1 # INSURANCE AMENDMENTS

2 2020 GENERAL SESSION

3 STATE OF UTAH

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

5 Senate Sponsor: Curtis S. Bramble

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7 **LONG TITLE**

8 **General Description:**

9 This bill amends and enacts provisions under the Insurance Code and related to certain

10 health benefit plans and the Health Reform Task Force.

11 **Highlighted Provisions:**

12 This bill:

13 ▸ defines terms;

14 ▸ amends provisions related to certain contractors and subcontractors and health

15 benefit plans;

16 ▸ amends the scope and applicability of the Insurance Code;

17 ▸ removes the requirement that the Insurance Department employ a chief examiner;

18 ▸ permits a signature of the insurance commissioner to be in a format that affixes an

19 exact copy of the signature;

20 ▸ prohibits more than two members of the Title and Escrow Commission to be

21 employees of an entity operating under an affiliated business arrangement;

22 ▸ amends requirements for doing business in relation to service contract providers and

23 warrantors;

24 ▸ amends provisions regarding required disclosures for a service contract or a vehicle

25 protection product warranty;

26 ▸ permits the insurance commissioner to exempt a health maintenance organization

27 from certain deposit requirements without a hearing;

28 ▸ amends the date before which a health insurer shall submit a written report

29 regarding coverage for opioids;
30 ▸ amends provisions regarding credit allowed a domestic ceding insurer against
31 reserves for reinsurance, including:
32 • establishing eligibility for credit;
33 • requiring the insurance commissioner to create and publish a list of reciprocal
34 jurisdictions;
35 • requiring the insurance commissioner to create and publish a list of qualified
36 assuming insurers;
37 • requiring rulemaking;
38 • establishing conditions for suspension of an assuming insurer's eligibility; and
39 • addressing the reduction or elimination of credit;
40 ▸ amends requirements for the loss and loss adjustment expense factors included in
41 rates filed in relation to workers' compensation;
42 ▸ amends certain filing requirements to reflect current practice;
43 ▸ amends the forms that the insurance commissioner may prohibit;
44 ▸ amends limitations of actions for an accident and health insurance policy;
45 ▸ enacts provisions regarding the Restatement of the Law of Liability Insurance;
46 ▸ outlines requirements for a notice of assignment related to a debt;
47 ▸ amends requirements related to the shared common purposes of association groups;
48 ▸ amends provisions regarding dependent coverage for accident and health insurance;
49 ▸ enacts the Limited Long-Term Care Insurance Act, which:
50 • defines terms;
51 • establishes disclosure and performance standards for limited long-term care
52 insurance;
53 • establishes parameters of a limited long-term care insurance policy offering a
54 nonforfeiture benefit; and
55 • requires the insurance commissioner to make rules;

56 ▸ amends provisions regarding the licensing of administrators;
57 ▸ amends jurisdictional provisions under the Insurance Receivership Act;
58 ▸ amends provisions related to health care claims practices;
59 ▸ enacts provisions related to the designation of a third party to receive notification of
60 lapse or cancellation of a policyholder's policy for nonpayment of premium;
61 ▸ permits a captive insurance company to provide reinsurance by another insurer with
62 prior approval of the commissioner;
63 ▸ amends the issues regarding which the Health Reform Task Force is required to
64 review and make recommendations; and
65 ▸ makes technical and conforming changes.
66 **Money Appropriated in this Bill:**
67 None
68 **Other Special Clauses:**
69 This bill provides a special effective date.
70 **Utah Code Sections Affected:**
71 AMENDS:
72 **17B-2a-818.5**, as last amended by Laws of Utah 2018, Chapter 319
73 **19-1-206**, as last amended by Laws of Utah 2018, Chapter 319
74 **26-40-115**, as last amended by Laws of Utah 2019, Chapter 393
75 **31A-1-103**, as last amended by Laws of Utah 2017, Chapter 27
76 **31A-1-301**, as last amended by Laws of Utah 2019, Chapter 193
77 **31A-2-104**, as last amended by Laws of Utah 2014, Chapters 290 and 300
78 **31A-2-110**, as last amended by Laws of Utah 1986, Chapter 204
79 **31A-2-212**, as last amended by Laws of Utah 2016, Chapter 138
80 **31A-2-218**, as last amended by Laws of Utah 2015, Chapter 283
81 **31A-2-309**, as last amended by Laws of Utah 2016, Chapter 138
82 **31A-2-403**, as last amended by Laws of Utah 2019, Chapter 193

