as amended, such as services
3257 directly related to health care access, portability, and renewability when offered in connection
3258 with accident and health insurance sold by a licensee;
3259 (t) sending proof of coverage to a third party with a legitimate interest in coverage;
3260 (u) providing information in a form approved by the commissioner and directly related
3261 to determining whether an insurance product sold by the licensee meets the requirements of a
3262 third party contract that requires or references insurance coverage;
3263 (v) facilitating risk management services directly related to property and casualty
3264 insurance products sold or offered for sale by the licensee, including:
3265 (i) risk management;
3266 (ii) claims and loss control services;
3267 (iii) risk assessment consulting, including analysis of:
3268 (A) employer's job descriptions; or
3269 (B) employer's safety procedures or manuals; and
3270 (iv) providing information and training on best practices;
3271 (w) otherwise providing services that are legitimately part of servicing an insurance
3272 product purchased from a licensee; and
3273 (x) providing other directly related services approved by the department.
3274 (5) An inducement prohibited under Subsection (1) includes a producer, consultant, or
3275 other licensee, or an officer or employee of a licensee:
3276 (a) (i) providing a premium or commission rebate;
3277 (ii) paying the salary of an employee of a person who purchases an insurance product
3278 from the licensee; or
3279 (iii) if the licensee is an insurer, or a third party administrator who contracts with an
3280 insurer, paying the salary for an onsite staff member to perform an act prohibited under
3281 Subsection (5)(b)(xii); or
3282 (b) engaging in one or more of the following unless a fee is paid in accordance with

3283 Subsection (8):
3284 (i) performing background checks of prospective employees;
3285 (ii) providing legal services by a person licensed to practice law;
3286 (iii) performing drug testing that is directly related to an insurance product purchased
3287 from the licensee;
3288 (iv) preparing employer or employee handbooks, except that a licensee may:
3289 (A) provide information for a medical benefit section of an employee handbook;
3290 (B) provide information for the section of an employee handbook directly related to an
3291 employment practices liability insurance product purchased from the licensee; or
3292 (C) prepare or print an employee benefit enrollment guide;
3293 (v) providing job descriptions, postings, and applications for a person;
3294 (vi) providing payroll services;
3295 (vii) providing performance reviews or performance review training;
3296 (viii) providing union advice;
3297 (ix) providing accounting services;
3298 (x) providing data analysis information technology programs, except as provided in
3299 Subsection (4)(h)(ii);
3300 (xi) providing administration of health reimbursement accounts or health savings
3301 accounts; or
3302 (xii) if the licensee is an insurer, or a third party administrator who contracts with an
3303 insurer, the insurer issuing an insurance policy that lists in the insurance policy one or more of
3304 the following prohibited benefits:
3305 (A) performing background checks of prospective employees;
3306 (B) providing legal services by a person licensed to practice law;
3307 (C) performing drug testing that is directly related to an insurance product purchased
3308 from the insurer;
3309 (D) preparing employer or employee handbooks;
3310 (E) providing job descriptions postings, and applications;
3311 (F) providing payroll services;
3312 (G) providing performance reviews or performance review training;
3313 (H) providing union advice;

3314 (I) providing accounting services;
3315 (J) providing discrimination testing; or
3316 (K) providing data analysis information technology programs.
3317 (6) A producer, consultant, or other licensee or an officer or employee of a licensee
3318 shall itemize and bill separately from any other insurance product or service offered or
3319 provided under Subsection (5)(b).
3320 (7) (a) A de minimis gift or meal not to exceed $25 for each individual receiving the
3321 gift or meal is presumed to be a social courtesy not conditioned on a quote or purchase of a
3322 particular insurance product for purposes of Subsection (4)(a).
3323 (b) Notwithstanding Subsection (4)(a), a de minimis gift or meal not to exceed $10
3324 may be conditioned on receipt of a quote of a particular insurance product if the de minimis gift
3325 or meal is provided by the insurer and not by a producer or consultant.
3326 (8) If as provided under Subsection (5)(b) a producer, consultant, or other licensee is
3327 paid a fee to provide an item listed in Subsection (5)(b), the licensee shall comply with
3328 Subsection 31A-23a-501(2) in charging the fee, except that the fee paid for the item shall equal
3329 or exceed the fair market value of the item.
3330 Section 27. Section **31A-23b-102** is amended to read:
3331 **31A-23b-102. Definitions.**
3332 As used in this chapter:
3333 (1) "Compensation" is as defined in:
3334 (a) Subsections 31A-23a-501(1)(a), (b), and (d); and
3335 (b) PPACA.
3336 (2) "Enroll" and "enrollment" mean to:
3337 (a) (i) obtain personally identifiable information about an individual; and
3338 (ii) inform an individual about accident and health insurance plans or public programs
3339 offered on an exchange;
3340 (b) solicit insurance; or
3341 (c) submit to the exchange:
3342 (i) personally identifiable information about an individual; and
3343 (ii) an individual's selection of a particular accident and health insurance plan or public
3344 program offered on the exchange.

3345 (3) (a) "Exchange" means an online marketplace[~~: (i) for an individual to purchase a~~
3346 ~~qualified health plan; and (ii)~~] that is certified by the United States Department of Health and
3347 Human Services as either a state-based small employer exchange or a federally facilitated
3348 individual exchange under PPACA.
3349 (b) [~~(i)~~] "Exchange" does not include[~~: (A)~~] an online marketplace for the purchase of
3350 health insurance if the online marketplace is not a certified exchange [~~under PPACA; or~~] in
3351 accordance with Subsection (3)(a).
3352 [~~(B) except as provided in Subsection (3)(b)(ii), an online marketplace for small~~
3353 ~~employers that is certified as a PPACA compliant SHOP exchange.~~]
3354 [~~(ii) For purposes of this chapter, exchange does include a small employer SHOP~~
3355 ~~exchange described under Subsection (3)(b)(i)(B) if:~~]
3356 [~~(A) federal regulations under PPACA require a small employer exchange to allow~~
3357 ~~navigators to assist small employers and their employees with selection of qualified health~~
3358 ~~plans on a small employer exchange; and~~]
3359 [~~(B) the state has not entered into an agreement with the United States Department of~~
3360 ~~Health and Human Services that permits the state to limit the scope of practice of navigators to~~
3361 ~~only the individual PPACA exchange.~~]
3362 (4) "Navigator":
3363 (a) means a person who facilitates enrollment in an exchange by offering to assist, or
3364 who advertises any services to assist, with:
3365 (i) the selection of and enrollment in a qualified health plan or a public program
3366 offered on an exchange; or
3367 (ii) applying for premium subsidies through an exchange; and
3368 (b) includes a person who is an in-person assister or [~~an~~] a certified application assister
3369 as described in[~~: (i)~~] federal regulations or guidance issued under PPACA[~~; and~~].
3370 [~~(ii) the state exchange blueprint published by the Center for Consumer Information~~
3371 ~~and Insurance Oversight within the Centers for Medicare and Medicaid Services in the United~~
3372 ~~States Department of Health and Human Services.~~]
3373 (5) "Personally identifiable information" is as defined in 45 C.F.R. Sec. 155.260.
3374 (6) "Public programs" means the state Medicaid program in Title 26, Chapter 18,
3375 Medical Assistance Act, and Chapter 40, Utah Children's Health Insurance Act.

3376 (7) "Resident" is as defined by rule made by the commissioner in accordance with Title
3377 63G, Chapter 3, Utah Administrative Rulemaking Act.
3378 [~~(7)~~] (8) "Solicit" is as defined in Section 31A-23a-102.
3379 Section 28. Section **31A-23b-202** is amended to read:
3380 **31A-23b-202. Qualifications for a license.**
3381 (1) (a) The commissioner shall issue or renew a license to a person to act as a navigator
3382 if the person:
3383 (i) satisfies the:
3384 (A) application requirements under Section 31A-23b-203;
3385 (B) character requirements under Section 31A-23b-204;
3386 (C) examination and training requirements under Section 31A-23b-205; and
3387 (D) continuing education requirements under Section 31A-23b-206;
3388 (ii) certifies that, to the extent applicable, the applicant:
3389 (A) is in compliance with the surety bond requirements of Section 31A-23b-207; and
3390 (B) will maintain compliance with Section 31A-23b-207 during the period for which
3391 the license is issued or renewed; and
3392 (iii) has not committed an act that is a ground for denial, suspension, or revocation as
3393 provided in Section 31A-23b-401.
3394 (b) A license issued under this chapter is valid for [~~two years~~] one year.
3395 (2) (a) A person shall report to the commissioner:
3396 (i) an administrative action taken against the person, including a denial of a new or
3397 renewal license application:
3398 (A) in another jurisdiction; or
3399 (B) by another regulatory agency in this state; and
3400 (ii) a criminal prosecution taken against the person in any jurisdiction.
3401 (b) The report required by Subsection (2)(a) shall be filed:
3402 (i) at the time the person files the application for an individual or agency license; and
3403 (ii) for an action or prosecution that occurs on or after the day on which the person files
3404 the application:
3405 (A) for an administrative action, within 30 days of the final disposition of the
3406 administrative action; or

3407 (B) for a criminal prosecution, within 30 days of the initial appearance before a court.
3408 (c) The report required by Subsection (2)(a) shall include a copy of the complaint or
3409 other relevant legal documents related to the action or prosecution described in Subsection
3410 (2)(a).
3411 (3) (a) The department may:
3412 (i) require a person applying for a license to submit to a criminal background check as
3413 a condition of receiving a license; or
3414 (ii) accept a background check conducted by another organization.
3415 (b) A person, if required to submit to a criminal background check under Subsection
3416 (3)(a), shall:
3417 (i) submit a fingerprint card in a form acceptable to the department; and
3418 (ii) consent to a fingerprint background check by:
3419 (A) the Utah Bureau of Criminal Identification; and
3420 (B) the Federal Bureau of Investigation.
3421 (c) For a person who submits a fingerprint card and consents to a fingerprint
3422 background check under Subsection (3)(b), the department may request:
3423 (i) criminal background information maintained pursuant to Title 53, Chapter 10, Part
3424 2, Bureau of Criminal Identification, from the Bureau of Criminal Identification; and
3425 (ii) complete Federal Bureau of Investigation criminal background checks through the
3426 national criminal history system.
3427 (d) Information obtained by the department from the review of criminal history records
3428 received under this Subsection (3) shall be used by the department for the purposes of:
3429 (i) determining if a person satisfies the character requirements under Section
3430 31A-23b-204 for issuance or renewal of a license;
3431 (ii) determining if a person failed to maintain the character requirements under Section
3432 31A-23b-204; and
3433 (iii) preventing a person who violates the federal Violent Crime Control and Law
3434 Enforcement Act of 1994, 18 U.S.C. Sec. 1033, from engaging in the business of a navigator or
3435 in-person assistor in the state.
3436 (e) If the department requests the criminal background information, the department
3437 shall:

3438 (i) pay to the Department of Public Safety the costs incurred by the Department of
3439 Public Safety in providing the department criminal background information under Subsection
3440 (3)(c)(i);
3441 (ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau
3442 of Investigation in providing the department criminal background information under
3443 Subsection (3)(c)(ii); and
3444 (iii) charge the person applying for a license a fee equal to the aggregate of Subsections
3445 (3)(e)(i) and (ii).
3446 (4) The commissioner may deny an application for a license under this chapter if the
3447 person applying for the license:
3448 (a) fails to satisfy the requirements of this section; or
3449 (b) commits an act that is grounds for denial, suspension, or revocation as set forth in
3450 Section 31A-23b-401.
3451 Section 29. Section **31A-23b-205** is amended to read:
3452 **31A-23b-205. Examination and training requirements.**
3453 (1) The commissioner may require [~~applicants~~] an applicant for a license to pass an
3454 examination and complete a training program as a requirement for a license.
3455 (2) The examination described in Subsection (1) shall reasonably relate to:
3456 (a) the duties and functions of a navigator;
3457 (b) requirements for navigators as established by federal regulation under PPACA; and
3458 (c) other requirements that may be established by the commissioner by administrative
3459 rule.
3460 (3) The examination may be administered by the commissioner or as otherwise
3461 specified by administrative rule.
3462 (4) The training required by Subsection (1) shall be approved by the commissioner and
3463 shall include:
3464 (a) accident and health insurance plans;
3465 (b) qualifications for and enrollment in public programs;
3466 (c) qualifications for and enrollment in premium subsidies;
3467 (d) cultural and linguistic competence;
3468 (e) conflict of interest standards;

3469 (f) exchange functions; and
3470 (g) other requirements that may be adopted by the commissioner by administrative
3471 rule.
3472 (5) The training required by Subsection (1) shall consist of:
3473 (a) at least 21 credit hours of training before obtaining a license;
3474 (b) at least 1 of the 21 credit hours of training described in Subsection (5)(a) on defined
3475 contribution arrangement and the small employer SHOP exchange; and
3476 (c) the navigator training and certification program developed by the Centers for
3477 Medicare and Medicaid Services.
3478 [(5)] (6) This section applies only to [applicants who are natural persons] an applicant
3479 who is a natural person.
3480 Section 30. Section **31A-23b-206** is amended to read:
3481 **31A-23b-206. Continuing education requirements.**
3482 (1) The commissioner shall, by rule, prescribe continuing education requirements for a
3483 navigator.
3484 (2) (a) The commissioner may not require a degree from an institution of higher
3485 education as part of continuing education.
3486 (b) The commissioner may state a continuing education requirement in terms of hours
3487 of instruction received in:
3488 (i) accident and health insurance;
3489 (ii) qualification for and enrollment in public programs;
3490 (iii) qualification for and enrollment in premium subsidies;
3491 (iv) cultural competency;
3492 (v) conflict of interest standards; and
3493 (vi) other exchange functions.
3494 (3) (a) Continuing education requirements shall require:
3495 (i) that a licensee complete [24] 12 credit hours of continuing education for every
3496 [two-year] one-year licensing period;
3497 (ii) that [3] at least 2 of the [24] 12 credit hours described in Subsection (3)(a)(i) be
3498 ethics courses; [and]
3499 [(iii) that the licensee complete at least half of the required hours through classroom

3500 hours of insurance and exchange related instruction.]
3501 (iii) that at least 1 of the 12 credit hours described in Subsection (3)(a)(i) be a defined
3502 contribution course that includes training on use of the Health Insurance Exchange; and
3503 (iv) that a licensee complete the annual navigator training and certification program
3504 developed by the Centers for Medicare and Medicaid Services.
3505 (b) An hour of continuing education in accordance with Subsection (3)(a)(i) may be
3506 obtained through:
3507 (i) classroom attendance;
3508 (ii) home study;
3509 (iii) watching a video recording; or
3510 [(iv) experience credit; or]
3511 [(v)] (iv) another method approved by rule.
3512 (c) A licensee may obtain continuing education hours at any time during the [two-year]
3513 one-year license period.
3514 (d) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the
3515 commissioner shall[:] by rule[: (i) publish a list of insurance professional designations whose
3516 continuing education requirements can be used to meet the requirements for continuing
3517 education under Subsection (3)(b); and (ii)] authorize one or more continuing education
3518 providers, including a state or national professional producer or consultant associations, to:
3519 [(A)] (i) offer a qualified program on a geographically accessible basis; and
3520 [(B)] (ii) collect a reasonable fee for funding and administration of a continuing
3521 education program, subject to the review and approval of the commissioner.
3522 (4) The commissioner shall approve a continuing education provider or a continuing
3523 education course that satisfies the requirements of this section.
3524 (5) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the
3525 commissioner shall by rule establish the procedures for continuing education provider
3526 registration and course approval.
3527 (6) This section applies only to a navigator who is a natural person.
3528 (7) A navigator shall keep documentation of completing the continuing education
3529 requirements of this section for two years after the end of the [two-year] one-year licensing
3530 period to which the continuing education applies.

3531 Section 31. Section **31A-23b-301** is amended to read:

3532 **31A-23b-301. Unfair practices -- Compensation -- Limit of scope of practice.**

3533 (1) As used in this section, "false or misleading information" includes, with intent to
3534 deceive a person examining it:

3535 (a) filing a report;

3536 (b) making a false entry in a record; or

3537 (c) willfully refraining from making a proper entry in a record.

3538 (2) (a) Communication that contains false or misleading information relating to
3539 enrollment in an insurance plan or a public program, including information that is false or
3540 misleading because it is incomplete, may not be made by:

3541 (i) a person who is or should be licensed under this title;

3542 (ii) an employee of a person described in Subsection (2)(a)(i);

3543 (iii) a person whose primary interest is as a competitor of a person licensed under this
3544 title; and

3545 (iv) a person on behalf of [~~any of the persons~~] a person listed in this Subsection (2)(a).

3546 (b) A licensee under this chapter may not:

3547 (i) use [~~any~~] a business name, slogan, emblem, or related device that is misleading or
3548 likely to cause the exchange, insurer, or other licensee to be mistaken for another governmental
3549 agency, a PPACA exchange, insurer, or other licensee already in business; or

3550 (ii) use [~~any~~] an advertisement or other insurance promotional material that would
3551 cause a reasonable person to mistakenly believe that a state or federal government agency,
3552 public program, or insurer:

3553 (A) is responsible for the insurance or public program enrollment assistance activities
3554 of the person;

3555 (B) stands behind the credit of the person; or

3556 (C) is a source of payment of [~~any~~] an insurance obligation of or sold by the person.

3557 (c) A person who is not an insurer may not assume or use [~~any~~] a name that deceptively
3558 implies or suggests that person is an insurer.