83 **31A-6a-101**, as last amended by Laws of Utah 2018, Chapter 319
84 **31A-6a-103**, as last amended by Laws of Utah 2015, Chapter 244
85 **31A-6a-104**, as last amended by Laws of Utah 2018, Chapter 319
86 **31A-8-211**, as last amended by Laws of Utah 2002, Chapter 308
87 **31A-17-404**, as last amended by Laws of Utah 2017, Chapter 168
88 **31A-17-404.3**, as last amended by Laws of Utah 2016, Chapter 138
89 **31A-17-601**, as last amended by Laws of Utah 2001, Chapter 116
90 **31A-19a-404**, as renumbered and amended by Laws of Utah 1999, Chapter 130
91 **31A-19a-405**, as renumbered and amended by Laws of Utah 1999, Chapter 130
92 **31A-19a-406**, as renumbered and amended by Laws of Utah 1999, Chapter 130
93 **31A-21-201**, as last amended by Laws of Utah 2019, Chapter 193
94 **31A-21-301**, as last amended by Laws of Utah 2010, Chapter 10
95 **31A-21-313**, as last amended by Laws of Utah 2015, Chapter 244
96 **31A-22-412**, as last amended by Laws of Utah 1986, Chapter 204
97 **31A-22-413**, as last amended by Laws of Utah 2013, Chapter 264
98 **31A-22-505**, as last amended by Laws of Utah 2017, Chapter 168
99 **31A-22-610.5**, as last amended by Laws of Utah 2018, Chapter 443
100 **31A-22-615.5**, as enacted by Laws of Utah 2017, Chapter 53
101 **31A-23a-111**, as last amended by Laws of Utah 2019, Chapter 193
102 **31A-23a-205**, as renumbered and amended by Laws of Utah 2003, Chapter 298
103 **31A-23a-415**, as last amended by Laws of Utah 2019, Chapter 193
104 **31A-23b-401**, as last amended by Laws of Utah 2019, Chapter 193
105 **31A-25-208**, as last amended by Laws of Utah 2019, Chapter 193
106 **31A-26-206**, as last amended by Laws of Utah 2014, Chapters 290 and 300
107 **31A-26-213**, as last amended by Laws of Utah 2019, Chapter 193
108 **31A-26-301.6**, as last amended by Laws of Utah 2009, Chapter 11
109 **31A-27a-105**, as enacted by Laws of Utah 2007, Chapter 309

110 **31A-27a-501**, as enacted by Laws of Utah 2007, Chapter 309
111 **31A-30-117**, as last amended by Laws of Utah 2015, Chapter 283
112 **31A-30-118**, as last amended by Laws of Utah 2019, Chapter 193
113 **31A-35-402**, as last amended by Laws of Utah 2016, Chapter 234
114 **31A-37-303**, as last amended by Laws of Utah 2017, Chapter 168
115 **31A-37-701**, as enacted by Laws of Utah 2019, Chapter 193
116 **34A-2-202**, as last amended by Laws of Utah 2009, Chapter 212
117 **36-29-106**, as enacted by Laws of Utah 2019, Chapter 193
118 **63A-5-205.5**, as enacted by Laws of Utah 2018, Chapter 319
119 **63C-9-403**, as last amended by Laws of Utah 2018, Chapter 319
120 **72-6-107.5**, as last amended by Laws of Utah 2018, Chapter 319
121 **79-2-404**, as last amended by Laws of Utah 2018, Chapter 319
122 ENACTS:
123 **31A-22-205**, Utah Code Annotated 1953
124 **31A-22-430**, Utah Code Annotated 1953
125 **31A-22-2001**, Utah Code Annotated 1953
126 **31A-22-2002**, Utah Code Annotated 1953
127 **31A-22-2003**, Utah Code Annotated 1953
128 **31A-22-2004**, Utah Code Annotated 1953
129 **31A-22-2005**, Utah Code Annotated 1953
130 **31A-22-2006**, Utah Code Annotated 1953
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132 *Be it enacted by the Legislature of the state of Utah:*
133 Section 1. Section **17B-2a-818.5** is amended to read:
134 **17B-2a-818.5. Contracting powers of public transit districts -- Health insurance**
135 **coverage.**
136 (1) As used in this section:

137 (a) "Aggregate" means the sum of all contracts, change orders, and modifications
138 related to a single project.
139 (b) "Change order" means the same as that term is defined in Section 63G-6a-103.
140 (c) "Employee" means, as defined in Section 34A-2-104, an "employee," "worker," or
141 "operative" who:
142 (i) works at least 30 hours per calendar week; and
143 (ii) meets employer eligibility waiting requirements for health care insurance, which
144 may not exceed the first day of the calendar month following 60 days after the day on which
145 the individual is hired.
146 (d) "Health benefit plan" means:
147 (i) the same as that term is defined in Section 31A-1-301[.]; or
148 (ii) an employee welfare benefit plan:
149 (A) established under the Employee Retirement Income Security Act of 1974, 29
150 U.S.C. Sec. 1001 et seq.;
151 (B) for an employer with 100 or more employees; and
152 (C) in which the employer establishes a self-funded or partially self-funded group
153 health plan to provide medical care for the employer's employees and dependents of the
154 employees.
155 (e) "Qualified health [~~insurance~~] coverage" means the same as that term is defined in
156 Section 26-40-115.
157 (f) "Subcontractor" means the same as that term is defined in Section 63A-5-208.
158 (g) "Third party administrator" or "administrator" means the same as that term is
159 defined in Section 31A-1-301.
160 (2) Except as provided in Subsection (3), the requirements of this section apply to:
161 (a) a contractor of a design or construction contract entered into by the public transit
162 district on or after July 1, 2009, if the prime contract is in an aggregate amount equal to or
163 greater than $2,000,000; and

164 (b) a subcontractor of a contractor of a design or construction contract entered into by
165 the public transit district on or after July 1, 2009, if the subcontract is in an aggregate amount
166 equal to or greater than $1,000,000.
167 (3) The requirements of this section do not apply to a contractor or subcontractor
168 described in Subsection (2) if:
169 (a) the application of this section jeopardizes the receipt of federal funds;
170 (b) the contract is a sole source contract; or
171 (c) the contract is an emergency procurement.
172 (4) A person that intentionally uses change orders, contract modifications, or multiple
173 contracts to circumvent the requirements of this section is guilty of an infraction.
174 (5) (a) A contractor subject to the requirements of this section shall demonstrate to the
175 public transit district that the contractor has and will maintain an offer of qualified health
176 [~~insurance~~] coverage for the contractor's employees and the employee's dependents during the
177 duration of the contract by submitting to the public transit district a written statement that:
178 (i) the contractor offers qualified health [~~insurance~~] coverage that complies with
179 Section 26-40-115;
180 (ii) is from:
181 (A) an actuary selected by the contractor or the contractor's insurer; [~~or~~]
182 (B) an underwriter who is responsible for developing the employer group's premium
183 rates; [~~and~~] or
184 (C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii),
185 an actuary or underwriter selected by a third party administrator; and
186 (iii) was created within one year before the day on which the statement is submitted.
187 (b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii)
188 shall provide the actuary or underwriter selected by an administrator, as described in
189 Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's
190 contribution to the health benefit plan and the actuarial value of the health benefit plan meet the

191 requirements of qualified health coverage.

192 (ii) A contractor may not make a change to the contractor's contribution to the health

193 benefit plan, unless the contractor provides notice to:

194 (A) the actuary or underwriter selected by an administrator as described in Subsection

195 (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in

196 Subsection (5)(a) in compliance with this section; and

197 (B) the public transit district.