3559 (3) A person may not engage in an unfair method of competition or any other unfair or
3560 deceptive act or practice in the business of insurance, as defined by the commissioner by rule,
3561 after a finding that the method of competition, the act, or the practice:

3562 (a) is misleading;
3563 (b) is deceptive;
3564 (c) is unfairly discriminatory;
3565 (d) provides an unfair inducement; or
3566 (e) unreasonably restrains competition.
3567 (4) A navigator licensed under this chapter is subject to the unfair marketing practices
3568 and inducement provisions of [~~Section~~] Sections 31A-23a-402 and 31A-23a-402.5.
3569 (5) A navigator licensed under this chapter or who should be licensed under this
3570 chapter:
3571 (a) may not receive direct or indirect compensation from an accident or health insurer
3572 or from an individual who receives services from a navigator in accordance with:
3573 (i) federal conflict of interest regulations established pursuant to PPACA; and
3574 (ii) administrative rule adopted by the department;
3575 (b) may be compensated by the exchange for performing the duties of a navigator;
3576 (c) (i) may perform, offer to perform, or advertise a service as a navigator only for a
3577 person selecting a qualified health plan or public program offered on an exchange; and
3578 (ii) may not perform, offer to perform, or advertise [~~any~~] services as a navigator for
3579 individuals or small employer groups selecting accident and health insurance plans, qualified
3580 health plans, public programs, business, or services that are not offered on an exchange; and
3581 (d) may not recommend a particular accident and health insurance plan or qualified
3582 health plan.
3583 Section 32. Section **31A-23b-401** is amended to read:
3584 **31A-23b-401. Revocation, suspension, surrender, lapsing, limiting, or otherwise**
3585 **terminating a license -- Rulemaking for renewal or reinstatement.**
3586 (1) A license as a navigator under this chapter remains in force until:
3587 (a) revoked or suspended under Subsection (4);
3588 (b) surrendered to the commissioner and accepted by the commissioner in lieu of
3589 administrative action;
3590 (c) the licensee dies or is adjudicated incompetent as defined under:
3591 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
3592 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and

3593 Minors;
3594 (d) lapsed under this section; or
3595 (e) voluntarily surrendered.
3596 (2) The following may be reinstated within one year after the day on which the license
3597 is no longer in force:
3598 (a) a lapsed license; or
3599 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may
3600 not be reinstated after the license period in which the license is voluntarily surrendered.
3601 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a
3602 license, submission and acceptance of a voluntary surrender of a license does not prevent the
3603 department from pursuing additional disciplinary or other action authorized under:
3604 (a) this title; or
3605 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah
3606 Administrative Rulemaking Act.
3607 (4) (a) If the commissioner makes a finding under Subsection (4)(b), as part of an
3608 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the
3609 commissioner may:
3610 (i) revoke a license;
3611 (ii) suspend a license for a specified period of 12 months or less;
3612 (iii) limit a license in whole or in part; or
3613 (iv) deny a license application.
3614 (b) The commissioner may take an action described in Subsection (4)(a) if the
3615 commissioner finds that the licensee:
3616 (i) is unqualified for a license under Section 31A-23b-204, 31A-23b-205, or
3617 31A-23b-206;
3618 (ii) violated:
3619 (A) an insurance statute;
3620 (B) a rule that is valid under Subsection 31A-2-201(3); or
3621 (C) an order that is valid under Subsection 31A-2-201(4);
3622 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other
3623 delinquency proceedings in any state;

3624 (iv) failed to pay a final judgment rendered against the person in this state within 60
3625 days after the day on which the judgment became final;
3626 (v) refused:
3627 (A) to be examined; or
3628 (B) to produce its accounts, records, and files for examination;
3629 (vi) had an officer who refused to:
3630 (A) give information with respect to the navigator's affairs; or
3631 (B) perform any other legal obligation as to an examination;
3632 (vii) provided information in the license application that is:
3633 (A) incorrect;
3634 (B) misleading;
3635 (C) incomplete; or
3636 (D) materially untrue;
3637 (viii) violated an insurance law, valid rule, or valid order of another state's insurance
3638 department;
3639 (ix) obtained or attempted to obtain a license through misrepresentation or fraud;
3640 (x) improperly withheld, misappropriated, or converted money or properties received
3641 in the course of doing insurance business;
3642 (xi) intentionally misrepresented the terms of an actual or proposed:
3643 (A) insurance contract;
3644 (B) application for insurance; or
3645 (C) application for public program;
3646 (xii) is convicted of a felony;
3647 (xiii) admitted or is found to have committed an insurance unfair trade practice or
3648 fraud;
3649 (xiv) in the conduct of business in this state or elsewhere:
3650 (A) used fraudulent, coercive, or dishonest practices; or
3651 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;
3652 (xv) had an insurance license, navigator license, or its equivalent, denied, suspended,
3653 or revoked in another state, province, district, or territory;
3654 (xvi) forged another's name to:

3655 (A) an application for insurance;
3656 (B) a document related to an insurance transaction;
3657 (C) a document related to an application for a public program; or
3658 (D) a document related to an application for premium subsidies;
3659 (xvii) improperly used notes or another reference material to complete an examination
3660 for a license;
3661 (xviii) knowingly accepted insurance business from an individual who is not licensed;
3662 (xix) failed to comply with an administrative or court order imposing a child support
3663 obligation;
3664 (xx) failed to:
3665 (A) pay state income tax; or
3666 (B) comply with an administrative or court order directing payment of state income
3667 tax;
3668 (xxi) violated or permitted others to violate the federal Violent Crime Control and Law
3669 Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and therefore under 18 U.S.C. Sec. [~~1033~~] 1034
3670 is prohibited from engaging in the business of insurance; or
3671 (xxii) engaged in a method or practice in the conduct of business that endangered the
3672 legitimate interests of customers and the public.
3673 (c) For purposes of this section, if a license is held by an agency, both the agency itself
3674 and any individual designated under the license are considered to be the holders of the license.
3675 (d) If an individual designated under the agency license commits an act or fails to
3676 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,
3677 the commissioner may suspend, revoke, or limit the license of:
3678 (i) the individual;
3679 (ii) the agency, if the agency:
3680 (A) is reckless or negligent in its supervision of the individual; or
3681 (B) knowingly participates in the act or failure to act that is the ground for suspending,
3682 revoking, or limiting the license; or
3683 (iii) (A) the individual; and
3684 (B) the agency if the agency meets the requirements of Subsection (4)(d)(ii).
3685 (5) A licensee under this chapter is subject to the penalties for acting as a licensee

3686 without a license if:
3687 (a) the licensee's license is:
3688 (i) revoked;
3689 (ii) suspended;
3690 (iii) surrendered in lieu of administrative action;
3691 (iv) lapsed; or
3692 (v) voluntarily surrendered; and
3693 (b) the licensee:
3694 (i) continues to act as a licensee; or
3695 (ii) violates the terms of the license limitation.
3696 (6) A licensee under this chapter shall immediately report to the commissioner:
3697 (a) a revocation, suspension, or limitation of the person's license in another state, the
3698 District of Columbia, or a territory of the United States;
3699 (b) the imposition of a disciplinary sanction imposed on that person by another state,
3700 the District of Columbia, or a territory of the United States; or
3701 (c) a judgment or injunction entered against that person on the basis of conduct
3702 involving:
3703 (i) fraud;
3704 (ii) deceit;
3705 (iii) misrepresentation; or
3706 (iv) a violation of an insurance law or rule.
3707 (7) (a) An order revoking a license under Subsection (4) or an agreement to surrender a
3708 license in lieu of administrative action may specify a time, not to exceed five years, within
3709 which the former licensee may not apply for a new license.
3710 (b) If no time is specified in an order or agreement described in Subsection (7)(a), the
3711 former licensee may not apply for a new license for five years from the day on which the order
3712 or agreement is made without the express approval of the commissioner.
3713 (8) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of
3714 a license issued under this chapter if so ordered by a court.
3715 (9) The commissioner shall by rule prescribe the license renewal and reinstatement
3716 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

3717 Section 33. Section **31A-23b-402** is amended to read:

3718 **31A-23b-402. Probation -- Grounds for revocation.**

3719 (1) The commissioner may place a licensee on probation for a period not to exceed 24
3720 months as follows:

3721 (a) after an adjudicative proceeding under Title 63G, Chapter 4, Administrative
3722 Procedures Act, for any circumstances that would justify a suspension under this section; or

3723 (b) at the issuance of a new license:

3724 (i) with an admitted violation under 18 U.S.C. [~~Secs.~~] Sec. 1033 [~~and 1034~~]; or

3725 (ii) with a response to background information questions on a new license application
3726 indicating that:

3727 (A) the person has been convicted of a crime that is listed by rule made in accordance
3728 with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is a ground for
3729 probation;

3730 (B) the person is currently charged with a crime that is listed by rule made in
3731 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is
3732 a ground for probation regardless of whether adjudication is withheld;

3733 (C) the person has been involved in an administrative proceeding regarding any
3734 professional or occupational license; or

3735 (D) any business in which the person is or was an owner, partner, officer, or director
3736 has been involved in an administrative proceeding regarding any professional or occupational
3737 license.

3738 (2) The commissioner may place a licensee on probation for a specified period no
3739 longer than 24 months if the licensee has admitted to a violation under 18 U.S.C. [~~Secs.~~] Sec.
3740 1033 [~~and 1034~~].

3741 (3) The probation order shall state the conditions for revocation or retention of the
3742 license, which shall be reasonable.

3743 (4) Any violation of the probation is a ground for revocation pursuant to any
3744 proceeding authorized under Title 63G, Chapter 4, Administrative Procedures Act.

3745 Section 34. Section **31A-25-208** is amended to read:

3746 **31A-25-208. Revocation, suspension, surrender, lapsing, limiting, or otherwise**
3747 **terminating a license -- Rulemaking for renewal and reinstatement.**

3748 (1) A license type issued under this chapter remains in force until:
3749 (a) revoked or suspended under Subsection (4);
3750 (b) surrendered to the commissioner and accepted by the commissioner in lieu of
3751 administrative action;
3752 (c) the licensee dies or is adjudicated incompetent as defined under:
3753 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
3754 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and
3755 Minors;
3756 (d) lapsed under Section 31A-25-210; or
3757 (e) voluntarily surrendered.
3758 (2) The following may be reinstated within one year after the day on which the license
3759 is no longer in force:
3760 (a) a lapsed license; or
3761 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may
3762 not be reinstated after the license period in which the license is voluntarily surrendered.
3763 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a
3764 license, submission and acceptance of a voluntary surrender of a license does not prevent the
3765 department from pursuing additional disciplinary or other action authorized under:
3766 (a) this title; or
3767 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah
3768 Administrative Rulemaking Act.
3769 (4) (a) If the commissioner makes a finding under Subsection (4)(b), as part of an
3770 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the
3771 commissioner may:
3772 (i) revoke a license;
3773 (ii) suspend a license for a specified period of 12 months or less;
3774 (iii) limit a license in whole or in part; or
3775 (iv) deny a license application.
3776 (b) The commissioner may take an action described in Subsection (4)(a) if the
3777 commissioner finds that the licensee:
3778 (i) is unqualified for a license under Section 31A-25-202, 31A-25-203, or 31A-25-204;

3779 (ii) has violated:
3780 (A) an insurance statute;
3781 (B) a rule that is valid under Subsection 31A-2-201(3); or
3782 (C) an order that is valid under Subsection 31A-2-201(4);
3783 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other
3784 delinquency proceedings in any state;
3785 (iv) fails to pay a final judgment rendered against the person in this state within 60
3786 days after the day on which the judgment became final;
3787 (v) fails to meet the same good faith obligations in claims settlement that is required of
3788 admitted insurers;
3789 (vi) is affiliated with and under the same general management or interlocking
3790 directorate or ownership as another third party administrator that transacts business in this state
3791 without a license;
3792 (vii) refuses:
3793 (A) to be examined; or
3794 (B) to produce its accounts, records, and files for examination;
3795 (viii) has an officer who refuses to:
3796 (A) give information with respect to the third party administrator's affairs; or
3797 (B) perform any other legal obligation as to an examination;
3798 (ix) provides information in the license application that is:
3799 (A) incorrect;
3800 (B) misleading;
3801 (C) incomplete; or
3802 (D) materially untrue;
3803 (x) has violated an insurance law, valid rule, or valid order of another state's insurance
3804 department;
3805 (xi) has obtained or attempted to obtain a license through misrepresentation or fraud;
3806 (xii) has improperly withheld, misappropriated, or converted money or properties
3807 received in the course of doing insurance business;
3808 (xiii) has intentionally misrepresented the terms of an actual or proposed:
3809 (A) insurance contract; or

3810 (B) application for insurance;
3811 (xiv) has been convicted of a felony;
3812 (xv) has admitted or been found to have committed an insurance unfair trade practice
3813 or fraud;
3814 (xvi) in the conduct of business in this state or elsewhere has:
3815 (A) used fraudulent, coercive, or dishonest practices; or
3816 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;
3817 (xvii) has had an insurance license or its equivalent, denied, suspended, or revoked in
3818 any other state, province, district, or territory;
3819 (xviii) has forged another's name to:
3820 (A) an application for insurance; or
3821 (B) a document related to an insurance transaction;
3822 (xix) has improperly used notes or any other reference material to complete an
3823 examination for an insurance license;
3824 (xx) has knowingly accepted insurance business from an individual who is not
3825 licensed;
3826 (xxi) has failed to comply with an administrative or court order imposing a child
3827 support obligation;
3828 (xxii) has failed to:
3829 (A) pay state income tax; or
3830 (B) comply with an administrative or court order directing payment of state income
3831 tax;
3832 (xxiii) has violated or permitted others to violate the federal Violent Crime Control and
3833 Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 [~~and 1034~~] and therefore under 18 U.S.C.
3834 Sec. 1034 is prohibited from engaging in the business of insurance; or
3835 (xxiv) has engaged in methods and practices in the conduct of business that endanger
3836 the legitimate interests of customers and the public.
3837 (c) For purposes of this section, if a license is held by an agency, both the agency itself
3838 and any individual designated under the license are considered to be the holders of the agency
3839 license.
3840 (d) If an individual designated under the agency license commits an act or fails to

3841 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,
3842 the commissioner may suspend, revoke, or limit the license of:
3843 (i) the individual;
3844 (ii) the agency if the agency:
3845 (A) is reckless or negligent in its supervision of the individual; or
3846 (B) knowingly participated in the act or failure to act that is the ground for suspending,
3847 revoking, or limiting the license; or
3848 (iii) (A) the individual; and
3849 (B) the agency if the agency meets the requirements of Subsection (4)(d)(ii).
3850 (5) A licensee under this chapter is subject to the penalties for acting as a licensee
3851 without a license if:
3852 (a) the licensee's license is:
3853 (i) revoked;
3854 (ii) suspended;
3855 (iii) limited;
3856 (iv) surrendered in lieu of administrative action;
3857 (v) lapsed; or
3858 (vi) voluntarily surrendered; and
3859 (b) the licensee:
3860 (i) continues to act as a licensee; or
3861 (ii) violates the terms of the license limitation.
3862 (6) A licensee under this chapter shall immediately report to the commissioner:
3863 (a) a revocation, suspension, or limitation of the person's license in any other state, the
3864 District of Columbia, or a territory of the United States;
3865 (b) the imposition of a disciplinary sanction imposed on that person by any other state,
3866 the District of Columbia, or a territory of the United States; or
3867 (c) a judgment or injunction entered against the person on the basis of conduct
3868 involving:
3869 (i) fraud;
3870 (ii) deceit;
3871 (iii) misrepresentation; or

3872 (iv) a violation of an insurance law or rule.
3873 (7) (a) An order revoking a license under Subsection (4) or an agreement to surrender a
3874 license in lieu of administrative action may specify a time, not to exceed five years, within
3875 which the former licensee may not apply for a new license.
3876 (b) If no time is specified in the order or agreement described in Subsection (7)(a), the
3877 former licensee may not apply for a new license for five years from the day on which the order
3878 or agreement is made without the express approval of the commissioner.
3879 (8) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of
3880 a license issued under this part if so ordered by the court.
3881 (9) The commissioner shall by rule prescribe the license renewal and reinstatement
3882 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
3883 Section 35. Section **31A-25-209** is amended to read:
3884 **31A-25-209. Probation -- Grounds for revocation.**
3885 (1) The commissioner may place a licensee on probation for a period not to exceed 24
3886 months as follows:
3887 (a) after an adjudicative proceeding under Title 63G, Chapter 4, Administrative
3888 Procedures Act, for any circumstances that would justify a suspension under Section
3889 31A-25-208; or
3890 (b) at the issuance of a new license:
3891 (i) with an admitted violation under 18 U.S.C. [~~Sections~~] <u>Sec.</u> 1033 [~~and 1034~~]; or
3892 (ii) with a response to a background information question on a new license application
3893 indicating that:
3894 (A) the person has been convicted of a crime that is listed by rule made in accordance
3895 with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is grounds for
3896 probation;
3897 (B) the person is currently charged with a crime that is listed by rule made in
3898 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is
3899 grounds for probation regardless of whether adjudication is withheld;
3900 (C) the person has been involved in an administrative proceeding regarding any
3901 professional or occupational license; or
3902 (D) any business in which the person is or was an owner, partner, officer, or director

3903 has been involved in an administrative proceeding regarding any professional or occupational
3904 license.
3905 (2) The commissioner may place a licensee on probation for a specified period no
3906 longer than 24 months if the licensee has admitted to a violation under 18 U.S.C. [~~Sections~~]
3907 Sec. 1033 [~~and 1034~~].
3908 (3) A probation order under this section shall state the conditions for retention of the
3909 license, which shall be reasonable.
3910 (4) A violation of the probation is grounds for revocation pursuant to any proceeding
3911 authorized under Title 63G, Chapter 4, Administrative Procedures Act.
3912 Section 36. Section **31A-26-102** is amended to read:
3913 **31A-26-102. Definitions.**
3914 As used in this chapter, unless expressly provided otherwise:
3915 (1) "Company adjuster" means a person employed by an insurer whose regular duties
3916 include insurance adjusting.
3917 (2) "Designated home state" means the state or territory of the United States or the
3918 District of Columbia:
3919 (a) in which an insurance adjuster does not maintain the adjuster's principal:
3920 (i) place of residence; or
3921 (ii) place of business;
3922 (b) if the resident state, territory, or District of Columbia of the adjuster does not
3923 license adjusters for the line of authority sought, the adjuster has qualified for the license as if
3924 the person were a resident in the state, territory, or District of Columbia described in
3925 Subsection (2)(a) including an applicable:
3926 (A) examination requirement;
3927 (B) fingerprint background check requirement; and
3928 (C) continuing education requirement; and
3929 (c) the adjuster has designated the state, territory, or District of Columbia as the
3930 designated home state.
3931 (3) "Home state" means:
3932 (a) a state or territory of the United States or the District of Columbia in which an
3933 insurance adjuster:

3934 (i) maintains the adjuster's principal:
3935 (A) place of residence; or
3936 (B) place of business; and
3937 (ii) is licensed to act as a resident adjuster; or
3938 (b) if the resident state, territory, or the District of Columbia described in Subsection
3939 (3)(a) does not license adjusters for the line of authority sought, a state, territory, or the District
3940 of Columbia:
3941 (i) in which the adjuster is licensed;
3942 (ii) in which the adjuster is in good standing; and
3943 (iii) that the adjuster has designated as the adjuster's designated home state.
3944 [(2)] (4) "Independent adjuster" means an insurance adjuster required to be licensed
3945 under Section 31A-26-201, who engages in insurance adjusting as a representative of one or
3946 more insurers.
3947 [(3)] (5) "Insurance adjusting" or "adjusting" means directing or conducting the
3948 investigation, negotiation, or settlement of a claim under an insurance policy, on behalf of an
3949 insurer, policyholder, or a claimant under an insurance policy.
3950 [(4)] (6) "Organization" means a person other than a natural person, and includes a sole
3951 proprietorship by which a natural person does business under an assumed name.
3952 [(5)] (7) "Portable electronics insurance" is as defined in Section 31A-22-1802.
3953 [(6)] (8) "Public adjuster" means a person required to be licensed under Section
3954 31A-26-201, who engages in insurance adjusting as a representative of insureds and claimants
3955 under insurance policies.
3956 Section 37. Section **31A-26-206** is amended to read:
3957 **31A-26-206. Continuing education requirements.**
3958 (1) Pursuant to this section, the commissioner shall by rule prescribe continuing
3959 education requirements for each class of license under Section 31A-26-204.
3960 (2) (a) The commissioner shall impose continuing education requirements in
3961 accordance with a two-year licensing period in which the licensee meets the requirements of
3962 this Subsection (2).
3963 (b) (i) Except as otherwise provided in this section, the continuing education
3964 requirements shall require:

3965 (A) that a licensee complete 24 credit hours of continuing education for every two-year
3966 licensing period;
3967 (B) that 3 of the 24 credit hours described in Subsection (2)(b)(i)(A) be ethics courses;
3968 and
3969 (C) that the licensee complete at least half of the required hours through classroom
3970 hours of insurance-related instruction.
3971 (ii) A continuing education hour completed in accordance with Subsection (2)(b)(i)
3972 may be obtained through:
3973 (A) classroom attendance;
3974 (B) home study;
3975 (C) watching a video recording;
3976 (D) experience credit; or
3977 (E) other methods provided by rule.
3978 (iii) Notwithstanding Subsections (2)(b)(i)(A) and (B), a title insurance adjuster is
3979 required to complete 12 credit hours of continuing education for every two-year licensing
3980 period, with 3 of the credit hours being ethics courses.
3981 (c) A licensee may obtain continuing education hours at any time during the two-year
3982 licensing period.
3983 (d) (i) A licensee is exempt from the continuing education requirements of this section
3984 if:
3985 (A) the licensee was first licensed before [~~April 1, 1978~~] December 31, 1982;
3986 (B) the license does not have a continuous lapse for a period of more than one year,
3987 except for a license for which the licensee has had an exemption approved before May 11,
3988 2011;
3989 (C) the licensee requests an exemption from the department; and
3990 (D) the department approves the exemption.
3991 (ii) If the department approves the exemption under Subsection (2)(d)(i), the licensee is
3992 not required to apply again for the exemption.
3993 (e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the
3994 commissioner shall by rule:
3995 (i) publish a list of insurance professional designations whose continuing education

3996 requirements can be used to meet the requirements for continuing education under Subsection
3997 (2)(b); and
3998 (ii) authorize a professional adjuster association to:
3999 (A) offer a qualified program for a classification of license on a geographically
4000 accessible basis; and
4001 (B) collect a reasonable fee for funding and administration of a qualified program,
4002 subject to the review and approval of the commissioner.
4003 (f) (i) A fee permitted under Subsection (2)(e)(ii)(B) that is charged to fund and
4004 administer a qualified program shall reasonably relate to the cost of administering the qualified
4005 program.
4006 (ii) Nothing in this section shall prohibit a provider of a continuing education program
4007 or course from charging a fee for attendance at a course offered for continuing education credit.
4008 (iii) A fee permitted under Subsection (2)(e)(ii)(B) that is charged for attendance at an
4009 association program may be less for an association member, on the basis of the member's
4010 affiliation expense, but shall preserve the right of a nonmember to attend without affiliation.
4011 (3) The continuing education requirements of this section apply only to a licensee who
4012 is an individual.
4013 (4) The continuing education requirements of this section do not apply to a member of
4014 the Utah State Bar.
4015 (5) The commissioner shall designate a course that satisfies the requirements of this
4016 section, including a course presented by an insurer.
4017 (6) A nonresident adjuster is considered to have satisfied this state's continuing
4018 education requirements if:
4019 (a) the nonresident adjuster satisfies the nonresident producer's home state's continuing
4020 education requirements for a licensed insurance adjuster; and
4021 (b) on the same basis the nonresident adjuster's home state considers satisfaction of
4022 Utah's continuing education requirements for a producer as satisfying the continuing education
4023 requirements of the home state.
4024 (7) A licensee subject to this section shall keep documentation of completing the
4025 continuing education requirements of this section for two years after the end of the two-year
4026 licensing period to which the continuing education requirement applies.