198 [(b)] (c) A contractor that is subject to the requirements of this section shall:

199 (i) place a requirement in each of the contractor's subcontracts that a subcontractor that

200 is subject to the requirements of this section shall obtain and maintain an offer of qualified

201 health [insurance] coverage for the subcontractor's employees and the employees' dependents

202 during the duration of the subcontract; and

203 (ii) obtain from a subcontractor that is subject to the requirements of this section a

204 written statement that:

205 (A) the subcontractor offers qualified health [insurance] coverage that complies with

206 Section 26-40-115;

207 (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, [or]

208 an underwriter who is responsible for developing the employer group's premium rates, or if the

209 subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or

210 underwriter selected by an administrator; and

211 (C) was created within one year before the day on which the contractor obtains the

212 statement.

213 [(c)] (d) (i) (A) A contractor that fails to maintain an offer of qualified health

214 [insurance] coverage as described in Subsection (5)(a) during the duration of the contract is

215 subject to penalties in accordance with an ordinance adopted by the public transit district under

216 Subsection (6).

217 (B) A contractor is not subject to penalties for the failure of a subcontractor to obtain

218 and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection
219 (5)[~~(b)~~](c)(i).
220 (ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health
221 [~~insurance~~] coverage described in Subsection (5)[~~(b)~~](c)(i) during the duration of the
222 subcontract is subject to penalties in accordance with an ordinance adopted by the public transit
223 district under Subsection (6).
224 (B) A subcontractor is not subject to penalties for the failure of a contractor to maintain
225 an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a).
226 (6) The public transit district shall adopt ordinances:
227 (a) in coordination with:
228 (i) the Department of Environmental Quality in accordance with Section 19-1-206;
229 (ii) the Department of Natural Resources in accordance with Section 79-2-404;
230 (iii) the State Building Board in accordance with Section 63A-5-205.5;
231 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403; and
232 (v) the Department of Transportation in accordance with Section 72-6-107.5; and
233 (b) that establish:
234 (i) the requirements and procedures a contractor and a subcontractor shall follow to
235 demonstrate compliance with this section, including:
236 (A) that a contractor or subcontractor's compliance with this section is subject to an
237 audit by the public transit district or the Office of the Legislative Auditor General;
238 (B) that a contractor that is subject to the requirements of this section shall obtain a
239 written statement described in Subsection (5)(a); and
240 (C) that a subcontractor that is subject to the requirements of this section shall obtain a
241 written statement described in Subsection (5)[~~(b)~~](c)(ii);
242 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally
243 violates the provisions of this section, which may include:
244 (A) a three-month suspension of the contractor or subcontractor from entering into

245 future contracts with the public transit district upon the first violation;
246 (B) a six-month suspension of the contractor or subcontractor from entering into future
247 contracts with the public transit district upon the second violation;
248 (C) an action for debarment of the contractor or subcontractor in accordance with
249 Section 63G-6a-904 upon the third or subsequent violation; and
250 (D) monetary penalties which may not exceed 50% of the amount necessary to
251 purchase qualified health [~~insurance~~] coverage for employees and dependents of employees of
252 the contractor or subcontractor who were not offered qualified health [~~insurance~~] coverage
253 during the duration of the contract; and
254 (iii) a website on which the district shall post the commercially equivalent benchmark,
255 for the qualified health [~~insurance~~] coverage identified in Subsection (1)(e), that is provided by
256 the Department of Health, in accordance with Subsection 26-40-115(2).
257 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(b)(ii), a contractor
258 or subcontractor who intentionally violates the provisions of this section is liable to the
259 employee for health care costs that would have been covered by qualified health [~~insurance~~]
260 coverage.
261 (ii) An employer has an affirmative defense to a cause of action under Subsection
262 (7)(a)(i) if:
263 (A) the employer relied in good faith on a written statement described in Subsection
264 (5)(a) or (5)[~~(b)~~](c)(ii); or
265 (B) a department or division determines that compliance with this section is not
266 required under the provisions of Subsection (3).
267 (b) An employee has a private right of action only against the employee's employer to
268 enforce the provisions of this Subsection (7).
269 (8) Any penalties imposed and collected under this section shall be deposited into the
270 Medicaid Restricted Account created in Section 26-18-402.
271 (9) The failure of a contractor or subcontractor to provide qualified health [~~insurance~~]