4027 Section 38. Section **31A-26-207** is amended to read:

4028 **31A-26-207. Examination requirements.**

4029 (1) The commissioner may require applicants for [~~any~~] a particular class of license
4030 under Section 31A-26-204 to pass an examination as a requirement to receiving a license. The
4031 examination shall reasonably relate to the specific license class for which it is prescribed. The
4032 examinations may be administered by the commissioner or as specified by rule.

4033 (2) The commissioner shall waive the requirement of an examination for a nonresident
4034 applicant who:

4035 (a) applies for an insurance adjuster license in this state;

4036 (b) has been licensed for the same line of authority in another state; and

4037 (c) (i) is licensed in the state described in Subsection (2)(b) at the time the applicant
4038 applies for an insurance producer license in this state; or

4039 (ii) if the application is received within 90 days of the cancellation of the applicant's
4040 previous license:

4041 (A) the prior state certifies that at the time of cancellation, the applicant was in good
4042 standing in that state; or

4043 (B) the state's producer database records maintained by the National Association of
4044 Insurance Commissioners or the National Association of Insurance Commissioner's affiliates or
4045 subsidiaries, indicates that the producer is or was licensed in good standing for the line of
4046 authority requested.

4047 (3) (a) To become a resident licensee in accordance with Sections 31A-26-202 and
4048 31A-26-203, a person licensed as an insurance producer in another state who moves to this
4049 state shall make application within 90 days of establishing legal residence in this state.

4050 (b) A person who becomes a resident licensee under Subsection (3)(a) may not be
4051 required to meet prelicensing education or examination requirements to obtain any line of
4052 authority previously held in the prior state unless:

4053 (i) the prior state would require a prior resident of this state to meet the prior state's
4054 prelicensing education or examination requirements to become a resident licensee; or

4055 (ii) the commissioner imposes the requirements by rule.

4056 (4) The requirements of this section only apply to [~~applicants who are natural persons~~]
4057 an applicant who is a natural person.

4058 (5) The requirements of this section do not apply to [members]:
4059 (a) a member of the Utah State Bar[.]; or
4060 (b) an applicant for the crop insurance license class who has satisfactorily completed:
4061 (i) a national crop adjuster program, as adopted by the commissioner by rule; or
4062 (ii) the loss adjustment training curriculum and competency testing required by the
4063 Federal Crop Insurance Corporation Standard Reinsurance Agreement through the Risk
4064 Management Agency of the United States Department of Agriculture.
4065 Section 39. Section **31A-26-213** is amended to read:
4066 **31A-26-213. Revocation, suspension, surrender, lapsing, limiting, or otherwise**
4067 **terminating a license -- Rulemaking for renewal or reinstatement.**
4068 (1) A license type issued under this chapter remains in force until:
4069 (a) revoked or suspended under Subsection (5);
4070 (b) surrendered to the commissioner and accepted by the commissioner in lieu of
4071 administrative action;
4072 (c) the licensee dies or is adjudicated incompetent as defined under:
4073 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
4074 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and
4075 Minors;
4076 (d) lapsed under Section 31A-26-214.5; or
4077 (e) voluntarily surrendered.
4078 (2) The following may be reinstated within one year after the day on which the license
4079 is no longer in force:
4080 (a) a lapsed license; or
4081 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may
4082 not be reinstated after the license period in which it is voluntarily surrendered.
4083 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a
4084 license, submission and acceptance of a voluntary surrender of a license does not prevent the
4085 department from pursuing additional disciplinary or other action authorized under:
4086 (a) this title; or
4087 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah
4088 Administrative Rulemaking Act.

4089 (4) A license classification issued under this chapter remains in force until:
4090 (a) the qualifications pertaining to a license classification are no longer met by the
4091 licensee; or
4092 (b) the supporting license type:
4093 (i) is revoked or suspended under Subsection (5); or
4094 (ii) is surrendered to the commissioner and accepted by the commissioner in lieu of
4095 administrative action.
4096 (5) (a) If the commissioner makes a finding under Subsection (5)(b) as part of an
4097 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the
4098 commissioner may:
4099 (i) revoke:
4100 (A) a license; or
4101 (B) a license classification;
4102 (ii) suspend for a specified period of 12 months or less:
4103 (A) a license; or
4104 (B) a license classification;
4105 (iii) limit in whole or in part:
4106 (A) a license; or
4107 (B) a license classification; or
4108 (iv) deny a license application.
4109 (b) The commissioner may take an action described in Subsection (5)(a) if the
4110 commissioner finds that the licensee:
4111 (i) is unqualified for a license or license classification under Section 31A-26-202,
4112 31A-26-203, 31A-26-204, or 31A-26-205;
4113 (ii) has violated:
4114 (A) an insurance statute;
4115 (B) a rule that is valid under Subsection 31A-2-201(3); or
4116 (C) an order that is valid under Subsection 31A-2-201(4);
4117 (iii) is insolvent, or the subject of receivership, conservatorship, rehabilitation, or other
4118 delinquency proceedings in any state;
4119 (iv) fails to pay a final judgment rendered against the person in this state within 60

4120 days after the judgment became final;
4121 (v) fails to meet the same good faith obligations in claims settlement that is required of
4122 admitted insurers;
4123 (vi) is affiliated with and under the same general management or interlocking
4124 directorate or ownership as another insurance adjuster that transacts business in this state
4125 without a license;
4126 (vii) refuses:
4127 (A) to be examined; or
4128 (B) to produce its accounts, records, and files for examination;
4129 (viii) has an officer who refuses to:
4130 (A) give information with respect to the insurance adjuster's affairs; or
4131 (B) perform any other legal obligation as to an examination;
4132 (ix) provides information in the license application that is:
4133 (A) incorrect;
4134 (B) misleading;
4135 (C) incomplete; or
4136 (D) materially untrue;
4137 (x) has violated an insurance law, valid rule, or valid order of another state's insurance
4138 department;
4139 (xi) has obtained or attempted to obtain a license through misrepresentation or fraud;
4140 (xii) has improperly withheld, misappropriated, or converted money or properties
4141 received in the course of doing insurance business;
4142 (xiii) has intentionally misrepresented the terms of an actual or proposed:
4143 (A) insurance contract; or
4144 (B) application for insurance;
4145 (xiv) has been convicted of a felony;
4146 (xv) has admitted or been found to have committed an insurance unfair trade practice
4147 or fraud;
4148 (xvi) in the conduct of business in this state or elsewhere has:
4149 (A) used fraudulent, coercive, or dishonest practices; or
4150 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;

4151 (xvii) has had an insurance license, or its equivalent, denied, suspended, or revoked in
4152 any other state, province, district, or territory;
4153 (xviii) has forged another's name to:
4154 (A) an application for insurance; or
4155 (B) a document related to an insurance transaction;
4156 (xix) has improperly used notes or any other reference material to complete an
4157 examination for an insurance license;
4158 (xx) has knowingly accepted insurance business from an individual who is not
4159 licensed;
4160 (xxi) has failed to comply with an administrative or court order imposing a child
4161 support obligation;
4162 (xxii) has failed to:
4163 (A) pay state income tax; or
4164 (B) comply with an administrative or court order directing payment of state income
4165 tax;
4166 (xxiii) has violated or permitted others to violate the federal Violent Crime Control and
4167 Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 [~~and 1034~~] and therefore under 18 U.S.C.
4168 Sec. 1034 is prohibited from engaging in the business of insurance; or
4169 (xxiv) has engaged in methods and practices in the conduct of business that endanger
4170 the legitimate interests of customers and the public.
4171 (c) For purposes of this section, if a license is held by an agency, both the agency itself
4172 and any individual designated under the license are considered to be the holders of the license.
4173 (d) If an individual designated under the agency license commits an act or fails to
4174 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,
4175 the commissioner may suspend, revoke, or limit the license of:
4176 (i) the individual;
4177 (ii) the agency, if the agency:
4178 (A) is reckless or negligent in its supervision of the individual; or
4179 (B) knowingly participated in the act or failure to act that is the ground for suspending,
4180 revoking, or limiting the license; or
4181 (iii) (A) the individual; and

4182 (B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).
4183 (6) A licensee under this chapter is subject to the penalties for conducting an insurance
4184 business without a license if:
4185 (a) the licensee's license is:
4186 (i) revoked;
4187 (ii) suspended;
4188 (iii) limited;
4189 (iv) surrendered in lieu of administrative action;
4190 (v) lapsed; or
4191 (vi) voluntarily surrendered; and
4192 (b) the licensee:
4193 (i) continues to act as a licensee; or
4194 (ii) violates the terms of the license limitation.
4195 (7) A licensee under this chapter shall immediately report to the commissioner:
4196 (a) a revocation, suspension, or limitation of the person's license in any other state, the
4197 District of Columbia, or a territory of the United States;
4198 (b) the imposition of a disciplinary sanction imposed on that person by any other state,
4199 the District of Columbia, or a territory of the United States; or
4200 (c) a judgment or injunction entered against that person on the basis of conduct
4201 involving:
4202 (i) fraud;
4203 (ii) deceit;
4204 (iii) misrepresentation; or
4205 (iv) a violation of an insurance law or rule.
4206 (8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a
4207 license in lieu of administrative action may specify a time not to exceed five years within
4208 which the former licensee may not apply for a new license.
4209 (b) If no time is specified in the order or agreement described in Subsection (8)(a), the
4210 former licensee may not apply for a new license for five years without the express approval of
4211 the commissioner.
4212 (9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of

4213 a license issued under this part if so ordered by a court.

4214 (10) The commissioner shall by rule prescribe the license renewal and reinstatement
4215 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

4216 Section 40. Section **31A-26-214** is amended to read:

4217 **31A-26-214. Probation -- Grounds for revocation.**

4218 (1) The commissioner may place a licensee on probation for a period not to exceed 24
4219 months as follows:

4220 (a) after an adjudicative proceeding under Title 63G, Chapter 4, Administrative
4221 Procedures Act, for any circumstances that would justify a suspension under Section
4222 31A-26-213; or

4223 (b) at the issuance of a new license:

4224 (i) with an admitted violation under 18 U.S.C. [~~Sections~~] Sec. 1033 [~~and 1034~~]; or

4225 (ii) with a response to a background information question on any new license
4226 application indicating that:

4227 (A) the person has been convicted of a crime, that is listed by rule made in accordance
4228 with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is grounds for
4229 probation;

4230 (B) the person is currently charged with a crime, that is listed by rule made in
4231 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as a crime that is
4232 grounds for probation regardless of whether adjudication was withheld;

4233 (C) the person has been involved in an administrative proceeding regarding any
4234 professional or occupational license; or

4235 (D) any business in which the person is or was an owner, partner, officer, or director
4236 has been involved in an administrative proceeding regarding any professional or occupational
4237 license.

4238 (2) The commissioner may put a licensee on probation for a specified period no longer
4239 than 24 months if the licensee has admitted to violations under 18 U.S.C. [~~Sections~~] Sec. 1033
4240 [~~and 1034~~].

4241 (3) A probation order under this section shall state the conditions for retention of the
4242 license, which shall be reasonable.

4243 (4) A violation of the probation is grounds for revocation pursuant to any proceeding

4244 authorized under Title 63G, Chapter 4, Administrative Procedures Act.
4245 Section 41. Section **31A-26-214.5** is amended to read:
4246 **31A-26-214.5. License lapse and voluntary surrender.**
4247 (1) (a) A license issued under this chapter shall lapse if the licensee fails to:
4248 (i) pay when due a fee under Section 31A-3-103;
4249 (ii) complete continuing education requirements under Section 31A-26-206 before
4250 submitting the license renewal application;
4251 (iii) submit a completed renewal application as required by Section 31A-26-202;
4252 (iv) submit additional documentation required to complete the licensing process as
4253 related to a specific license type or license classification; or
4254 (v) maintain an active license in [~~a resident~~] the licensee's home state if the licensee is
4255 a nonresident licensee.
4256 (b) (i) A licensee whose license lapses due to the following may request an action
4257 described in Subsection (1)(b)(ii):
4258 (A) military service;
4259 (B) voluntary service for a period of time designated by the person for whom the
4260 licensee provides voluntary service; or
4261 (C) some other extenuating circumstances, such as long-term medical disability.
4262 (ii) A licensee described in Subsection (1)(b)(i) may request:
4263 (A) reinstatement of the license no later than one year after the day on which the
4264 license lapses; and
4265 (B) waiver of any of the following imposed for failure to comply with renewal
4266 procedures:
4267 (I) an examination requirement;
4268 (II) reinstatement fees set under Section 31A-3-103;
4269 (III) continuing education requirements; or
4270 (IV) other sanction imposed for failure to comply with renewal procedures.
4271 (2) If a license issued under this chapter is voluntarily surrendered, the license may be
4272 reinstated:
4273 (a) during the license period in which it is voluntarily surrendered; and
4274 (b) no later than one year after the day on which the license is voluntarily surrendered.

4275 Section 42. Section **31A-27a-102** is amended to read:

4276 **31A-27a-102. Definitions.**

4277 As used in this chapter:

4278 (1) "Admitted assets" is as defined by and is measured in accordance with the National
4279 Association of Insurance Commissioner's Statements of Statutory Accounting Principles, as
4280 incorporated in this state by rules made by the department in accordance with Title 63G,
4281 Chapter 3, Utah Administrative Rulemaking Act, for the purposes of Subsection
4282 31A-4-113(1)(b)(ii).

4283 (2) "Affected guaranty association" means a guaranty association that is or may
4284 become liable for payment of a covered claim.

4285 (3) "Affiliate" is as defined in Section 31A-1-301.

4286 (4) Notwithstanding Section 31A-1-301, "alien insurer" means an insurer incorporated
4287 or organized under the laws of a jurisdiction that is not a state.

4288 (5) Notwithstanding Section 31A-1-301, "claimant" or "creditor" means a person
4289 having a claim against an insurer whether the claim is:

4290 (a) matured or not matured;

4291 (b) liquidated or unliquidated;

4292 (c) secured or unsecured;

4293 (d) absolute; or

4294 (e) fixed or contingent.

4295 (6) "Commissioner" is as defined in Section 31A-1-301.

4296 (7) "Commodity contract" means:

4297 (a) a contract for the purchase or sale of a commodity for future delivery on, or subject
4298 to the rules of:

4299 (i) a board of trade or contract market under the Commodity Exchange Act, 7 U.S.C.
4300 Sec. 1 et seq.; or

4301 (ii) a board of trade outside the United States;

4302 (b) an agreement that is:

4303 (i) subject to regulation under Section 19 of the Commodity Exchange Act, 7 U.S.C.
4304 Sec. 1 et seq.; and

4305 (ii) commonly known to the commodities trade as:

4306 (A) a margin account;
4307 (B) a margin contract;
4308 (C) a leverage account; or
4309 (D) a leverage contract;
4310 (c) an agreement or transaction that is:
4311 (i) subject to regulation under Section 4c(b) of the Commodity Exchange Act, 7 U.S.C.
4312 Sec. 1 et seq.; and
4313 (ii) commonly known to the commodities trade as a commodity option;
4314 (d) a combination of the agreements or transactions referred to in this Subsection (7);
4315 or
4316 (e) an option to enter into an agreement or transaction referred to in this Subsection (7).
4317 (8) "Control" is as defined in Section 31A-1-301.
4318 (9) "Delinquency proceeding" means a:
4319 (a) proceeding instituted against an insurer for the purpose of rehabilitating or
4320 liquidating the insurer; and
4321 (b) summary proceeding under Section 31A-27a-201.
4322 (10) "Department" is as defined in Section 31A-1-301 unless the context requires
4323 otherwise.
4324 (11) "Doing business," "doing insurance business," and "business of insurance"
4325 includes any of the following acts, whether effected by mail, electronic means, or otherwise:
4326 (a) issuing or delivering a contract, certificate, or binder relating to insurance or
4327 annuities:
4328 (i) to a person who is resident in this state; or
4329 (ii) covering a risk located in this state;
4330 (b) soliciting an application for the contract, certificate, or binder described in
4331 Subsection (11)(a);
4332 (c) negotiating preliminary to the execution of the contract, certificate, or binder
4333 described in Subsection (11)(a);
4334 (d) collecting premiums, membership fees, assessments, or other consideration for the
4335 contract, certificate, or binder described in Subsection (11)(a);
4336 (e) transacting matters:

4337 (i) subsequent to execution of the contract, certificate, or binder described in
4338 Subsection (11)(a); and
4339 (ii) arising out of the contract, certificate, or binder described in Subsection (11)(a);
4340 (f) operating as an insurer under a license or certificate of authority issued by the
4341 department; or
4342 (g) engaging in an act identified in Chapter 15, Unauthorized Insurers, Surplus Lines,
4343 and Risk Retention Groups.
4344 (12) Notwithstanding Section 31A-1-301, "domiciliary state" means the state in which
4345 an insurer is incorporated or organized, except that "domiciliary state" means:
4346 (a) in the case of an alien insurer, its state of entry; or
4347 (b) in the case of a risk retention group, the state in which the risk retention group is
4348 chartered as contemplated in the Liability Risk Retention Act, 15 U.S.C. Sec. 3901 et seq.
4349 (13) "Estate" has the same meaning as "property of the insurer" as defined in
4350 Subsection (30).
4351 (14) "Fair consideration" is given for property or an obligation:
4352 (a) when in exchange for the property or obligation, as a fair equivalent for it, and in
4353 good faith:
4354 (i) property is conveyed;
4355 (ii) services are rendered;
4356 (iii) an obligation is incurred; or
4357 (iv) an antecedent debt is satisfied; or
4358 (b) when the property or obligation is received in good faith to secure a present
4359 advance or an antecedent debt in amount not disproportionately small compared to the value of
4360 the property or obligation obtained.
4361 (15) Notwithstanding Section 31A-1-301, "foreign insurer" means an insurer domiciled
4362 in another state.
4363 (16) "Formal delinquency proceeding" means a rehabilitation or liquidation
4364 proceeding.
4365 (17) "Forward contract" is as defined in the Federal Deposit Insurance Act, 12 U.S.C.
4366 Sec. 1821(e)(8)(D).
4367 (18) (a) "General assets" include all property of the estate that is not:

4368 (i) subject to a properly perfected secured claim;
4369 (ii) subject to a valid and existing express trust for the security or benefit of a specified
4370 person or class of person; or
4371 (iii) required by the insurance laws of this state or any other state to be held for the
4372 benefit of a specified person or class of person.
4373 (b) "General assets" include [all] the property of the estate or its proceeds in excess of
4374 the amount necessary to discharge a claim described in Subsection (18)(a).
4375 (19) "Good faith" means honesty in fact and intention, and in regard to Part 5, Asset
4376 Recovery, also requires the absence of:
4377 (a) information that would lead a reasonable person in the same position to know that
4378 the insurer is financially impaired or insolvent; and
4379 (b) knowledge regarding the imminence or pendency of a delinquency proceeding
4380 against the insurer.
4381 (20) "Guaranty association" means:
4382 (a) a mechanism mandated by Chapter 28, Guaranty Associations; or
4383 (b) a similar mechanism in another state that is created for the payment of claims or
4384 continuation of policy obligations of a financially impaired or insolvent insurer.
4385 (21) "Impaired" means that an insurer:
4386 (a) does not have admitted assets at least equal to the sum of:
4387 (i) all its liabilities; and
4388 (ii) the minimum surplus required to be maintained by Section 31A-5-211 or
4389 31A-8-209; or
4390 (b) has a total adjusted capital that is less than its authorized control level RBC, as
4391 defined in Section 31A-17-601.
4392 (22) "Insolvency" or "insolvent" means that an insurer:
4393 (a) is unable to pay its obligations when they are due;
4394 (b) does not have admitted assets at least equal to all of its liabilities; or
4395 (c) has a total adjusted capital that is less than its mandatory control level RBC, as
4396 defined in Section 31A-17-601.
4397 (23) Notwithstanding Section 31A-1-301, "insurer" means a person who:
4398 (a) is doing, has done, purports to do, or is licensed to do the business of insurance;