272 coverage as required by this section:
273 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,
274 or contractor under:
275 (i) Section 63G-6a-1602; or
276 (ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and
277 (b) may not be used by the procurement entity or a prospective bidder, offeror, or
278 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
279 or construction.
280 (10) An administrator, including an administrator's actuary or underwriter, who
281 provides a written statement under Subsection (5)(a) or (c) regarding the qualified health
282 coverage of a contractor or subcontractor who provides a health benefit plan described in
283 Subsection (1)(d)(ii):
284 (a) subject to Subsection (10)(b), is not liable for an error in the written statement,
285 unless the administrator commits gross negligence in preparing the written statement;
286 (b) is not liable for any error in the written statement if the administrator relied in good
287 faith on information from the contractor or subcontractor; and
288 (c) may require as a condition of providing the written statement that a contractor or
289 subcontractor hold the administrator harmless for an action arising under this section.
290 Section 2. Section **19-1-206** is amended to read:
291 **19-1-206. Contracting powers of department -- Health insurance coverage.**
292 (1) As used in this section:
293 (a) "Aggregate" means the sum of all contracts, change orders, and modifications
294 related to a single project.
295 (b) "Change order" means the same as that term is defined in Section 63G-6a-103.
296 (c) "Employee" means, as defined in Section 34A-2-104, an "employee," "worker," or
297 "operative" who:
298 (i) works at least 30 hours per calendar week; and

299 (ii) meets employer eligibility waiting requirements for health care insurance, which
300 may not exceed the first day of the calendar month following 60 days after the day on which
301 the individual is hired.
302 (d) "Health benefit plan" means:
303 (i) the same as that term is defined in Section 31A-1-301[.]; or
304 (ii) an employee welfare benefit plan:
305 (A) established under the Employee Retirement Income Security Act of 1974, 29
306 U.S.C. Sec. 1001 et seq.;
307 (B) for an employer with 100 or more employees; and
308 (C) in which the employer establishes a self-funded or partially self-funded group
309 health plan to provide medical care for the employer's employees and dependents of the
310 employees.
311 (e) "Qualified health [~~insurance~~] coverage" means the same as that term is defined in
312 Section 26-40-115.
313 (f) "Subcontractor" means the same as that term is defined in Section 63A-5-208.
314 (g) "Third party administrator" or "administrator" means the same as that term is
315 defined in Section 31A-1-301.
316 (2) Except as provided in Subsection (3), the requirements of this section apply to:
317 (a) a contractor of a design or construction contract entered into by, or delegated to, the
318 department, or a division or board of the department, on or after July 1, 2009, if the prime
319 contract is in an aggregate amount equal to or greater than $2,000,000; and
320 (b) a subcontractor of a contractor of a design or construction contract entered into by,
321 or delegated to, the department, or a division or board of the department, on or after July 1,
322 2009, if the subcontract is in an aggregate amount equal to or greater than $1,000,000.
323 (3) This section does not apply to contracts entered into by the department or a division
324 or board of the department if:
325 (a) the application of this section jeopardizes the receipt of federal funds;

326 (b) the contract or agreement is between:
327 (i) the department or a division or board of the department; and
328 (ii) (A) another agency of the state;
329 (B) the federal government;
330 (C) another state;
331 (D) an interstate agency;
332 (E) a political subdivision of this state; or
333 (F) a political subdivision of another state;
334 (c) the executive director determines that applying the requirements of this section to a
335 particular contract interferes with the effective response to an immediate health and safety
336 threat from the environment; or
337 (d) the contract is:
338 (i) a sole source contract; or
339 (ii) an emergency procurement.
340 (4) A person that intentionally uses change orders, contract modifications, or multiple
341 contracts to circumvent the requirements of this section is guilty of an infraction.
342 (5) (a) A contractor subject to the requirements of this section shall demonstrate to the
343 executive director that the contractor has and will maintain an offer of qualified health
344 [~~insurance~~] coverage for the contractor's employees and the employees' dependents during the
345 duration of the contract by submitting to the executive director a written statement that:
346 (i) the contractor offers qualified health [~~insurance~~] coverage that complies with
347 Section 26-40-115;
348 (ii) is from:
349 (A) an actuary selected by the contractor or the contractor's insurer; [~~or~~]
350 (B) an underwriter who is responsible for developing the employer group's premium
351 rates; [~~and~~] or
352 (C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii),

353 an actuary or underwriter selected by a third party administrator; and

354 (iii) was created within one year before the day on which the statement is submitted.