4399 (b) is or has been subject to the authority of, or to rehabilitation, liquidation,
4400 reorganization, supervision, or conservation by an insurance commissioner; or
4401 (c) is included under Section 31A-27a-104.
4402 (24) "Liabilities" is as defined by and is measured in accordance with the National
4403 Association of Insurance Commissioner's Statements of Statutory Accounting Principles, as
4404 incorporated in this state by rules made by the department in accordance with Title 63G,
4405 Chapter 3, Utah Administrative Rulemaking Act, for the purposes of Subsection
4406 31A-4-113(1)(b)(ii).
4407 (25) (a) Subject to Subsection (21)(b), "netting agreement" means:
4408 (i) a contract or agreement that:
4409 (A) documents one or more transactions between the parties to the agreement for or
4410 involving one or more qualified financial contracts; and
4411 (B) provides for the netting, liquidation, setoff, termination, acceleration, or close out
4412 under or in connection with:
4413 (I) one or more qualified financial contracts; or
4414 (II) present or future payment or delivery obligations or payment or delivery
4415 entitlements under the agreement, including liquidation or close-out values relating to the
4416 obligations or entitlements, among the parties to the netting agreement;
4417 (ii) a master agreement or bridge agreement for one or more master agreements
4418 described in Subsection (25)(a)(i); or
4419 (iii) any of the following related to a contract or agreement described in Subsection
4420 (25)(a)(i) or (ii):
4421 (A) a security agreement;
4422 (B) a security arrangement;
4423 (C) other credit enhancement or guarantee; or
4424 (D) a reimbursement obligation.
4425 (b) If a contract or agreement described in Subsection (25)(a)(i) or (ii) relates to an
4426 agreement or transaction that is not a qualified financial contract, the contract or agreement
4427 described in Subsection (25)(a)(i) or (ii) is considered a netting agreement only with respect to
4428 an agreement or transaction that is a qualified financial contract.
4429 (c) "Netting agreement" includes:

4430 (i) a term or condition incorporated by reference in the contract or agreement described
4431 in Subsection (25)(a); or
4432 (ii) a master agreement described in Subsection (25)(a).
4433 (d) A master agreement described in Subsection (25)(a), together with all schedules,
4434 confirmations, definitions, and addenda to that master agreement and transactions under any of
4435 the items described in this Subsection (25)(d), are treated as one netting agreement.
4436 (26) (a) "New value" means:
4437 (i) money;
4438 (ii) money's worth in goods, services, or new credit; or
4439 (iii) release by a transferee of property previously transferred to the transferee in a
4440 transaction that is neither void nor voidable by the insurer or the receiver under [~~any~~]
4441 applicable law, including proceeds of the property.
4442 (b) "New value" does not include an obligation substituted for an existing obligation.
4443 (27) "Party in interest" means:
4444 (a) the commissioner;
4445 (b) a nondomiciliary commissioner in whose state the insurer has outstanding claims
4446 liabilities;
4447 (c) an affected guaranty association; and
4448 (d) the following parties if the party files a request with the receivership court for
4449 inclusion as a party in interest and to be on the service list:
4450 (i) an insurer that ceded to or assumed business from the insurer;
4451 (ii) a policyholder;
4452 (iii) a third party claimant;
4453 (iv) a creditor;
4454 (v) a 10% or greater equity security holder in the insolvent insurer; and
4455 (vi) a person, including an indenture trustee, with a financial or regulatory interest in
4456 the delinquency proceeding.
4457 (28) (a) Notwithstanding Section 31A-1-301, "policy" means, notwithstanding what it
4458 is called:
4459 (i) a written contract of insurance;
4460 (ii) a written agreement for or affecting insurance; or

4461 (iii) a certificate of a written contract or agreement described in this Subsection (28)(a).
4462 (b) "Policy" includes all clauses, riders, endorsements, and papers that are a part of a
4463 policy.
4464 (c) "Policy" does not include a contract of reinsurance.
4465 (29) "Preference" means a transfer of property of an insurer to or for the benefit of a
4466 creditor:
4467 (a) for or on account of an antecedent debt, made or allowed by the insurer within one
4468 year before the day on which a successful petition for rehabilitation or liquidation is filed under
4469 this chapter;
4470 (b) the effect of which transfer may enable the creditor to obtain a greater percentage of
4471 the creditor's debt than another creditor of the same class would receive; and
4472 (c) if a liquidation order is entered while the insurer is already subject to a
4473 rehabilitation order and the transfer otherwise qualifies, that is made or allowed within the
4474 shorter of:
4475 (i) one year before the day on which a successful petition for rehabilitation is filed; or
4476 (ii) two years before the day on which a successful petition for liquidation is filed.
4477 (30) "Property of the insurer" or "property of the estate" includes:
4478 (a) a right, title, or interest of the insurer in property:
4479 (i) whether:
4480 (A) legal or equitable;
4481 (B) tangible or intangible; or
4482 (C) choate or inchoate; and
4483 (ii) including choses in action, contract rights, and any other interest recognized under
4484 the laws of this state;
4485 (b) entitlements that exist before the entry of an order of rehabilitation or liquidation;
4486 (c) entitlements that may arise by operation of this chapter or other provisions of law
4487 allowing the receiver to avoid prior transfers or assert other rights; and
4488 (d) (i) records or data that is otherwise the property of the insurer; and
4489 (ii) records or data similar to those described in Subsection (30)(d)(i) that are within
4490 the possession, custody, or control of a managing general agent, a third party administrator, a
4491 management company, a data processing company, an accountant, an attorney, an affiliate, or

4492 other person.

4493 (31) Subject to Subsection 31A-27a-611(10), "qualified financial contract" means any

4494 of the following:

4495 (a) a commodity contract;

4496 (b) a forward contract;

4497 (c) a repurchase agreement;

4498 (d) a securities contract;

4499 (e) a swap agreement; or

4500 (f) [~~any~~] a similar agreement that the commissioner determines by rule or order to be a

4501 qualified financial contract for purposes of this chapter.

4502 (32) As the context requires, "receiver" means the commissioner or the commissioner's

4503 designee, including a rehabilitator, liquidator, or ancillary receiver.

4504 (33) As the context requires, "receivership" means a rehabilitation, liquidation, or

4505 ancillary receivership.

4506 (34) Unless the context requires otherwise, "receivership court" refers to the court in

4507 which a delinquency proceeding is pending.

4508 (35) "Reciprocal state" means [~~any~~] a state other than this state that:

4509 (a) enforces a law substantially similar to this chapter;

4510 (b) requires the commissioner to be the receiver of a delinquent insurer; and

4511 (c) has laws for the avoidance of fraudulent conveyances and preferential transfers by

4512 the receiver of a delinquent insurer.

4513 (36) "Record," when used as a noun, means [~~any~~] information or data, in whatever

4514 form maintained, including:

4515 (a) a book;

4516 (b) a document;

4517 (c) a paper;

4518 (d) a file;

4519 (e) an application file;

4520 (f) a policyholder list;

4521 (g) policy information;

4522 (h) a claim or claim file;

4523 (i) an account;
4524 (j) a voucher;
4525 (k) a litigation file;
4526 (l) a premium record;
4527 (m) a rate book;
4528 (n) an underwriting manual;
4529 (o) a personnel record;
4530 (p) a financial record; or
4531 (q) other material.
4532 (37) "Reinsurance" means a transaction or contract under which an assuming insurer
4533 agrees to indemnify a ceding insurer against all, or a part, of [~~any~~] a loss that the ceding insurer
4534 may sustain under the one or more policies that the ceding insurer issues or will issue.
4535 (38) "Repurchase agreement" is as defined in the Federal Deposit Insurance Act, 12
4536 U.S.C. Sec. 1821(e)(8)(D).
4537 (39) (a) "Secured claim" means, subject to Subsection (39)(b):
4538 (i) a claim secured by an asset that is not a general asset; or
4539 (ii) the right to set off as provided in Section 31A-27a-510.
4540 (b) "Secured claim" does not include:
4541 (i) a special deposit claim;
4542 (ii) a claim based on mere possession; or
4543 (iii) a claim arising from a constructive or resulting trust.
4544 (40) "Securities contract" is as defined in the Federal Deposit Insurance Act, 12 U.S.C.
4545 Sec. 1821(e)(8)(D).
4546 (41) "Special deposit" means a deposit established pursuant to statute for the security
4547 or benefit of a limited class or classes of persons.
4548 (42) (a) Subject to Subsection (42)(b), "special deposit claim" means a claim secured
4549 by a special deposit.
4550 (b) "Special deposit claim" does not include a claim against the general assets of the
4551 insurer.
4552 (43) "State" means a state, district, or territory of the United States.
4553 (44) "Subsidiary" is as defined in Section 31A-1-301.

4554 (45) "Swap agreement" is as defined in the Federal Deposit Insurance Act, 12 U.S.C.
4555 Sec. 1821(e)(8)(D).
4556 (46) (a) "Transfer" includes the sale and every other and different mode of disposing of
4557 or parting with property or with an interest in property, whether:
4558 (i) directly or indirectly;
4559 (ii) absolutely or conditionally;
4560 (iii) voluntarily or involuntarily; or
4561 (iv) by or without judicial proceedings.
4562 (b) An interest in property includes:
4563 (i) a set off;
4564 (ii) having possession of the property; or
4565 (iii) fixing a lien on the property or on an interest in the property.
4566 (c) The retention of a security title in property delivered to an insurer and foreclosure
4567 of the insurer's equity of redemption is considered a transfer suffered by the insurer.
4568 (47) Notwithstanding Section 31A-1-301, "unauthorized insurer" means an insurer
4569 transacting the business of insurance in this state that has not received a certificate of authority
4570 from this state, or some other type of authority that allows for the transaction of the business of
4571 insurance in this state.
4572 Section 43. Section **31A-27a-107** is amended to read:
4573 **31A-27a-107. Notice and hearing on matters submitted by the receiver for**
4574 **receivership court approval.**
4575 (1) (a) Upon written request to the receiver, a person shall be placed on the service list
4576 to receive notice of matters filed by the receiver. The person shall include in a written request
4577 under this Subsection (1)(a) the person's address, facsimile number, and electronic mail
4578 address.
4579 (b) It is the responsibility of the person requesting notice to:
4580 (i) inform the receiver in writing of any changes in the person's address, facsimile
4581 number, and electronic mail address; or
4582 (ii) request that the person's name be deleted from the service list.
4583 (c) (i) The receiver may serve on a person on the service list a request to confirm
4584 continuation on the service list by returning a form.

4585 (ii) The request to confirm continuation may be served periodically but not more
4586 frequently than every 12 months.
4587 (iii) A person who fails to return the form described in this Subsection (1)(c) may be
4588 removed from the service list.
4589 (d) Inclusion on the service list does not confer standing in the delinquency proceeding
4590 to raise, appear, or be heard on any issue.
4591 (e) The receiver shall:
4592 (i) file a copy of the service list with the receivership court; and
4593 (ii) periodically provide to the receivership court notice of changes to the service list.
4594 (f) Notice may be provided by first-class mail postage paid, electronic mail, or
4595 facsimile transmission, at the receiver's discretion.
4596 (2) Except as otherwise provided by this chapter, notice and hearing of any matter
4597 submitted by the receiver to the receivership court for approval under this chapter shall be
4598 conducted in accordance with this Subsection (2).
4599 (a) The receiver:
4600 (i) shall file a motion:
4601 (A) explaining the proposed action; and
4602 (B) the basis for the proposed action; and
4603 (ii) may include any evidence in support of the motion.
4604 (b) If a document, material, or other information supporting the motion is confidential,
4605 the document, material, or other information may be submitted to the receivership court under
4606 seal for in camera inspection.
4607 (c) (i) The receiver shall provide notice and a copy of the motion to:
4608 (A) all persons on the service list; and
4609 (B) any other person as may be required by the receivership court.
4610 (ii) Notice may be provided by first-class mail postage paid, electronic mail, or
4611 facsimile transmission, at the receiver's discretion.
4612 (iii) For purposes of this section, notice is considered to be given on the day on which
4613 it is deposited with the United States Postmaster or transmitted, as applicable, to the
4614 last-known address as shown on the service list.
4615 (d) (i) A party in interest objecting to the motion shall:

4616 (A) file an objection specifying the grounds for the objection within:
4617 (I) 10 days of the day on which the notice of the filing of the motion is sent; or
4618 (II) such other time as the receivership court may specify; and
4619 (B) serve copies on:
4620 (I) the receiver; and
4621 (II) any other person served with the motion within the time period described in this
4622 Subsection (2)(d)(i).
4623 (ii) In accordance with the Utah Rules of Civil Procedure, days may be added to the
4624 time for filing an objection if the notice of the motion is sent only by way of United States
4625 mail.
4626 (iii) An objecting party has the burden of showing why the receivership court should
4627 not authorize the proposed action.
4628 (e) (i) If no objection to the motion is timely filed:
4629 (A) the receivership court may:
4630 (I) enter an order approving the motion without a hearing; or
4631 (II) hold a hearing to determine if the receiver's motion should be approved; and
4632 (B) the receiver may request that the receivership court enter an order or hold a hearing
4633 on an expedited basis.
4634 (ii) (A) If an objection is timely filed, the receivership court may hold a hearing.
4635 (B) If the receivership court approves the motion and, upon a motion by the receiver,
4636 determines that the objection is frivolous or filed merely for delay or for other improper
4637 purpose, the receivership court may order the objecting party to pay the receiver's reasonable
4638 costs and fees of defending against the objection.
4639 Section 44. Section **31A-27a-201** is amended to read:
4640 **31A-27a-201. Receivership court's seizure order.**
4641 (1) The commissioner may file in the Third District Court for Salt Lake County a
4642 petition:
4643 (a) with respect to:
4644 (i) an insurer domiciled in this state;
4645 (ii) an unauthorized insurer; or
4646 (iii) pursuant to Section 31A-27a-901, a foreign insurer;

4647 (b) alleging that:
4648 (i) there exists grounds that would justify a court order for a formal delinquency
4649 proceeding against the insurer under this chapter; and
4650 (ii) the interests of policyholders, creditors, or the public will be endangered by delay;
4651 and
4652 (c) setting forth the contents of a seizure order considered necessary by the
4653 commissioner.
4654 (2) (a) Upon a filing under Subsection (1), the receivership court may issue the
4655 requested seizure order:
4656 (i) immediately, ex parte, and without notice or hearing;
4657 (ii) that directs the commissioner to take possession and control of:
4658 (A) all or a part of the property, accounts, and records of an insurer; and
4659 (B) the premises occupied by the insurer for transaction of the insurer's business; and
4660 (iii) that until further order of the receivership court, enjoins the insurer and its officers,
4661 managers, agents, and employees from disposition of its property and from the transaction of
4662 its business except with the written consent of the commissioner.
4663 (b) [~~Any~~] A person having possession or control of and refusing to deliver any of the
4664 records or assets of a person against whom a seizure order is issued under this Subsection (2) is
4665 guilty of a class B misdemeanor.
4666 (3) (a) A petition that requests injunctive relief:
4667 (i) shall be verified by the commissioner or the commissioner's designee; and
4668 (ii) is not required to plead or prove irreparable harm or inadequate remedy at law.
4669 (b) The commissioner shall provide only the notice that the receivership court may
4670 require.
4671 (4) (a) The receivership court shall specify in the seizure order the duration of the
4672 seizure, which shall be the time the receivership court considers necessary for the
4673 commissioner to ascertain the condition of the insurer.
4674 (b) The receivership court may from time to time:
4675 (i) hold a hearing that the receivership court considers desirable:
4676 (A) (I) on motion of the commissioner;
4677 (II) on motion of the insurer; or

4678 (III) on its own motion; and
4679 (B) after the notice the receivership court considers appropriate; and
4680 (ii) extend, shorten, or modify the terms of the seizure order.
4681 (c) The receivership court shall vacate the seizure order if the commissioner fails to
4682 commence a formal proceeding under this chapter after having had a reasonable opportunity to
4683 commence a formal proceeding under this chapter.
4684 (d) An order of the receivership court pursuant to a formal proceeding under this
4685 chapter vacates the seizure order.
4686 (5) Entry of a seizure order under this section does not constitute a breach or an
4687 anticipatory breach of [~~any~~] a contract of the insurer.
4688 (6) (a) An insurer subject to an ex parte seizure order under this section may petition
4689 the receivership court at any time after the issuance of a seizure order for a hearing and review
4690 of the basis for the seizure order.
4691 (b) The receivership court shall hold the hearing and review requested under this
4692 Subsection (6) not more than 15 days after the day on which the request is received or as soon
4693 thereafter as the court may allow.
4694 (c) A hearing under this Subsection (6):
4695 (i) may be held privately in chambers; and
4696 (ii) shall be held privately in chambers if the insurer proceeded against requests that it
4697 be private.
4698 (7) (a) If, at any time after the issuance of a seizure order, it appears to the receivership
4699 court that a person whose interest is or will be substantially affected by the seizure order did
4700 not appear at the hearing and has not been served, the receivership court may order that notice
4701 be given to the person.
4702 (b) An order under this Subsection (7) that notice be given may not stay the effect of
4703 [~~any~~] a seizure order previously issued by the receivership court.
4704 (8) Whenever the commissioner makes a seizure as provided in Subsection (2), on the
4705 demand of the commissioner, it shall be the duty of the sheriff of a county of this state, and of
4706 the police department of a municipality in the state to furnish the commissioner with necessary
4707 deputies or officers to assist the commissioner in making and enforcing the seizure order.
4708 (9) The commissioner may appoint a receiver under this section. The insurer shall pay

4709 the costs and expenses of the receiver appointed.

4710 Section 45. Section **31A-27a-701** is amended to read:

4711 **31A-27a-701. Priority of distribution.**

4712 (1) (a) The priority of payment of distributions on unsecured claims shall be in
4713 accordance with the order in which each class of claim is set forth in this section except as
4714 provided in Section 31A-27a-702.

4715 (b) All claims in each class shall be paid in full or adequate funds retained for the
4716 claim's payment before a member of the next class receives payment.

4717 (c) All claims within a class shall be paid substantially the same percentage.

4718 (d) Except as provided in Subsections (2)(a)(i)(E), (2)(k), and (2)(m), subclasses may
4719 not be established within a class.

4720 (e) A claim by a shareholder, policyholder, or other creditor may not be permitted to
4721 circumvent the priority classes through the use of equitable remedies.

4722 (2) The order of distribution of claims shall be as follows:

4723 (a) a Class 1 claim, which:

4724 (i) is a cost or expense of administration expressly approved or ratified by the
4725 liquidator, including the following:

4726 (A) the actual and necessary costs of preserving or recovering the property of the
4727 insurer;

4728 (B) reasonable compensation for all services rendered on behalf of the administrative
4729 supervisor or receiver;

4730 (C) a necessary filing fee;

4731 (D) the fees and mileage payable to a witness;

4732 (E) an unsecured loan obtained by the receiver, which:

4733 (I) unless its terms otherwise provide, has priority over all other costs of
4734 administration; and

4735 (II) absent agreement to the contrary, shares pro rata with all other claims described in
4736 this Subsection (2)(a)(i)(E); and

4737 (F) an expense approved by the rehabilitator of the insurer, if any, incurred in the
4738 course of the rehabilitation that is unpaid at the time of the entry of the order of liquidation; and

4739 (ii) except as expressly approved by the receiver, excludes any expense arising from a

4740 duty to indemnify a director, officer, or employee of the insurer which expense, if allowed, is a
4741 Class 7 claim;
4742 (b) a Class 2 claim, which:
4743 (i) is a reasonable expense of a guaranty association, including overhead, salaries, or
4744 other general administrative expenses allocable to the receivership such as:
4745 (A) an administrative or claims handling expense;
4746 (B) an expense in connection with arrangements for ongoing coverage; and
4747 (C) in the case of a property and casualty guaranty association, a loss adjustment
4748 expense, including:
4749 (I) an adjusting or other expense; and
4750 (II) a defense or cost containment expense; and
4751 (ii) excludes an expense incurred in the performance of duties under Section
4752 31A-28-112 or similar duties under the statute governing a similar organization in another
4753 state;
4754 (c) a Class 3 claim, which:
4755 (i) is:
4756 (A) a claim under a policy of insurance including a third party claim;
4757 (B) a claim under an annuity contract or funding agreement;
4758 (C) a claim under a nonassessable policy for unearned premium;
4759 (D) a claim of an obligee and, subject to the discretion of the receiver, a completion
4760 contractor under a surety bond or surety undertaking, except for:
4761 (I) a bail bond;
4762 (II) a mortgage guaranty;
4763 (III) a financial guaranty; or
4764 (IV) other form of insurance offering protection against investment risk or warranties;
4765 (E) a claim by a principal under a surety bond or surety undertaking for wrongful
4766 dissipation of collateral by the insurer or its agents;
4767 (F) an indemnity payment on:
4768 (I) a covered claim; or
4769 [~~(II) unearned premium; or~~]
4770 [~~(III)~~] (II) a payment for the continuation of coverage made by an entity responsible for

4771 the payment of a claim or continuation of coverage of an insolvent health maintenance
4772 organization;
4773 (G) a claim for unearned premium;
4774 [(G)] (H) a claim incurred during the extension of coverage provided for in Sections
4775 31A-27a-402 and 31A-27a-403; or
4776 [(H)] (I) all other claims incurred in fulfilling the statutory obligations of a guaranty
4777 association not included in Class 2, including:
4778 (I) an indemnity payment on covered claims; and
4779 (II) in the case of a life and health guaranty association, a claim:
4780 (Aa) as a creditor of the impaired or insolvent insurer for a payment of and liabilities
4781 incurred on behalf of a covered claim or covered obligation of the insurer; and
4782 (Bb) for the funds needed to reinsure the obligations described under this Subsection
4783 (2)(c)(i)(H)(II) with a solvent insurer; and
4784 (ii) notwithstanding any other provision of this chapter, excludes the following which
4785 shall be paid under Class 7, except as provided in this section:
4786 (A) an obligation of the insolvent insurer arising out of a reinsurance contract;
4787 (B) an obligation that is incurred pursuant to an occurrence policy or reported pursuant
4788 to a claims made policy after:
4789 (I) the expiration date of the policy;
4790 (II) the policy is replaced by the insured;
4791 (III) the policy is canceled at the insured's request; or
4792 (IV) the policy is canceled as provided in this chapter;
4793 (C) an obligation to an insurer, insurance pool, or underwriting association and the
4794 insurer's, insurance pool's, or underwriting association's claim for contribution, indemnity, or
4795 subrogation, equitable or otherwise, except for direct claims under a policy where the insurer is
4796 the named insured;
4797 (D) an amount accrued as punitive or exemplary damages unless expressly covered
4798 under the terms of the policy, which shall be paid as a claim in Class 9;
4799 (E) a tort claim of any kind against the insurer;
4800 (F) a claim against the insurer for bad faith or wrongful settlement practices; and
4801 (G) a claim of a guaranty association for assessments not paid by the insurer, which

4802 claims shall be paid as claims in Class 7; and
4803 (iii) notwithstanding Subsection (2)(c)(ii)(B), does not exclude an unearned premium
4804 claim on a policy, other than a reinsurance agreement;
4805 (d) a Class 4 claim, which is a claim under a policy for mortgage guaranty, financial
4806 guaranty, or other forms of insurance offering protection against investment risk or warranties;
4807 (e) a Class 5 claim, which is a claim of the federal government not included in Class 3
4808 or 4;
4809 (f) a Class 6 claim, which is a debt due an employee for services or benefits:
4810 (i) to the extent that the expense:
4811 (A) does not exceed the lesser of:
4812 (I) $5,000; or
4813 (II) two months' salary; and
4814 (B) represents payment for services performed within one year before the day on which
4815 the initial order of receivership is issued; and
4816 (ii) which priority is in lieu of any other similar priority that may be authorized by law
4817 as to wages or compensation of employees;
4818 (g) a Class 7 claim, which is a claim of an unsecured creditor not included in Classes 1
4819 through 6, including:
4820 (i) a claim under a reinsurance contract;
4821 (ii) a claim of a guaranty association for an assessment not paid by the insurer; and
4822 (iii) other claims excluded from Class 3 or 4, unless otherwise assigned to Classes 8
4823 through 13;
4824 (h) subject to Subsection (3), a Class 8 claim, which is:
4825 (i) a claim of a state or local government, except a claim specifically classified
4826 elsewhere in this section; or
4827 (ii) a claim for services rendered and expenses incurred in opposing a formal
4828 delinquency proceeding;
4829 (i) a Class 9 claim, which is a claim for penalties, punitive damages, or forfeitures,
4830 unless expressly covered under the terms of a policy of insurance;
4831 (j) a Class 10 claim, which is, except as provided in Subsections 31A-27a-601(2) and
4832 31A-27a-601(3), a late filed claim that would otherwise be classified in Classes 3 through 9;

4833 (k) subject to Subsection (4), a Class 11 claim, which is:
4834 (i) a surplus note;
4835 (ii) a capital note;
4836 (iii) a contribution note;
4837 (iv) a similar obligation;
4838 (v) a premium refund on an assessable policy; or
4839 (vi) any other claim specifically assigned to this class;
4840 (l) a Class 12 claim, which is a claim for interest on an allowed claim of Classes 1
4841 through 11, according to the terms of a plan to pay interest on allowed claims proposed by the
4842 liquidator and approved by the receivership court; and
4843 (m) subject to Subsection (4), a Class 13 claim, which is a claim of a shareholder or
4844 other owner arising out of:
4845 (i) the shareholder's or owner's capacity as shareholder or owner or any other capacity;
4846 and
4847 (ii) except as the claim may be qualified in Class 3, 4, 7, or 12.
4848 (3) To prove a claim described in Class 8, the claimant shall show that:
4849 (a) the insurer that is the subject of the delinquency proceeding incurred the fee or
4850 expense on the basis of the insurer's best knowledge, information, and belief:
4851 (i) formed after reasonable inquiry indicating opposition is in the best interests of the
4852 insurer;
4853 (ii) that is well grounded in fact; and
4854 (iii) is warranted by existing law or a good faith argument for the extension,
4855 modification, or reversal of existing law; and
4856 (b) opposition is not pursued for any improper purpose, such as to harass, to cause
4857 unnecessary delay, or to cause needless increase in the cost of the litigation.
4858 (4) (a) A claim in Class 11 is subject to a subordination agreement related to other
4859 claims in Class 11 that exist before the entry of a liquidation order.
4860 (b) A claim in Class 13 is subject to a subordination agreement, related to other claims
4861 in Class 13 that exist before the entry of a liquidation order.
4862 Section 46. Section **31A-29-106** is amended to read:
4863 **31A-29-106. Powers of board.**

4864 (1) The board shall have the general powers and authority granted under the laws of
4865 this state to insurance companies licensed to transact health care insurance business. In
4866 addition, the board shall have the specific authority to:
4867 (a) enter into contracts to carry out the provisions and purposes of this chapter,
4868 including, with the approval of the commissioner, contracts with:
4869 (i) similar pools of other states for the joint performance of common administrative
4870 functions; or
4871 (ii) persons or other organizations for the performance of administrative functions;
4872 (b) sue or be sued, including taking such legal action necessary to avoid the payment of
4873 improper claims against the pool or the coverage provided through the pool;
4874 (c) establish appropriate rates, rate schedules, rate adjustments, expense allowances,
4875 agents' referral fees, claim reserve formulas, and any other actuarial function appropriate to the
4876 operation of the pool;
4877 (d) issue policies of insurance in accordance with the requirements of this chapter;
4878 (e) retain an executive director and appropriate legal, actuarial, and other personnel as
4879 necessary to provide technical assistance in the operations of the pool;
4880 (f) establish rules, conditions, and procedures for reinsuring risks under this chapter;
4881 (g) cause the pool to have an annual audit of its operations by the state auditor;
4882 (h) coordinate with the Department of Health in seeking to obtain from the Centers for
4883 Medicare and Medicaid Services, or other appropriate office or agency of government, all
4884 appropriate waivers, authority, and permission needed to coordinate the coverage available
4885 from the pool with coverage available under Medicaid, either before or after Medicaid
4886 coverage, or as a conversion option upon completion of Medicaid eligibility, without the
4887 necessity for requalification by the enrollee;
4888 (i) provide for and employ cost containment measures and requirements including
4889 preadmission certification, concurrent inpatient review, and individual case management for
4890 the purpose of making the pool more cost-effective;
4891 (j) offer pool coverage through contracts with health maintenance organizations,
4892 preferred provider organizations, and other managed care systems that will manage costs while
4893 maintaining quality care;
4894 (k) establish annual limits on benefits payable under the pool to or on behalf of any

4895 enrollee;

4896 (l) exclude from coverage under the pool specific benefits, medical conditions, and

4897 procedures for the purpose of protecting the financial viability of the pool;

4898 (m) administer the Pool Fund;

4899 (n) make rules in accordance with Title 63G, Chapter 3, Utah Administrative

4900 Rulemaking Act, to implement this chapter;

4901 (o) adopt, trademark, and copyright a trade name for the pool for use in marketing and

4902 publicizing the pool and its products; and

4903 (p) transition health care coverage for all individuals covered under the pool as part of

4904 the conversion to health insurance coverage, regardless of preexisting conditions, under

4905 PPACA.

4906 (2) (a) The board shall prepare and submit an annual report to the Legislature which

4907 shall include:

4908 (i) the net premiums anticipated;

4909 (ii) actuarial projections of payments required of the pool;

4910 (iii) the expenses of administration; and

4911 (iv) the anticipated reserves or losses of the pool.

4912 (b) The budget for operation of the pool is subject to the approval of the board.

4913 (c) The administrative budget of the board and the commissioner under this chapter

4914 shall comply with the requirements of Title 63J, Chapter 1, Budgetary Procedures Act, and is

4915 subject to review and approval by the Legislature.

4916 [~~(3) (a) The board shall on or before September 1, 2004, require the plan administrator~~

4917 ~~or an independent actuarial consultant retained by the plan administrator to redetermine the~~

4918 ~~reasonable equivalent of the criteria for uninsurability required under Subsection~~

4919 ~~31A-30-106(1)(h) that is used by the board to determine eligibility for coverage in the pool.~~]

4920 [~~(b) The board shall redetermine the criteria established in Subsection (3)(a) at least~~

4921 ~~every five years thereafter.~~]

4922 Section 47. Section **31A-29-111** is amended to read:

4923 **31A-29-111. Eligibility -- Limitations.**

4924 (1) (a) Except as provided in Subsection (1)(b), an individual who is not HIPAA

4925 eligible is eligible for pool coverage if the individual:

4926 (i) pays the established premium;
4927 (ii) is a resident of this state; and
4928 (iii) meets the health underwriting criteria under Subsection (5)(a).
4929 (b) Notwithstanding Subsection (1)(a), an individual who is not HIPAA eligible is not
4930 eligible for pool coverage if one or more of the following conditions apply:
4931 (i) the individual is eligible for health care benefits under Medicaid or Medicare,
4932 except as provided in Section 31A-29-112;
4933 (ii) the individual has terminated coverage in the pool, unless:
4934 (A) 12 months have elapsed since the termination date; or
4935 (B) the individual demonstrates that creditable coverage has been involuntarily
4936 terminated for any reason other than nonpayment of premium;
4937 (iii) the pool has paid the maximum lifetime benefit to or on behalf of the individual;
4938 (iv) the individual is an inmate of a public institution;
4939 (v) the individual is eligible for a public health plan, as defined in federal regulations
4940 adopted pursuant to 42 U.S.C. Sec. 300gg;
4941 (vi) the individual's health condition does not meet the criteria established under
4942 Subsection (5);
4943 (vii) the individual is eligible for coverage under an employer group that offers a health
4944 benefit plan or a self-insurance arrangement to its eligible employees, dependents, or members
4945 as:
4946 (A) an eligible employee;
4947 (B) a dependent of an eligible employee; or
4948 (C) a member;
4949 (viii) the individual is covered under any other health benefit plan;
4950 (ix) except as provided in Subsections (3) and (6), at the time of application, the
4951 individual has not resided in Utah for at least 12 consecutive months preceding the date of
4952 application; or
4953 (x) the individual's employer pays any part of the individual's health benefit plan
4954 premium, either as an insured or a dependent, for pool coverage.
4955 (2) (a) Except as provided in Subsection (2)(b), an individual who is HIPAA eligible is
4956 eligible for pool coverage if the individual:

4957 (i) pays the established premium; and
4958 (ii) is a resident of this state.
4959 (b) Notwithstanding Subsection (2)(a), a HIPAA eligible individual is not eligible for
4960 pool coverage if one or more of the following conditions apply:
4961 (i) the individual is eligible for health care benefits under Medicaid or Medicare,
4962 except as provided in Section 31A-29-112;
4963 (ii) the individual is eligible for a public health plan, as defined in federal regulations
4964 adopted pursuant to 42 U.S.C. Sec. 300gg;
4965 (iii) the individual is covered under any other health benefit plan;
4966 (iv) the individual is eligible for coverage under an employer group that offers a health
4967 benefit plan or self-insurance arrangements to its eligible employees, dependents, or members
4968 as:
4969 (A) an eligible employee;
4970 (B) a dependent of an eligible employee; or
4971 (C) a member;
4972 (v) the pool has paid the maximum lifetime benefit to or on behalf of the individual;
4973 (vi) the individual is an inmate of a public institution; or
4974 (vii) the individual's employer pays any part of the individual's health benefit plan
4975 premium, either as an insured or a dependent, for pool coverage.
4976 (3) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under Subsection
4977 (1)(a), an individual whose health care insurance coverage from a state high risk pool with
4978 similar coverage is terminated because of nonresidency in another state is eligible for coverage
4979 under the pool subject to the conditions of Subsections (1)(b)(i) through (viii).
4980 (b) Coverage under Subsection (3)(a) shall be applied for within 63 days after the
4981 termination date of the previous high risk pool coverage.
4982 (c) The effective date of this state's pool coverage shall be the date of termination of
4983 the previous high risk pool coverage.
4984 (d) The waiting period of an individual with a preexisting condition applying for
4985 coverage under this chapter shall be waived:
4986 (i) to the extent to which the waiting period was satisfied under a similar plan from
4987 another state; and

4988 (ii) if the other state's benefit limitation was not reached.
4989 (4) (a) If an eligible individual applies for pool coverage within 30 days of being
4990 denied coverage by an individual carrier, the effective date for pool coverage shall be no later
4991 than the first day of the month following the date of submission of the completed insurance
4992 application to the carrier.
4993 (b) Notwithstanding Subsection (4)(a), for individuals eligible for coverage under
4994 Subsection (3), the effective date shall be the date of termination of the previous high risk pool
4995 coverage.
4996 (5) (a) The board shall establish and adjust, as necessary, health underwriting criteria
4997 based on:
4998 (i) health condition; and
4999 (ii) expected claims so that the expected claims are anticipated to remain within
5000 available funding.
5001 (b) The board, with approval of the commissioner, may contract with one or more
5002 providers under Title 63G, Chapter 6a, Utah Procurement Code, to develop underwriting
5003 criteria under Subsection (5)(a).
5004 [~~(c) If an individual is denied coverage by the pool under the criteria established in~~
5005 ~~Subsection (5)(a), the pool shall issue a certificate of insurability to the individual for coverage~~
5006 ~~under Subsection 31A-30-108(3).~~]
5007 (6) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under Subsection
5008 (1)(a), an individual whose individual health care insurance coverage was involuntarily
5009 terminated, is eligible for coverage under the pool subject to the conditions of Subsections
5010 (1)(b)(i) through (viii) and (x).
5011 (b) Coverage under Subsection (6)(a) shall be applied for within 63 days after the
5012 termination date of the previous individual health care insurance coverage.
5013 (c) The effective date of this state's pool coverage shall be the date of termination of
5014 the previous individual coverage.
5015 (d) The waiting period of an individual with a preexisting condition applying for
5016 coverage under this chapter shall be waived to the extent to which the waiting period was
5017 satisfied under the individual health insurance plan.
5018 Section 48. Section **31A-29-115** is amended to read:

5019 **31A-29-115. Cancellation -- Notice.**
5020 (1) [~~(a)~~] On the date of renewal, the pool may cancel an enrollee's policy if:
5021 [~~(i)~~] (a) the enrollee's health condition does not meet the criteria established in
5022 Subsection 31A-29-111(5); and
5023 [~~(ii)~~] (b) the pool has provided written notice to the enrollee's last-known address no
5024 less than 60 days before cancellation[~~; and~~].
5025 [~~(iii) at least one individual carrier has not reached the individual enrollment cap~~
5026 ~~established in Section 31A-30-110.~~]
5027 [~~(b) The pool shall issue a certificate of insurability to an enrollee whose policy is~~
5028 ~~cancelled under Subsection (1)(a) for coverage under Subsection 31A-30-108(3) if the~~
5029 ~~requirements of Subsection 31A-29-111(5) are met.~~]
5030 (2) The pool may cancel an enrollee's policy at any time if:
5031 (a) the pool has provided written notice to the enrollee's last-known address no less
5032 than 15 days before cancellation; and
5033 (b) (i) the enrollee establishes a residency outside of Utah for three consecutive
5034 months;
5035 (ii) there is nonpayment of premiums; or
5036 (iii) the pool determines that the enrollee does not meet the eligibility requirements set
5037 forth in Section 31A-29-111, in which case:
5038 (A) the policy may be retroactively terminated for the period of time in which the
5039 enrollee was not eligible;
5040 (B) retroactive termination may not exceed three years; and
5041 (C) the board's remedy under this Subsection (2)(b) shall be a cause of action against
5042 the enrollee for benefits paid during the period of ineligibility in accordance with Subsection
5043 31A-29-119(3).
5044 Section 49. Section **31A-30-102** is amended to read:
5045 **31A-30-102. Purpose statement.**
5046 The purpose of this chapter is to:
5047 (1) prevent abusive rating practices;
5048 (2) require disclosure of rating practices to purchasers;
5049 (3) establish rules regarding:

5050 (a) a universal individual and small group application; and
5051 (b) renewability of coverage;
5052 (4) improve the overall fairness and efficiency of the individual and small group
5053 insurance market;
5054 (5) provide increased access for individuals and small employers to health insurance;
5055 and
5056 (6) provide an employer with the opportunity to establish a defined contribution
5057 arrangement for an employee to purchase a health benefit plan through the [~~Internet portal~~]
5058 Health Insurance Exchange created by Section 63M-1-2504.
5059 Section 50. Section **31A-30-103** is amended to read:
5060 **31A-30-103. Definitions.**
5061 As used in this chapter:
5062 (1) "Actuarial certification" means a written statement by a member of the American
5063 Academy of Actuaries or other individual approved by the commissioner that a covered carrier
5064 is in compliance with [~~Sections 31A-30-106 and 31A-30-106.1~~] this chapter, based upon the
5065 examination of the covered carrier, including review of the appropriate records and of the
5066 actuarial assumptions and methods used by the covered carrier in establishing premium rates
5067 for applicable health benefit plans.
5068 (2) "Affiliate" or "affiliated" means [~~any entity or~~] a person who directly or indirectly
5069 through one or more intermediaries, controls or is controlled by, or is under common control
5070 with, a specified [~~entity or~~] person.
5071 (3) "Base premium rate" means, for each class of business as to a rating period, the
5072 lowest premium rate charged or that could have been charged under a rating system for that
5073 class of business by the covered carrier to covered insureds with similar case characteristics for
5074 health benefit plans with the same or similar coverage.
5075 (4) (a) "Bona fide employer association" means an association of employers:
5076 (i) that meets the requirements of Subsection 31A-22-701(2)(b);
5077 (ii) in which the employers of the association, either directly or indirectly, exercise
5078 control over the plan;
5079 (iii) that is organized:
5080 (A) based on a commonality of interest between the employers and their employees

5081 that participate in the plan by some common economic or representation interest or genuine
5082 organizational relationship unrelated to the provision of benefits; and
5083 (B) to act in the best interests of its employers to provide benefits for the employer's
5084 employees and their spouses and dependents, and other benefits relating to employment; and
5085 (iv) whose association sponsored health plan complies with 45 C.F.R. 146.121.
5086 (b) The commissioner shall consider the following with regard to determining whether
5087 an association of employers is a bona fide employer association under Subsection (4)(a):
5088 (i) how association members are solicited;
5089 (ii) who participates in the association;
5090 (iii) the process by which the association was formed;
5091 (iv) the purposes for which the association was formed, and what, if any, were the
5092 pre-existing relationships of its members;
5093 (v) the powers, rights and privileges of employer members; and
5094 (vi) who actually controls and directs the activities and operations of the benefit
5095 programs.
5096 (5) "Carrier" means [~~any~~] a person [~~or entity~~] that provides health insurance in this
5097 state including:
5098 (a) an insurance company;
5099 (b) a prepaid hospital or medical care plan;
5100 (c) a health maintenance organization;
5101 (d) a multiple employer welfare arrangement; and
5102 (e) [~~any other~~] another person [~~or entity~~] providing a health insurance plan under this
5103 title.
5104 (6) (a) Except as provided in Subsection (6)(b), "case characteristics" means
5105 demographic or other objective characteristics of a covered insured that are considered by the
5106 carrier in determining premium rates for the covered insured.
5107 (b) "Case characteristics" do not include:
5108 (i) duration of coverage since the policy was issued;
5109 (ii) claim experience; and
5110 (iii) health status.
5111 (7) "Class of business" means all or a separate grouping of covered insureds that is

5112 permitted by the commissioner in accordance with Section 31A-30-105.