355 (b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii)

356 shall provide the actuary or underwriter selected by an administrator, as described in

357 Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's

358 contribution to the health benefit plan and the actuarial value of the health benefit plan meet the

359 requirements of qualified health coverage.

360 (ii) A contractor may not make a change to the contractor's contribution to the health

361 benefit plan, unless the contractor provides notice to:

362 (A) the actuary or underwriter selected by an administrator, as described in Subsection

363 (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in

364 Subsection (5)(a) in compliance with this section; and

365 (B) the department.

366 [~~(b)~~] (c) A contractor that is subject to the requirements of this section shall:

367 (i) place a requirement in each of the contractor's subcontracts that a subcontractor that

368 is subject to the requirements of this section shall obtain and maintain an offer of qualified

369 health [~~insurance~~] coverage for the subcontractor's employees and the employees' dependents

370 during the duration of the subcontract; and

371 (ii) obtain from a subcontractor that is subject to the requirements of this section a

372 written statement that:

373 (A) the subcontractor offers qualified health [~~insurance~~] coverage that complies with

374 Section 26-40-115;

375 (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, [~~or~~]

376 an underwriter who is responsible for developing the employer group's premium rates, or if the

377 subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or

378 underwriter selected by an administrator; and

379 (C) was created within one year before the day on which the contractor obtains the

380 statement.
381 [(c)] (d) (i) (A) A contractor that fails to maintain an offer of qualified health
382 [insurance] coverage described in Subsection (5)(a) during the duration of the contract is
383 subject to penalties in accordance with administrative rules adopted by the department under
384 Subsection (6).
385 (B) A contractor is not subject to penalties for the failure of a subcontractor to obtain
386 and maintain an offer of qualified health [insurance] coverage described in Subsection
387 (5)[(b)](c)(i).
388 (ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health
389 [insurance] coverage described in Subsection (5)[(b)](c) during the duration of the subcontract
390 is subject to penalties in accordance with administrative rules adopted by the department under
391 Subsection (6).
392 (B) A subcontractor is not subject to penalties for the failure of a contractor to maintain
393 an offer of qualified health [insurance] coverage described in Subsection (5)(a).
394 (6) The department shall adopt administrative rules:
395 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;
396 (b) in coordination with:
397 (i) a public transit district in accordance with Section 17B-2a-818.5;
398 (ii) the Department of Natural Resources in accordance with Section 79-2-404;
399 (iii) the State Building Board in accordance with Section 63A-5-205.5;
400 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;
401 (v) the Department of Transportation in accordance with Section 72-6-107.5; and
402 (vi) the Legislature's Administrative Rules Review Committee; and
403 (c) that establish:
404 (i) the requirements and procedures a contractor and a subcontractor shall follow to
405 demonstrate compliance with this section, including:
406 (A) that a contractor or subcontractor's compliance with this section is subject to an

407 audit by the department or the Office of the Legislative Auditor General;
408 (B) that a contractor that is subject to the requirements of this section shall obtain a
409 written statement described in Subsection (5)(a); and
410 (C) that a subcontractor that is subject to the requirements of this section shall obtain a
411 written statement described in Subsection (5)[~~(b)~~](c)(ii);
412 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally
413 violates the provisions of this section, which may include:
414 (A) a three-month suspension of the contractor or subcontractor from entering into
415 future contracts with the state upon the first violation;
416 (B) a six-month suspension of the contractor or subcontractor from entering into future
417 contracts with the state upon the second violation;
418 (C) an action for debarment of the contractor or subcontractor in accordance with
419 Section 63G-6a-904 upon the third or subsequent violation; and
420 (D) notwithstanding Section 19-1-303, monetary penalties which may not exceed 50%
421 of the amount necessary to purchase qualified health [~~insurance~~] coverage for an employee and
422 the dependents of an employee of the contractor or subcontractor who was not offered qualified
423 health [~~insurance~~] coverage during the duration of the contract; and
424 (iii) a website on which the department shall post the commercially equivalent
425 benchmark, for the qualified health [~~insurance~~] coverage identified in Subsection (1)(e), that is
426 provided by the Department of Health, in accordance with Subsection 26-40-115(2).
427 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor
428 or subcontractor who intentionally violates the provisions of this section is liable to the
429 employee for health care costs that would have been covered by qualified health [~~insurance~~]
430 coverage.
431 (ii) An employer has an affirmative defense to a cause of action under Subsection
432 (7)(a)(i) if:
433 (A) the employer relied in good faith on a written statement described in Subsection