5113 [(8) "Conversion policy" means a policy providing coverage under the conversion

5114 provisions required in Chapter 22, Part 7, Group Accident and Health Insurance.]

5115 [(9)] (8) "Covered carrier" means [any] an individual carrier or small employer carrier

5116 subject to this chapter.

5117 [(10)] (9) "Covered individual" means [any] an individual who is covered under a

5118 health benefit plan subject to this chapter.

5119 [(11)] (10) "Covered insureds" means small employers and individuals who are issued

5120 a health benefit plan that is subject to this chapter.

5121 [(12)] (11) "Dependent" means an individual to the extent that the individual is defined

5122 to be a dependent by:

5123 (a) the health benefit plan covering the covered individual; and

5124 (b) Chapter 22, Part 6, Accident and Health Insurance.

5125 [(13)] (12) "Established geographic service area" means a geographical area approved

5126 by the commissioner within which the carrier is authorized to provide coverage.

5127 [(14)] (13) "Index rate" means, for each class of business as to a rating period for

5128 covered insureds with similar case characteristics, the arithmetic average of the applicable base

5129 premium rate and the corresponding highest premium rate.

5130 [(15)] (14) "Individual carrier" means a carrier that provides coverage on an individual

5131 basis through a health benefit plan regardless of whether:

5132 (a) coverage is offered through:

5133 (i) an association;

5134 (ii) a trust;

5135 (iii) a discretionary group; or

5136 (iv) other similar groups; or

5137 (b) the policy or contract is situated out-of-state.

5138 [(16)] (15) "Individual conversion policy" means a conversion policy issued to:

5139 (a) an individual; or

5140 (b) an individual with a family.

5141 [(17) "Individual coverage count" means the number of natural persons covered under

5142 a carrier's health benefit products that are individual policies.]

5143 [~~(18) "Individual enrollment cap" means the percentage set by the commissioner in~~
5144 ~~accordance with Section 31A-30-110.~~]
5145 [~~(19)~~] (16) "New business premium rate" means, for each class of business as to a
5146 rating period, the lowest premium rate charged or offered, or that could have been charged or
5147 offered, by the carrier to covered insureds with similar case characteristics for newly issued
5148 health benefit plans with the same or similar coverage.
5149 [~~(20)~~] (17) "Premium" means money paid by covered insureds and covered individuals
5150 as a condition of receiving coverage from a covered carrier, including [~~any~~] fees or other
5151 contributions associated with the health benefit plan.
5152 [~~(21)~~] (18) (a) "Rating period" means the calendar period for which premium rates
5153 established by a covered carrier are assumed to be in effect, as determined by the carrier.
5154 (b) A covered carrier may not have:
5155 (i) more than one rating period in any calendar month; and
5156 (ii) no more than 12 rating periods in any calendar year.
5157 [~~(22) "Resident" means an individual who has resided in this state for at least 12~~
5158 ~~consecutive months immediately preceding the date of application.~~]
5159 [~~(23)~~] (19) "Short-term limited duration insurance" means a health benefit product that:
5160 (a) is not renewable; and
5161 (b) has an expiration date specified in the contract that is less than 364 days after the
5162 date the plan became effective.
5163 [~~(24)~~] (20) "Small employer carrier" means a carrier that provides health benefit plans
5164 covering eligible employees of one or more small employers in this state, regardless of
5165 whether:
5166 (a) coverage is offered through:
5167 (i) an association;
5168 (ii) a trust;
5169 (iii) a discretionary group; or
5170 (iv) other similar grouping; or
5171 (b) the policy or contract is situated out-of-state.
5172 [~~(25) "Uninsurable" means an individual who:~~]
5173 [~~(a) is eligible for the Comprehensive Health Insurance Pool coverage under the~~

5174 underwriting criteria established in Subsection 31A-29-111(5); or]
5175 [(b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and]
5176 [(ii) has a condition of health that does not meet consistently applied underwriting
5177 criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(g)
5178 and (h) for which coverage the applicant is applying.]
5179 [(26) "Uninsurable percentage" for a given calendar year equals UC/CI where, for
5180 purposes of this formula:]
5181 [(a) "CI" means the carrier's individual coverage count as of December 31 of the
5182 preceding year; and]
5183 [(b) "UC" means the number of uninsurable individuals who were issued an individual
5184 policy on or after July 1, 1997.]
5185 Section 51. Section **31A-30-104** is amended to read:
5186 **31A-30-104. Applicability and scope.**
5187 (1) This chapter applies to any:
5188 (a) health benefit plan that provides coverage to:
5189 (i) individuals;
5190 (ii) small employers, except as provided in Subsection (3); or
5191 (iii) both Subsections (1)(a)(i) and (ii); or
5192 (b) individual conversion policy for purposes of Sections 31A-30-106.5 and
5193 31A-30-107.5.
5194 (2) This chapter applies to a health benefit plan that provides coverage to small
5195 employers or individuals regardless of:
5196 (a) whether the contract is issued to:
5197 (i) an association, except as provided in Subsection (3);
5198 (ii) a trust;
5199 (iii) a discretionary group; or
5200 (iv) other similar grouping; or
5201 (b) the situs of delivery of the policy or contract.
5202 (3) This chapter does not apply to:
5203 (a) short-term limited duration health insurance;
5204 (b) federally funded or partially funded programs; or

5205 (c) a bona fide employer association.
5206 (4) (a) Except as provided in Subsection (4)(b), for the purposes of this chapter:
5207 (i) carriers that are affiliated companies or that are eligible to file a consolidated tax
5208 return shall be treated as one carrier; and
5209 (ii) any restrictions or limitations imposed by this chapter shall apply as if all health
5210 benefit plans delivered or issued for delivery to covered insureds in this state by the affiliated
5211 carriers were issued by one carrier.
5212 (b) Upon a finding of the commissioner, an affiliated carrier that is a health
5213 maintenance organization having a certificate of authority under this title may be considered to
5214 be a separate carrier for the purposes of this chapter.
5215 (c) Unless otherwise authorized by the commissioner or by Chapter 42, Defined
5216 Contribution Risk Adjuster Act, a covered carrier may not enter into one or more ceding
5217 arrangements with respect to health benefit plans delivered or issued for delivery to covered
5218 insureds in this state if the ceding arrangements would result in less than 50% of the insurance
5219 obligation or risk for the health benefit plans being retained by the ceding carrier.
5220 (d) Section 31A-22-1201 applies if a covered carrier cedes or assumes all of the
5221 insurance obligation or risk with respect to one or more health benefit plans delivered or issued
5222 for delivery to covered insureds in this state.
5223 (5) (a) A Taft Hartley trust created in accordance with Section 302(c)(5) of the Federal
5224 Labor Management Relations Act, or a carrier with the written authorization of such a trust,
5225 may make a written request to the commissioner for a waiver from the application of any of the
5226 provisions of [~~Subsection~~] Subsections 31A-30-106(1) and 31A-30-106.1(1) with respect to a
5227 health benefit plan provided to the trust.
5228 (b) The commissioner may grant a trust or carrier described in Subsection (5)(a) a
5229 waiver if the commissioner finds that application with respect to the trust would:
5230 (i) have a substantial adverse effect on the participants and beneficiaries of the trust;
5231 and
5232 (ii) require significant modifications to one or more collective bargaining arrangements
5233 under which the trust is established or maintained.
5234 (c) A waiver granted under this Subsection (5) may not apply to an individual if the
5235 person participates in a Taft Hartley trust as an associate member of any employee

5236 organization.

5237 (6) Sections 31A-30-106, 31A-30-106.1, 31A-30-106.5, 31A-30-106.7, 31A-30-107,

5238 and 31A-30-108, [and 31A-30-111] apply to:

5239 (a) any insurer engaging in the business of insurance related to the risk of a small

5240 employer for medical, surgical, hospital, or ancillary health care expenses of the small

5241 employer's employees provided as an employee benefit; and

5242 (b) any contract of an insurer, other than a workers' compensation policy, related to the

5243 risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of the

5244 small employer's employees provided as an employee benefit.

5245 (7) The commissioner may make rules requiring that the marketing practices be

5246 consistent with this chapter for:

5247 (a) a small employer carrier;

5248 (b) a small employer carrier's agent;

5249 (c) an insurance producer;

5250 (d) an insurance consultant; and

5251 (e) a navigator.

5252 Section 52. Section **31A-30-106** is amended to read:

5253 **31A-30-106. Individual premiums -- Rating restrictions -- Disclosure.**

5254 (1) Premium rates for health benefit plans for individuals under this chapter are subject

5255 to this section.

5256 (a) The index rate for a rating period for any class of business may not exceed the

5257 index rate for any other class of business by more than 20%.

5258 (b) (i) For a class of business, the premium rates charged during a rating period to

5259 covered insureds with similar case characteristics for the same or similar coverage, or the rates

5260 that could be charged to the individual under the rating system for that class of business, may

5261 not vary from the index rate by more than 30% of the index rate except as provided under

5262 Subsection (1)(b)(ii).

5263 (ii) A carrier that offers individual and small employer health benefit plans may use the

5264 small employer index rates to establish the rate limitations for individual policies, even if some

5265 individual policies are rated below the small employer base rate.

5266 (c) The percentage increase in the premium rate charged to a covered insured for a new

5267 rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of
5268 the following:
5269 (i) the percentage change in the new business premium rate measured from the first day
5270 of the prior rating period to the first day of the new rating period;
5271 (ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods
5272 of less than one year, due to the claim experience, health status, or duration of coverage of the
5273 covered individuals as determined from the rate manual for the class of business of the carrier
5274 offering an individual health benefit plan; and
5275 (iii) any adjustment due to change in coverage or change in the case characteristics of
5276 the covered insured as determined from the rate manual for the class of business of the carrier
5277 offering an individual health benefit plan.
5278 (d) (i) A carrier offering an individual health benefit plan shall apply rating factors,
5279 including case characteristics, consistently with respect to all covered insureds in a class of
5280 business.
5281 (ii) Rating factors shall produce premiums for identical individuals that:
5282 (A) differ only by the amounts attributable to plan design; and
5283 (B) do not reflect differences due to the nature of the individuals assumed to select
5284 particular health benefit products.
5285 (iii) A carrier offering an individual health benefit plan shall treat all health benefit
5286 plans issued or renewed in the same calendar month as having the same rating period.
5287 (e) For the purposes of this Subsection (1), a health benefit plan that uses a restricted
5288 network provision may not be considered similar coverage to a health benefit plan that does not
5289 use a restricted network provision, provided that use of the restricted network provision results
5290 in substantial difference in claims costs.
5291 (f) A carrier offering a health benefit plan to an individual may not, without prior
5292 approval of the commissioner, use case characteristics other than:
5293 (i) age;
5294 (ii) gender;
5295 (iii) geographic area; and
5296 (iv) family composition.
5297 (g) (i) The commissioner shall establish rules in accordance with Title 63G, Chapter 3,

5298 Utah Administrative Rulemaking Act, to:
5299 (A) implement this chapter; [and]
5300 (B) assure that rating practices used by carriers who offer health benefit plans to
5301 individuals are consistent with the purposes of this chapter[.]; and
5302 (C) promote transparency of rating practices of health benefit plans.
5303 (ii) The rules described in Subsection (1)(g)(i) may include rules that:
5304 (A) assure that differences in rates charged for health benefit products by carriers who
5305 offer health benefit plans to individuals are reasonable and reflect objective differences in plan
5306 design, not including differences due to the nature of the individuals assumed to select
5307 particular health benefit products; and
5308 (B) prescribe the manner in which case characteristics may be used by carriers who
5309 offer health benefit plans to individuals[;].
5310 [(C) implement the individual enrollment cap under Section 31A-30-110, including
5311 specifying:]
5312 [(I) the contents for certification;]
5313 [(II) auditing standards;]
5314 [(III) underwriting criteria for uninsurable classification; and]
5315 [(IV) limitations on high risk enrollees under Section 31A-30-111; and]
5316 [(D) establish the individual enrollment cap under Subsection 31A-30-110(1).]
5317 [(h) Before implementing regulations for underwriting criteria for uninsurable
5318 classification, the commissioner shall contract with an independent consulting organization to
5319 develop industry-wide underwriting criteria for uninsurability based on an individual's expected
5320 claims under open enrollment coverage exceeding 325% of that expected for a standard
5321 insurable individual with the same case characteristics.]
5322 [(i)] (h) The commissioner shall revise rules issued for Sections 31A-22-602 and
5323 31A-22-605 regarding individual accident and health policy rates to allow rating in accordance
5324 with this section.
5325 (2) For purposes of Subsection (1)(c)(i), if a health benefit product is a health benefit
5326 product into which the covered carrier is no longer enrolling new covered insureds, the covered
5327 carrier shall use the percentage change in the base premium rate, provided that the change does
5328 not exceed, on a percentage basis, the change in the new business premium rate for the most

5329 similar health benefit product into which the covered carrier is actively enrolling new covered
5330 insureds.
5331 (3) (a) A covered carrier may not transfer a covered insured involuntarily into or out of
5332 a class of business.
5333 (b) A covered carrier may not offer to transfer a covered insured into or out of a class
5334 of business unless the offer is made to transfer all covered insureds in the class of business
5335 without regard to:
5336 (i) case characteristics;
5337 (ii) claim experience;
5338 (iii) health status; or
5339 (iv) duration of coverage since issue.
5340 (4) (a) A carrier who offers a health benefit plan to an individual shall maintain at the
5341 carrier's principal place of business a complete and detailed description of its rating practices
5342 and renewal underwriting practices, including information and documentation that demonstrate
5343 that the carrier's rating methods and practices are:
5344 (i) based upon commonly accepted actuarial assumptions; and
5345 (ii) in accordance with sound actuarial principles.
5346 (b) (i) [Each] A carrier subject to this section shall file with the commissioner, on or
5347 before April 1 of each year, in a form, manner, and containing such information as prescribed
5348 by the commissioner, an actuarial certification certifying that:
5349 (A) the carrier is in compliance with this chapter; and
5350 (B) the rating methods of the carrier are actuarially sound.
5351 (ii) A copy of the certification required by Subsection (4)(b)(i) shall be retained by the
5352 carrier at the carrier's principal place of business.
5353 (c) A carrier shall make the information and documentation described in this
5354 Subsection (4) available to the commissioner upon request.
5355 (d) [Records] Except as provided in Subsection (1)(g) or required by PPACA, a record
5356 submitted to the commissioner under this section shall be maintained by the commissioner as a
5357 protected [records] record under Title 63G, Chapter 2, Government Records Access and
5358 Management Act.
5359 Section 53. Section **31A-30-106.7** is amended to read:

5360 **31A-30-106.7. Surcharge for groups changing carriers.**

5361 (1) (a) Except as provided in Subsection (1)(b), if prior notice is given, a covered
5362 carrier may impose upon a small group that changes coverage to that carrier from another
5363 carrier a one-time surcharge of up to 25% of the annualized premium that the carrier could
5364 otherwise charge under Section [~~31A-30-106~~] 31A-30-106.1.

5365 (b) A covered carrier may not impose the surcharge described in Subsection (1)(a) if:

5366 (i) the change in carriers occurs on the anniversary of the plan year, as defined in
5367 Section 31A-1-301;

5368 (ii) the previous coverage was terminated under Subsection 31A-30-107(3)(e); [~~or~~]

5369 (iii) employees from an existing group form a new business[~~.~~]; and

5370 (iv) the surcharge is not applied uniformly to all similarly situated small groups.

5371 (2) A covered carrier may not impose the surcharge described in Subsection (1) if the
5372 offer to cover the group occurs at a time other than the anniversary of the plan year because:

5373 (a) (i) the application for coverage is made prior to the anniversary date in accordance
5374 with the covered carrier's published policies; and

5375 (ii) the offer to cover the group is not issued until after the anniversary date; or

5376 (b) (i) the application for coverage is made prior to the anniversary date in accordance
5377 with the covered carrier's published policies; and

5378 (ii) additional underwriting or rating information requested by the covered carrier is not
5379 received until after the anniversary date.

5380 (3) If a covered carrier chooses to apply a surcharge under Subsection (1), the
5381 application of the surcharge and the criteria for incurring or avoiding the surcharge shall be
5382 clearly stated in the:

5383 (a) written application materials provided to the applicant at the time of application;
5384 and

5385 (b) written producer guidelines.

5386 (4) The commissioner shall adopt rules in accordance with Title 63G, Chapter 3, Utah
5387 Administrative Rulemaking Act, to ensure compliance with this section.

5388 Section 54. Section **31A-30-107** is amended to read:

5389 **31A-30-107. Renewal -- Limitations -- Exclusions -- Discontinuance and**
5390 **nonrenewal.**

5391 (1) Except as otherwise provided in this section, a small employer health benefit plan is
5392 renewable and continues in force:
5393 (a) with respect to all eligible employees and dependents; and
5394 (b) at the option of the plan sponsor.
5395 (2) A small employer health benefit plan may be discontinued or nonrenewed:
5396 (a) for a network plan, if[: (i)] there is no longer any enrollee under the group health
5397 plan who lives, resides, or works in:
5398 [(A)] (i) the service area of the covered carrier; or
5399 [(B)] (ii) the area for which the covered carrier is authorized to do business; [and] or
5400 [(ii) in the case of the small employer market, the small employer carrier applies the
5401 same criteria the small employer carrier would apply in denying enrollment in the plan under
5402 Subsection 31A-30-108(7); or]
5403 (b) for coverage made available in the small or large employer market only through an
5404 association, if:
5405 (i) the employer's membership in the association ceases; and
5406 (ii) the coverage is terminated uniformly without regard to any health status-related
5407 factor relating to any covered individual.
5408 (3) A small employer health benefit plan may be discontinued if:
5409 (a) a condition described in Subsection (2) exists;
5410 (b) except as prohibited by Section 31A-30-206, the plan sponsor fails to pay
5411 premiums or contributions in accordance with the terms of the contract;
5412 (c) the plan sponsor:
5413 (i) performs an act or practice that constitutes fraud; or
5414 (ii) makes an intentional misrepresentation of material fact under the terms of the
5415 coverage;
5416 (d) the covered carrier:
5417 (i) elects to discontinue offering a particular small employer health benefit product
5418 delivered or issued for delivery in this state; and
5419 (ii) (A) provides notice of the discontinuation in writing:
5420 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
5421 (II) at least 90 days before the date the coverage will be discontinued;

5422 (B) provides notice of the discontinuation in writing:
5423 (I) to the commissioner; and
5424 (II) at least three working days prior to the date the notice is sent to the affected plan
5425 sponsors, employees, and dependents of the plan sponsors or employees;
5426 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all
5427 other small employer health benefit products currently being offered by the small employer
5428 carrier in the market; and
5429 (D) in exercising the option to discontinue that product and in offering the option of
5430 coverage in this section, acts uniformly without regard to:
5431 (I) the claims experience of a plan sponsor;
5432 (II) any health status-related factor relating to any covered participant or beneficiary; or
5433 (III) any health status-related factor relating to any new participant or beneficiary who
5434 may become eligible for the coverage; or
5435 (e) the covered carrier:
5436 (i) elects to discontinue all of the covered carrier's small employer health benefit plans
5437 in:
5438 (A) the small employer market;
5439 (B) the large employer market; or
5440 (C) both the small employer and large employer markets; and
5441 (ii) (A) provides notice of the discontinuation in writing:
5442 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
5443 (II) at least 180 days before the date the coverage will be discontinued;
5444 (B) provides notice of the discontinuation in writing:
5445 (I) to the commissioner in each state in which an affected insured individual is known
5446 to reside; and
5447 (II) at least 30 working days prior to the date the notice is sent to the affected plan
5448 sponsors, employees, and the dependents of the plan sponsors or employees;
5449 (C) discontinues and nonrenews all plans issued or delivered for issuance in the
5450 market; and
5451 (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.
5452 (4) A small employer health benefit plan may be discontinued or nonrenewed:

5453 (a) if a condition described in Subsection (2) exists; or
5454 (b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's
5455 employer contribution requirements.
5456 (5) A small employer health benefit plan may be nonrenewed:
5457 (a) if a condition described in Subsection (2) exists; or
5458 (b) except as prohibited by Section 31A-30-206, for noncompliance with the insurer's
5459 minimum participation requirements.
5460 (6) (a) Except as provided in Subsection (6)(d), an eligible employee may be
5461 discontinued if after issuance of coverage the eligible employee:
5462 (i) engages in an act or practice that constitutes fraud in connection with the coverage;
5463 or
5464 (ii) makes an intentional misrepresentation of material fact in connection with the
5465 coverage.
5466 (b) An eligible employee that is discontinued under Subsection (6)(a) may reenroll:
5467 (i) 12 months after the date of discontinuance; and
5468 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
5469 to reenroll.
5470 (c) At the time the eligible employee's coverage is discontinued under Subsection
5471 (6)(a), the covered carrier shall notify the eligible employee of the right to reenroll when
5472 coverage is discontinued.
5473 (d) An eligible employee may not be discontinued under this Subsection (6) because of
5474 a fraud or misrepresentation that relates to health status.
5475 (7) For purposes of this section, a reference to "plan sponsor" includes a reference to
5476 the employer:
5477 (a) with respect to coverage provided to an employer member of the association; and
5478 (b) if the small employer health benefit plan is made available by a covered carrier in
5479 the employer market only through:
5480 (i) an association;
5481 (ii) a trust; or
5482 (iii) a discretionary group.
5483 (8) A covered carrier may modify a small employer health benefit plan only:

5484 (a) at the time of coverage renewal; and
5485 (b) if the modification is effective uniformly among all plans with that product.
5486 Section 55. Section **31A-30-107.5** is amended to read:
5487 **31A-30-107.5. Preexisting condition exclusion -- Condition-specific exclusion**
5488 **riders -- Limitation periods.**
5489 (1) [~~A~~] For policies issued or renewed before January 1, 2014, a health benefit plan
5490 may impose a preexisting condition exclusion only if the provision complies with Subsection
5491 31A-22-605.1(4).
5492 (2) For policies issued or renewed before January 1, 2014:
5493 [~~(2)~~] (a) In accordance with Subsection (2)(b), an individual carrier:
5494 (i) may, when the individual carrier and the insured mutually agree in writing to a
5495 condition-specific exclusion rider, offer to issue an individual policy that excludes all treatment
5496 and prescription drugs related to:
5497 (A) a specific physical condition;
5498 (B) a specific disease or disorder; and
5499 (C) [~~any~~] a specific prescription drug or class of prescription drugs; and
5500 (ii) may offer an individual policy that may establish separate cost sharing
5501 requirements including, deductibles and maximum limits that are specific to covered services
5502 and supplies, including drugs, when utilized for the treatment and care of the conditions,
5503 diseases, or disorders listed in Subsection (2)(b).
5504 (b) (i) Except as provided in Section 31A-22-630 and Subsection (2)(b)(ii), the
5505 following may be the subject of a condition-specific exclusion rider:
5506 (A) conditions, diseases, and disorders of the bones or joints of the ankle, arm, elbow,
5507 fingers, foot, hand, hip, knee, leg, mandible, mastoid, wrist, shoulder, spine, and toes, including
5508 bone spurs, bunions, carpal tunnel syndrome, club foot, cubital tunnel syndrome, hammertoe,
5509 syndactylism, and treatment and prosthetic devices related to amputation;
5510 (B) anal fistula, anal fissure, anal stricture, breast implants, breast reduction, chronic
5511 cystitis, chronic prostatitis, cystocele, rectocele, enuresis, hemorrhoids, hydrocele, hypospadius,
5512 interstitial cystitis, kidney stones, uterine leiomyoma, varicocele, spermatocele, endometriosis;
5513 (C) allergic rhinitis, nonallergic rhinitis, hay fever, dust allergies, pollen allergies,
5514 deviated nasal septum, and sinus related conditions, diseases, and disorders;

5515 (D) hemangioma, keloids, scar revisions, and other skin related conditions, diseases,
5516 and disorders;
5517 (E) goiter and other thyroid related conditions, diseases, or disorders;
5518 (F) cataracts, cornea transplant, detached retina, glaucoma, keratoconus, macular
5519 degeneration, strabismus and other eye related conditions, diseases, and disorders;
5520 (G) otitis media, cholesteatoma, otosclerosis, and other internal/external ear conditions,
5521 diseases, and disorders;
5522 (H) Baker's cyst, ganglion cyst;
5523 (I) abdominoplasty, esophageal reflux, hernia, Meniere's disease, migraines, TIC
5524 Doulourex, varicose veins, vestibular disorders;
5525 (J) sleep disorders and speech disorders; and
5526 (K) [~~any~~] a specific prescription drug or class of prescription drugs.
5527 (ii) Subsection (2)(b)(i) does not apply:
5528 (A) for the treatment of asthma; or
5529 (B) when the condition is due to cancer.
5530 (iii) A condition-specific exclusion rider:
5531 (A) shall be limited to the excluded condition, disease, or disorder and any
5532 complications from that condition, disease, or disorder;
5533 (B) may not extend to any secondary medical condition; and
5534 (C) shall include the following informed consent paragraph: "I agree by signing below,
5535 to the terms of this rider, which excludes coverage for all treatment, including medications,
5536 related to the specific condition(s), disease(s), and/or disorder(s) stated herein and that if
5537 treatment or medications are received that I have the responsibility for payment for those
5538 services and items. I further understand that this rider does not extend to any secondary
5539 medical condition, disease, or disorder."
5540 (c) If an individual carrier issues a condition-specific exclusion rider, the
5541 condition-specific exclusion rider shall remain in effect for the duration of the policy at the
5542 individual carrier's option.
5543 (d) An individual policy issued in accordance with this Subsection (2) is not subject to
5544 Subsection 31A-26-301.6(7).
5545 (3) Notwithstanding the other provisions of this section, a health benefit plan may

5546 impose a limitation period if:
5547 (a) each policy that imposes a limitation period under the health benefit plan specifies
5548 the physical condition, disease, or disorder that is excluded from coverage during the limitation
5549 period;
5550 (b) the limitation period does not exceed 12 months;
5551 (c) the limitation period is applied uniformly; and
5552 (d) the limitation period is reduced in compliance with Subsections
5553 31A-22-605.1(4)(a) and (4)(b).
5554 Section 56. Section **31A-30-108** is amended to read:
5555 **31A-30-108. Eligibility for small employer and individual market.**
5556 (1) (a) [~~Small employer carriers shall accept residents~~] A small employer carrier shall
5557 accept a small employer that applies for small group coverage as set forth in the Health
5558 Insurance Portability and Accountability Act, Sec. 2701(f) and 2711(a), and PPACA, Sec.
5559 2702.
5560 [~~(b) Individual carriers shall accept residents for individual coverage pursuant to:~~]
5561 [~~(i) Health Insurance Portability and Accountability Act, Sec. 2741(a)-(b); and~~]
5562 [~~(ii) Subsection (3).~~]
5563 (b) An individual carrier shall accept an individual that applies for individual coverage
5564 as set forth in PPACA, Section 2702.
5565 (2) (a) [~~Small~~] A small employer [~~carriers~~] carrier shall offer to accept all eligible
5566 employees and their dependents at the same level of benefits under any health benefit plan
5567 provided to a small employer.
5568 (b) [~~Small~~] A small employer [~~carriers~~] carrier may:
5569 (i) request a small employer to submit a copy of the small employer's quarterly income
5570 tax withholdings to determine whether the employees for whom coverage is provided or
5571 requested are bona fide employees of the small employer; and
5572 (ii) deny or terminate coverage if the small employer refuses to provide documentation
5573 requested under Subsection (2)(b)(i).
5574 [~~(3) Except as provided in Subsections (5) and (6) and Section 31A-30-110, individual~~
5575 ~~carriers shall accept for coverage individuals to whom all of the following conditions apply:~~]
5576 [~~(a) the individual is not covered or eligible for coverage:~~]

5577 [(i) (A) as an employee of an employer;]
5578 [(B) as a member of an association; or]
5579 [(C) as a member of any other group; and]
5580 [(ii) under:]
5581 [(A) a health benefit plan; or]
5582 [(B) a self-insured arrangement that provides coverage similar to that provided by a
5583 health benefit plan as defined in Section 31A-1-301;]
5584 [(b) the individual is not covered and is not eligible for coverage under any public
5585 health benefits arrangement including:]
5586 [(i) the Medicare program established under Title XVIII of the Social Security Act;]
5587 [(ii) any act of Congress or law of this or any other state that provides benefits
5588 comparable to the benefits provided under this chapter; or]
5589 [(iii) coverage under the Comprehensive Health Insurance Pool Act created in Chapter
5590 29, Comprehensive Health Insurance Pool Act;]
5591 [(c) unless the maximum benefit has been reached the individual is not covered or
5592 eligible for coverage under any:]
5593 [(i) Medicare supplement policy;]
5594 [(ii) conversion option;]
5595 [(iii) continuation or extension under COBRA; or]
5596 [(iv) state extension;]
5597 [(d) the individual has not terminated or declined coverage described in Subsection
5598 (3)(a), (b), or (c) within 93 days of application for coverage, unless the individual is eligible for
5599 individual coverage under Health Insurance Portability and Accountability Act, Sec. 2741(b),
5600 in which case, the requirement of this Subsection (3)(d) does not apply; and]
5601 [(e) the individual is certified as ineligible for the Health Insurance Pool if:]
5602 [(i) the individual applies for coverage with the Comprehensive Health Insurance Pool
5603 within 30 days after being rejected or refused coverage by the covered carrier and reapplies for
5604 coverage with that covered carrier within 30 days after the date of issuance of a certificate
5605 under Subsection 31A-29-111(5)(c); or]
5606 [(ii) the individual applies for coverage with any individual carrier within 45 days
5607 after:]

5608 [(A) notice of cancellation of coverage under Subsection 31A-29-115(1); or]
5609 [(B) the date of issuance of a certificate under Subsection 31A-29-111(5)(c) if the
5610 individual applied first for coverage with the Comprehensive Health Insurance Pool.]
5611 [(4) (a) If coverage is obtained under Subsection (3)(e)(i) and the required premium is
5612 paid, the effective date of coverage shall be the first day of the month following the individual's
5613 submission of a completed insurance application to that covered carrier.]
5614 [(b) If coverage is obtained under Subsection (3)(e)(ii) and the required premium is
5615 paid, the effective date of coverage shall be the day following the:]
5616 [(i) cancellation of coverage under Subsection 31A-29-115(1); or]
5617 [(ii) submission of a completed insurance application to the Comprehensive Health
5618 Insurance Pool.]
5619 [(5) (a) An individual carrier is not required to accept individuals for coverage under
5620 Subsection (3) if the carrier issues no new individual policies in the state after July 1, 1997.]
5621 [(b) A carrier described in Subsection (5)(a) may not issue new individual policies in
5622 the state for five years from July 1, 1997.]
5623 [(c) Notwithstanding Subsection (5)(b), a carrier may request permission to issue new
5624 policies after July 1, 1999, which may only be granted if:]
5625 [(i) the carrier accepts uninsurables as is required of a carrier entering the market under
5626 Subsection 31A-30-110; and]
5627 [(ii) the commissioner finds that the carrier's issuance of new individual policies:]
5628 [(A) is in the best interests of the state; and]
5629 [(B) does not provide an unfair advantage to the carrier.]
5630 [(6) (a) If the Comprehensive Health Insurance Pool, as set forth under Chapter 29,
5631 Comprehensive Health Insurance Pool Act, is dissolved or discontinued, or if enrollment is
5632 capped or suspended, an individual carrier may decline to accept individuals applying for
5633 individual enrollment, other than individuals applying for coverage as set forth in Health
5634 Insurance Portability and Accountability Act, Sec. 2741 (a)-(b).]
5635 [(b) Within two calendar days of taking action under Subsection (6)(a), an individual
5636 carrier will provide written notice to the department.]
5637 [(7) (a) If a small employer carrier offers health benefit plans to small employers
5638 through a network plan, the small employer carrier may:]

5639 [~~(i) limit the employers that may apply for the coverage to those employers with~~
5640 ~~eligible employees who live, reside, or work in the service area for the network plan; and~~]
5641 [~~(ii) within the service area of the network plan, deny coverage to an employer if the~~
5642 ~~small employer carrier has demonstrated to the commissioner that the small employer carrier:~~]
5643 [~~(A) will not have the capacity to deliver services adequately to enrollees of any~~
5644 ~~additional groups because of the small employer carrier's obligations to existing group contract~~
5645 ~~holders and enrollees; and~~]
5646 [~~(B) applies this section uniformly to all employers without regard to:~~]
5647 [~~(I) the claims experience of an employer, an employer's employee, or a dependent of~~
5648 ~~an employee; or~~]
5649 [~~(II) any health status-related factor relating to an employee or dependent of an~~
5650 ~~employee.~~]
5651 [~~(b) (i) A small employer carrier that denies a health benefit product to an employer in~~
5652 ~~any service area in accordance with this section may not offer coverage in the small employer~~
5653 ~~market within the service area to any employer for a period of 180 days after the date the~~
5654 ~~coverage is denied.~~]
5655 [~~(ii) This Subsection (7)(b) does not:~~]
5656 [~~(A) limit the small employer carrier's ability to renew coverage that is in force; or~~]
5657 [~~(B) relieve the small employer carrier of the responsibility to renew coverage that is in~~
5658 ~~force.~~]
5659 [~~(c) Coverage offered within a service area after the 180-day period specified in~~
5660 ~~Subsection (7)(b) is subject to the requirements of this section.~~]
5661 Section 57. Section **31A-30-207** is amended to read:
5662 **31A-30-207. Rating and underwriting restrictions for health plans in the defined**
5663 **contribution arrangement market.**
5664 (1) Except as provided in Subsection (2), rating and underwriting restrictions for
5665 defined contribution arrangement health benefit plans offered in the Health Insurance
5666 Exchange shall be in accordance with Section 31A-30-106.1, and the plan adopted under
5667 Chapter 42, Defined Contribution Risk Adjuster Act.
5668 (2) Notwithstanding [~~the provisions of~~] Subsections 31A-30-106.1(9)(b)(ii) and (iii), a
5669 carrier offering a defined contribution arrangement in the Health Insurance Exchange under

5670 this part[: (a)] shall calculate rates based on a family tier rating structure that includes four tiers
5671 in compliance with Subsection 31A-30-106.1(9)(b)(i)[; and].
5672 [(b) may not calculate rates based on a family tier rating structure that includes five or
5673 six tiers as described in Subsection 31A-30-106(9)(b)(ii) or (iii).]
5674 (3) All insurers who participate in the defined contribution market shall:
5675 (a) participate in the risk adjuster mechanism developed under Chapter 42, Defined
5676 Contribution Risk Adjuster Act for all defined contribution arrangement health benefit plans;
5677 (b) provide the risk adjuster board with:
5678 (i) an employer group's risk factor; and
5679 (ii) carrier enrollment data; and
5680 (c) submit rates to the exchange that are net of commissions.
5681 (4) When an employer group enters the defined contribution arrangement market and
5682 the employer group has a health plan with an insurer who is participating in the defined
5683 contribution arrangement market, the risk factor applied to the employer group when it enters
5684 the defined contribution arrangement market may not be greater than the employer group's
5685 renewal risk factor for the same group of covered employees and the same effective date, as
5686 determined by the employer group's insurer.
5687 Section 58. Section **31A-30-209** is amended to read:
5688 **31A-30-209. Appointment of insurance producers to Health Insurance Exchange.**
5689 (1) A producer may be listed on the Health Insurance Exchange as a credentialed
5690 producer [for the defined contribution arrangement market in accordance with Section
5691 63M-1-2504], if the producer is designated as [an appointed] a credentialed agent for the
5692 [defined contribution arrangement market] Health Insurance Exchange in accordance with
5693 Subsection (2).
5694 (2) A producer whose license under this title authorizes the producer to sell [defined
5695 contribution arrangement health benefit plans may be appointed to the defined contribution
5696 arrangement market on] accident and health insurance may be credentialed by the Health
5697 Insurance Exchange [by the Insurance Department] and may sell any product on the Health
5698 Insurance Exchange, if the producer:
5699 [(a) submits an application to the Insurance Department to be appointed as a producer
5700 for the defined contribution arrangement market on the Health Insurance Exchange;]

5701 [(b) is an appointed agent in accordance with Subsection (3), for products offered in
5702 the defined contribution arrangement market of the Health Insurance Exchange, with the
5703 carriers that offer a defined contribution arrangement health benefit plan on the Health
5704 Insurance Exchange; and]
5705 [(c) has completed continuing education for the defined contribution arrangement
5706 market that:]
5707 [(i) is required by administrative rule adopted by the commissioner; and]
5708 [(ii) provides training on premium assistance programs.]
5709 (a) is an appointed producer with all carriers that offer a plan on the Health Insurance
5710 Exchange; and
5711 (b) completes each year the Health Insurance Exchange training that includes training
5712 on premium assistance programs.
5713 (3) A carrier shall appoint a producer to sell the carrier's products [in the defined
5714 contribution arrangement market of] on the Health Insurance Exchange, within 30 days of the
5715 notice required in Subsection (3)(b), if:
5716 (a) the producer is currently appointed by a majority of the carriers in the Health
5717 Insurance Exchange to sell products either outside or inside of the Health Insurance Exchange;
5718 and
5719 (b) the producer informs the carrier that the producer is:
5720 (i) applying to be appointed to [the defined contribution arrangement market in] sell
5721 the carrier's products on the Health Insurance Exchange;
5722 (ii) appointed by a majority of the carriers [in the defined contribution arrangement
5723 market in] on the Health Insurance Exchange;
5724 (iii) willing to complete training regarding the carrier's products offered on [the defined
5725 contribution arrangement market in] the Health Insurance Exchange; and
5726 (iv) willing to sign the contracts and business associate's agreements that the carrier
5727 requires for appointed producers in the Health Insurance Exchange.
5728 Section 59. Section **31A-30-211** is amended to read:
5729 **31A-30-211. Insurer disclosure.**
5730 [(1) The Health Insurance Exchange shall provide an employer's producer with the
5731 group's risk factor used to calculate the employer group's premium at the time of:]

5732 [(a) the initial offering of a health benefit plan; and]
5733 [(b) the renewal of a health benefit plan.]
5734 [(2) For health benefit plans that renew on or after March 1, 2012:]
5735 (1) (a) [a] A carrier shall provide an employer and the employer's producer with
5736 premium renewal rates at least 60 days [prior to] before the group's renewal date for a plan
5737 offered under Part 1, Individual and Small Employer Group[; and].
5738 (b) [the] The Health Insurance Exchange shall provide an employer and the employer's
5739 producer with premium renewal rates at least 60 days [prior to] before the group's renewal date
5740 for a plan offered under Part 2, Defined Contribution Arrangements.
5741 [(3)] (2) An insurer does not have to provide additional notice of premium renewal
5742 rates to the employer or the employer's producer if the Health Insurance Exchange provides
5743 notice in accordance with Subsection [(2)] (1)(b).
5744 Section 60. Section **31A-37-501** is amended to read:
5745 **31A-37-501. Reports to commissioner.**
5746 (1) A captive insurance company is not required to make a report except those
5747 provided in this chapter.
5748 (2) (a) Before March 1 of each year, a captive insurance company shall submit to the
5749 commissioner a report of the financial condition of the captive insurance company, verified by
5750 oath of two of the executive officers of the captive insurance company.
5751 (b) Except as provided in Sections 31A-37-204 and 31A-37-205, a captive insurance
5752 company shall report:
5753 (i) using generally accepted accounting principles, except to the extent that the
5754 commissioner requires, approves, or accepts the use of a statutory accounting principle;
5755 (ii) using a useful or necessary modification or adaptation to an accounting principle
5756 that is required, approved, or accepted by the commissioner for the type of insurance and kind
5757 of insurer to be reported upon; and
5758 (iii) supplemental or additional information required by the commissioner.
5759 (c) Except as otherwise provided:
5760 (i) [an association captive insurance company and an industrial insured group] a
5761 licensed captive insurance company shall file the report required by Section 31A-4-113; and
5762 (ii) an industrial insured group shall comply with Section 31A-4-113.5.

5763 (3) (a) A pure captive insurance company may make written application to file the
5764 required report on a fiscal year end that is consistent with the fiscal year of the parent company
5765 of the pure captive insurance company.
5766 (b) If the commissioner grants an alternative reporting date for a pure captive insurance
5767 company requested under Subsection (3)(a), the annual report is due 60 days after the fiscal
5768 year end.
5769 (4) (a) Sixty days after the fiscal year end, a branch captive insurance company shall
5770 file with the commissioner a copy of [~~all~~] the reports and statements required to be filed under
5771 the laws of the jurisdiction in which the alien captive insurance company is formed, verified by
5772 oath by two of the alien captive insurance company's executive officers.
5773 (b) If the commissioner is satisfied that the annual report filed by the alien captive
5774 insurance company in the jurisdiction in which the alien captive insurance company is formed
5775 provides adequate information concerning the financial condition of the alien captive insurance
5776 company, the commissioner may waive the requirement for completion of the annual statement
5777 required for a captive insurance company under this section with respect to business written in
5778 the alien jurisdiction.
5779 (c) A waiver by the commissioner under Subsection (4)(b):
5780 (i) shall be in writing; and
5781 (ii) is subject to public inspection.
5782 Section 61. Section **31A-40-203** is amended to read:
5783 **31A-40-203. Covered employee.**
5784 (1) (a) An individual is a covered employee of a professional employer organization if
5785 the individual is coemployed pursuant to a professional employer agreement subject to this
5786 chapter.
5787 (b) An individual who is a covered employee under a professional employer agreement
5788 is a covered [~~employer~~] employee, whether or not the professional employer organization
5789 provides the notice required by Subsection 31A-40-202(3), the earlier of the day on which:
5790 (i) the employee is first compensated by the professional employer organization; or
5791 (ii) the client notifies the professional employer organization of a new hire.
5792 (2) An individual who is an officer, director, shareholder, partner, or manager of a
5793 client is a covered employee:

5794 (a) to the extent that the client and the professional employer organization expressly
5795 agree in the professional employer agreement that the individual is a covered employee;
5796 (b) if the conditions of Subsection (1) are met; and
5797 (c) if the individual acts as an operational manager or performs day-to-day an
5798 operational service for the client.
5799 Section 62. Section **31A-40-209** is amended to read:
5800 **31A-40-209. Workers' compensation.**
5801 (1) In accordance with Section 34A-2-103, a client is responsible for securing workers'
5802 compensation coverage for a covered employee.
5803 (2) Subject to the requirements of Section 34A-2-103, if a professional employer
5804 organization obtains or assists a client in obtaining workers' compensation insurance pursuant
5805 to a professional employer agreement:
5806 (a) the professional employer organization shall ensure that the client maintains and
5807 provides workers' compensation coverage for a covered employee in accordance with
5808 Subsection 34A-2-201(1) or (2) and rules of the Labor Commission, made in accordance with
5809 Title 63G, Chapter 3, Utah Administrative Rulemaking Act;
5810 (b) the workers' compensation coverage may show the professional employer
5811 organization as the named insured through a [~~multiple coordinated~~] master policy, if:
5812 (i) the client is shown as an insured by means of an endorsement for each individual
5813 client;
5814 (ii) the experience modification of a client is used; and
5815 (iii) the insurer files the endorsement with the Division of Industrial Accidents as
5816 directed by a rule of the Labor Commission, made in accordance with Title 63G, Chapter 3,
5817 Utah Administrative Rulemaking Act;
5818 (c) at the termination of the professional employer agreement, if requested by the
5819 client, the insurer shall provide the client records regarding the loss experience related to
5820 workers' compensation insurance provided to a covered employee pursuant to the professional
5821 employer agreement; and
5822 (d) the insurer shall notify a client if the workers' compensation coverage for the client
5823 is terminated.
5824 (3) In accordance with Section 34A-2-105, the exclusive remedy provisions of Section

5825 34A-2-105 apply to both the client and the professional employer organization under a
5826 professional employer agreement regulated under this chapter.
5827 (4) Notwithstanding the other provisions in this section, an insurer may choose whether
5828 to issue:
5829 (a) a policy for a client; or
5830 (b) a [~~multiple coordinated~~] master policy with the client shown as an additional
5831 insured by means of an individual endorsement.
5832 Section 63. Section **31A-42-202** is amended to read:
5833 **31A-42-202. Contents of plan.**
5834 (1) The board shall submit a plan of operation for the risk adjuster to the
5835 commissioner. The plan shall:
5836 (a) establish the methodology for implementing:
5837 (i) Subsection (2) for the defined contribution arrangement market established under
5838 Chapter 30, Part 2, Defined Contribution Arrangements; and
5839 (ii) the participation of small employer group defined contribution arrangement health
5840 benefit plans;
5841 (b) establish regular times and places for meetings of the board;
5842 (c) establish procedures for keeping records of all financial transactions and for
5843 sending annual fiscal reports to the commissioner;
5844 (d) contain additional provisions necessary and proper for the execution of the powers
5845 and duties of the risk adjuster; and
5846 (e) establish procedures in compliance with Title 63A, Utah Administrative Services
5847 Code, to pay for administrative expenses incurred.
5848 (2) (a) The plan adopted by the board for the defined contribution arrangement market
5849 shall include:
5850 (i) parameters an employer may use to designate eligible employees for the defined
5851 contribution arrangement market; and
5852 (ii) underwriting mechanisms and employer eligibility guidelines:
5853 (A) consistent with the federal Health Insurance Portability and Accountability Act;
5854 and
5855 (B) necessary to protect insurance carriers from adverse selection in the defined

5856 contribution market.
5857 (b) The plan required by Subsection (2)(a) shall outline how premium rates for a
5858 qualified individual in the defined contribution arrangement market are determined, including:
5859 (i) the identification of an initial rate for a qualified individual based on:
5860 (A) standardized age bands submitted by participating insurers; and
5861 (B) wellness incentives for the individual as permitted by federal law; and
5862 (ii) the identification of a group risk factor to be applied to the initial age rate of a
5863 qualified individual based on the health conditions of all qualified individuals in the same
5864 employer group and, for small employers, in accordance with Sections 31A-30-105 and
5865 31A-30-106.1.
5866 (c) The plan adopted under Subsection (2)(a) for the defined contribution arrangement
5867 market shall outline how:
5868 (i) premium contributions for qualified individuals shall be submitted to the Health
5869 Insurance Exchange in the amount determined under Subsection (2)(b); and
5870 (ii) the Health Insurance Exchange shall distribute premiums to the insurers selected by
5871 qualified individuals within an employer group based on each individual's rating factor
5872 determined in accordance with the plan.
5873 (d) The plan adopted under Subsection (2)(a) shall outline a mechanism for adjusting
5874 risk between defined contribution arrangement market insurers that:
5875 (i) identifies health care conditions subject to risk adjustment;
5876 (ii) establishes an adjustment amount for each identified health care condition;
5877 (iii) determines the extent to which an insurer has more or less individuals with an
5878 identified health condition than would be expected; and
5879 (iv) computes all risk adjustments.
5880 (e) The board may amend the plan if necessary to:
5881 (i) maintain the proper functioning and solvency of the defined contribution
5882 arrangement market and the risk adjuster mechanism;
5883 (ii) mitigate significant issues of risk selection; or
5884 (iii) improve the administration of the risk adjuster mechanism.
5885 (3) The board shall establish a mechanism in which the defined contribution
5886 arrangement market participating carriers shall submit their plan base rates, rating factors, and

5887 premiums to the commissioner for an actuarial review under [~~the provisions of~~] Section
5888 31A-30-115 [~~prior to~~] before the publication of the premium rates on the Health Insurance
5889 Exchange.
5890 Section 64. Section **31A-43-102** is amended to read:
5891 **31A-43-102. Definitions.**
5892 For purposes of this chapter:
5893 (1) "Actuarial certification" means a written statement by a member of the American
5894 Academy of Actuaries, or by another individual acceptable to the commissioner, that an insurer
5895 is in compliance with [~~the provisions of~~] this chapter, based upon the individual's examination
5896 and including a review of the appropriate records and the actuarial assumptions and methods
5897 used by the stop-loss insurer in establishing attachment points and other applicable
5898 determinations in conjunction with the provision of stop-loss insurance coverage.
5899 (2) "Aggregate attachment point" means the dollar amount [~~in losses for eligible~~
5900 ~~expenses~~] of covered claims incurred by a small employer plan beyond which the stop-loss
5901 insurer incurs liability for [~~all or part of the~~] losses incurred by the small employer plan, subject
5902 to limitations included in the contract.
5903 (3) "Coverage" means the combination of the employer plan design and the stop-loss
5904 contract design.
5905 (4) "Expected claims" means the amount of claims that, in the absence of [~~a~~] aggregate
5906 stop-loss [~~contract~~] insurance, are projected to be incurred by a small employer health plan
5907 using reasonable and accepted actuarial principles.
5908 (5) "Lasering":
5909 (a) means increasing or removing stop-loss coverage for a specific individual within an
5910 employer group; and
5911 (b) includes other practices that are prohibited by the commissioner by administrative
5912 rule that result in lowering the stop-loss premium for the employer by transferring the risk for
5913 an [~~individual~~] individual's claims back to the employer.
5914 (6) "Small employer" means an employer who, with respect to a calendar year and to a
5915 plan year:
5916 (a) employed an average of at least two employees but not more than 50 eligible
5917 employees on each business day during the preceding calendar year; and

5918 (b) employs at least two employees on the first day of the plan year.
5919 (7) "Specific attachment point" means the dollar amount [~~in losses for eligible~~
5920 ~~expenses~~] of covered claims attributable to a single individual covered by a small employer
5921 plan in a contract year beyond which the stop-loss insurer assumes [~~all or part of~~] the liability
5922 for losses incurred by the small employer plan, subject to limitations included in the contract.
5923 (8) "Stop-loss insurance" means insurance purchased by a small employer for which
5924 the stop-loss insurer assumes[~~, on a per-loss basis,~~] all loss amounts of the small employer's
5925 plan in excess of a stated amount, subject to the policy limit.
5926 Section 65. Section **31A-43-301** is amended to read:
5927 **31A-43-301. Stop-loss insurance coverage standards.**
5928 (1) A small employer stop-loss insurance contract shall:
5929 (a) be issued to the small employer to provide insurance to the group health benefit
5930 plan, not the employees of the small employer;
5931 (b) use a standard application form developed by the commissioner by administrative
5932 rule;
5933 (c) have a contract term with guaranteed rates for at least 12 months, without
5934 adjustment, unless there is a change in the benefits provided under the small employer's health
5935 plan during the contract period;
5936 (d) include both a specific attachment point and an aggregate attachment point in a
5937 contract;
5938 (e) align stop-loss plan benefit limitations and exclusions with a small employer's
5939 health plan benefit limitations and exclusions, including any annual or lifetime limits in the
5940 employer's health plan;
5941 (f) have an annual specific attachment point that is at least $10,000;
5942 (g) have an annual aggregate attachment point that may not be less than 90% of
5943 expected claims;
5944 (h) pay stop-loss claims:
5945 (i) incurred during the contract period; and
5946 (ii) [~~submitted~~] paid within 12 months after the expiration date of the contract; and
5947 (i) include provisions to cover incurred and unpaid claims if a small employer plan
5948 terminates.

5949 (2) A small employer stop-loss contract shall not:
5950 (a) include lasering; and
5951 (b) pay claims directly to an individual employee, member, or participant.
5952 Section 66. Section **31A-43-302** is amended to read:
5953 **31A-43-302. Stop-loss restrictions -- Filing requirements.**
5954 [~~(1) A stop-loss insurer shall demonstrate to the commissioner that the rates associated~~
5955 ~~with specific and aggregate attachment points retained by a small employer group under the~~
5956 ~~insurer's stop-loss plan are actuarially sound.~~]
5957 [~~(2)~~] (1) A stop-loss insurer shall file the stop-loss insurance contract form and [~~rates~~]
5958 rate methodology with the commissioner pursuant to Sections 31A-2-201 and 31A-2-201.1
5959 before the stop-loss insurance contract may be issued or delivered in the state.
5960 [~~(3)~~] (2) A stop-loss insurer shall file with the commissioner, annually on or before
5961 April 1, in a form and manner required by the commissioner by administrative rule adopted by
5962 the commissioner:
5963 (a) an actuarial memorandum and certification which demonstrates that the insurer is in
5964 compliance with this chapter; and
5965 (b) the stop-loss insurer's stop-loss experience.
5966 [~~(4) Each~~] (3) An insurer shall maintain at its principal place of business:
5967 (a) a complete and detailed description of its rating practices and renewal underwriting
5968 practices, including information and documentation that demonstrate the rating methods and
5969 practices are:
5970 (i) based upon commonly accepted actuarial assumptions; and
5971 (ii) in accordance with sound actuarial principles; and
5972 (b) a copy of the [~~actuarial certification~~] annual filing required by Subsection [~~(3)~~] (2).
5973 Section 67. Section **31A-43-303** is amended to read:
5974 **31A-43-303. Stop-loss insurance disclosure.**
5975 A stop-loss insurance contract delivered, issued for delivery, or entered into shall
5976 include the disclosure exhibit required by the commissioner through administrative rule, which
5977 shall include at least the following information:
5978 (1) the complete costs for the stop-loss contract;
5979 (2) the date on which the insurance takes effect and terminates, including renewability

5980 provisions;
5981 (3) the aggregate attachment point and the specific attachment point;
5982 (4) [~~any~~] limitations on coverage;
5983 (5) an explanation of monthly accommodation and disclosure about any monthly
5984 accommodation features included in the stop-loss contract; [~~and~~]
5985 (6) a description of terminal liability funding, including[~~: (a)~~] the cost of processing
5986 claims before and after the termination of the contract; and
5987 [~~(b)~~] (7) maximum claims liability to the employer.
5988 Section 68. Section **31A-43-304** is amended to read:
5989 **31A-43-304. Administrative rules.**
5990 The commissioner may adopt administrative rules in accordance with Title 63G,
5991 Chapter 3, Utah Administrative Rulemaking Act, to:
5992 (1) implement this chapter;
5993 [~~(2) assure that differences in rates charged are reasonable and reflect objective~~
5994 ~~differences in plan design;~~]
5995 [~~(3)~~] (2) define lasering practices that are prohibited by this chapter;
5996 [~~(4)~~] (3) establish the form and manner of the actuarial certification and the annual
5997 report on stop-loss experience required by Section 31A-43-302;
5998 [~~(5)~~] (4) establish the form and manner of the disclosure required by Section
5999 31A-43-303;
6000 [~~(6)~~] (5) assure the rates associated with the specific attachment points and aggregate
6001 attachment points are actuarially sound and are not against the public interest; and
6002 [~~(7)~~] (6) assure that stop-loss contracts include provisions to cover incurred and unpaid
6003 claims if a small employer plan terminates.
6004 Section 69. Section **53-13-103** is amended to read:
6005 **53-13-103. Law enforcement officer.**
6006 (1) (a) "Law enforcement officer" means a sworn and certified peace officer who is an
6007 employee of a law enforcement agency that is part of or administered by the state or any of its
6008 political subdivisions, and whose primary and principal duties consist of the prevention and
6009 detection of crime and the enforcement of criminal statutes or ordinances of this state or any of
6010 its political subdivisions.

6011 (b) "Law enforcement officer" specifically includes the following:
6012 (i) any sheriff or deputy sheriff, chief of police, police officer, or marshal of any
6013 county, city, or town;
6014 (ii) the commissioner of public safety and any member of the Department of Public
6015 Safety certified as a peace officer;
6016 (iii) all persons specified in Sections 23-20-1.5 and 79-4-501;
6017 (iv) any police officer employed by any college or university;
6018 (v) investigators for the Motor Vehicle Enforcement Division;
6019 (vi) investigators for the Department of Insurance, Fraud Division;
6020 [(vi)] (vii) special agents or investigators employed by the attorney general, district
6021 attorneys, and county attorneys;
6022 [(vii)] (viii) employees of the Department of Natural Resources designated as peace
6023 officers by law;
6024 [(viii)] (ix) school district police officers as designated by the board of education for
6025 the school district;
6026 [(ix)] (x) the executive director of the Department of Corrections and any correctional
6027 enforcement or investigative officer designated by the executive director and approved by the
6028 commissioner of public safety and certified by the division;
6029 [(x)] (xi) correctional enforcement, investigative, or adult probation and parole officers
6030 employed by the Department of Corrections serving on or before July 1, 1993;
6031 [(xi)] (xii) members of a law enforcement agency established by a private college or
6032 university provided that the college or university has been certified by the commissioner of
6033 public safety according to rules of the Department of Public Safety;
6034 [(xii)] (xiii) airport police officers of any airport owned or operated by the state or any
6035 of its political subdivisions; and
6036 [(xiii)] (xiv) transit police officers designated under Section 17B-2a-823.
6037 (2) Law enforcement officers may serve criminal process and arrest violators of any
6038 law of this state and have the right to require aid in executing their lawful duties.
6039 (3) (a) A law enforcement officer has statewide full-spectrum peace officer authority,
6040 but the authority extends to other counties, cities, or towns only when the officer is acting
6041 under Title 77, Chapter 9, Uniform Act on Fresh Pursuit, unless the law enforcement officer is

6042 employed by the state.
6043 (b) (i) A local law enforcement agency may limit the jurisdiction in which its law
6044 enforcement officers may exercise their peace officer authority to a certain geographic area.
6045 (ii) Notwithstanding Subsection (3)(b)(i), a law enforcement officer may exercise
6046 authority outside of the limited geographic area, pursuant to Title 77, Chapter 9, Uniform Act
6047 on Fresh Pursuit, if the officer is pursuing an offender for an offense that occurred within the
6048 limited geographic area.
6049 (c) The authority of law enforcement officers employed by the Department of
6050 Corrections is regulated by Title 64, Chapter 13, Department of Corrections - State Prison.
6051 (4) A law enforcement officer shall, prior to exercising peace officer authority:
6052 (a) (i) have satisfactorily completed the requirements of Section 53-6-205; or
6053 (ii) have met the waiver requirements in Section 53-6-206; and
6054 (b) have satisfactorily completed annual certified training of at least 40 hours per year
6055 as directed by the director of the division, with the advice and consent of the council.
6056 Section 70. **Repealer.**
6057 This bill repeals:
6058 Section **31A-30-110, Individual enrollment cap.**
6059 Section **31A-30-111, Limitations on high risk enrollees.**
6060 Section 71. **Effective date -- Retrospective operation.**
6061 (1) This bill takes effect on May 13, 2014, except that the amendments to Section
6062 31A-3-304 (Effective 07/01/15) take effect on July 1, 2015.
6063 (2) The amendments to the following sections have retrospective operation to January
6064 1, 2014:
6065 (a) Section 31A-22-605.1;
6066 (b) Section 31A-22-625; and
6067 (c) Section 31A-30-107.5.

Legislative Review Note
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Office of Legislative Research and General Counsel