434 (5)(a) or (5)[~~(b)~~]<u>(c)</u>(ii); or
435 (B) the department determines that compliance with this section is not required under
436 the provisions of Subsection (3).
437 (b) An employee has a private right of action only against the employee's employer to
438 enforce the provisions of this Subsection (7).
439 (8) Any penalties imposed and collected under this section shall be deposited into the
440 Medicaid Restricted Account created in Section 26-18-402.
441 (9) The failure of a contractor or subcontractor to provide qualified health [~~insurance~~]
442 coverage as required by this section:
443 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,
444 or contractor under:
445 (i) Section 63G-6a-1602; or
446 (ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and
447 (b) may not be used by the procurement entity or a prospective bidder, offeror, or
448 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
449 or construction.
450 <u>(10) An administrator, including an administrator's actuary or underwriter, who</u>
451 <u>provides a written statement under Subsection (5)(a) or (c) regarding the qualified health</u>
452 <u>coverage of a contractor or subcontractor who provides a health benefit plan described in</u>
453 <u>Subsection (1)(d)(ii):</u>
454 <u>(a) subject to Subsection (10)(b), is not liable for an error in the written statement,</u>
455 <u>unless the administrator commits gross negligence in preparing the written statement;</u>
456 <u>(b) is not liable for any error in the written statement if the administrator relied in good</u>
457 <u>faith on information from the contractor or subcontractor; and</u>
458 <u>(c) may require as a condition of providing the written statement that a contractor or</u>
459 <u>subcontractor hold the administrator harmless for an action arising under this section.</u>
460 Section 3. Section **26-40-115** is amended to read:

461 **26-40-115. State contractor -- Employee and dependent health benefit plan**
462 **coverage.**
463 (1) For purposes of Sections 17B-2a-818.5, 19-1-206, 63A-5-205.5, 63C-9-403,
464 72-6-107.5, and 79-2-404, "qualified health [~~insurance~~] coverage" means, at the time the
465 contract is entered into or renewed:
466 (a) a health benefit plan and employer contribution level with a combined actuarial
467 value at least actuarially equivalent to the combined actuarial value of:
468 (i) the benchmark plan determined by the program under Subsection
469 26-40-106(1)(a)[~~,~~]; and
470 (ii) a contribution level at which the employer pays at least 50% of the premium or
471 contribution amounts for the employee and the dependents of the employee who reside or work
472 in the state; or
473 (b) a federally qualified high deductible health plan that, at a minimum:
474 (i) has a deductible that is:
475 (A) the lowest deductible permitted for a federally qualified high deductible health
476 plan; or
477 (B) a deductible that is higher than the lowest deductible permitted for a federally
478 qualified high deductible health plan, but includes an employer contribution to a health savings
479 account in a dollar amount at least equal to the dollar amount difference between the lowest
480 deductible permitted for a federally qualified high deductible plan and the deductible for the
481 employer offered federally qualified high deductible plan;
482 (ii) has an out-of-pocket maximum that does not exceed three times the amount of the
483 annual deductible; and
484 (iii) provides that the employer pays 60% of the premium or contribution amounts for
485 the employee and the dependents of the employee who work or reside in the state.
486 (2) The department shall:
487 (a) on or before July 1, 2016:

488 (i) determine the commercial equivalent of the benchmark plan described in Subsection
489 (1)(a); and
490 (ii) post the commercially equivalent benchmark plan described in Subsection (2)(a)(i)
491 on the department's website, noting the date posted; and
492 (b) update the posted commercially equivalent benchmark plan annually and at the
493 time of any change in the benchmark.
494 Section 4. Section **31A-1-103** is amended to read:
495 **31A-1-103. Scope and applicability of title.**
496 (1) This title does not apply to:
497 (a) a retainer contract made by an attorney-at-law:
498 (i) with an individual client; and
499 (ii) under which fees are based on estimates of the nature and amount of services to be
500 provided to the specific client;
501 (b) a contract similar to a contract described in Subsection (1)(a) made with a group of
502 clients involved in the same or closely related legal matters;
503 (c) an arrangement for providing benefits that do not exceed a limited amount of
504 consultations, advice on simple legal matters, either alone or in combination with referral
505 services, or the promise of fee discounts for handling other legal matters;
506 (d) limited legal assistance on an informal basis involving neither an express
507 contractual obligation nor reasonable expectations, in the context of an employment,
508 membership, educational, or similar relationship;
509 (e) legal assistance by employee organizations to their members in matters relating to
510 employment;
511 (f) death, accident, health, or disability benefits provided to a person by an organization
512 or its affiliate if:
513 (i) the organization is tax exempt under Section 501(c)(3) of the Internal Revenue
514 Code and has had its principal place of business in Utah for at least five years;

515 (ii) the person is not an employee of the organization; and

516 (iii) (A) substantially all the person's time in the organization is spent providing

517 voluntary services:

518 (I) in furtherance of the organization's purposes;

519 (II) for a designated period of time; and

520 (III) for which no compensation, other than expenses, is paid; or

521 (B) the time since the service under Subsection (1)(f)(iii)(A) was completed is no more

522 than 18 months; or

523 (g) a prepaid contract of limited duration that provides for scheduled maintenance only.

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

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

526 Utah law.

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

528 (a) those activities of an insurer where state jurisdiction is preempted by Section 514 of

529 the federal Employee Retirement Income Security Act of 1974, as amended;

530 (b) ocean marine insurance;

531 (c) death, accident, health, or disability benefits provided by an organization if the

532 organization:

533 (i) has as [~~its~~] the organization's principal purpose to achieve charitable, educational,

534 social, or religious objectives rather than to provide death, accident, health, or disability

535 benefits;

536 (ii) does not incur a legal obligation to pay a specified amount; and

537 (iii) does not create reasonable expectations of receiving a specified amount on the part

538 of an insured person;

539 (d) other business specified in rules adopted by the commissioner on a finding that:

540 (i) the transaction of the business in this state does not require regulation for the

541 protection of the interests of the residents of this state; or

542 (ii) it would be impracticable to require compliance with this title;
543 (e) except as provided in Subsection (4), a transaction independently procured through
544 negotiations under Section 31A-15-104;
545 (f) self-insurance;
546 (g) reinsurance;
547 (h) subject to Subsection (5), employee and labor union group or blanket insurance
548 covering risks in this state if:
549 (i) the policyholder exists primarily for purposes other than to procure insurance;
550 (ii) the policyholder:
551 (A) is not a resident of this state;
552 (B) is not a domestic corporation; or
553 (C) does not have [~~its~~] the policyholder's principal office in this state;
554 (iii) no more than 25% of the certificate holders or insureds are residents of this state;
555 (iv) on request of the commissioner, the insurer files with the department a copy of the
556 policy and a copy of each form or certificate; and
557 (v) (A) the insurer agrees to pay premium taxes on the Utah portion of [~~its~~] the
558 insurer's business, as if [~~it~~] the insurer were authorized to do business in this state; and
559 (B) the insurer provides the commissioner with the security the commissioner
560 considers necessary for the payment of premium taxes under Title 59, Chapter 9, Taxation of
561 Admitted Insurers;
562 (i) to the extent provided in Subsection (6):
563 (i) a manufacturer's or seller's warranty; and
564 (ii) a manufacturer's or seller's service contract;
565 (j) except to the extent provided in Subsection (7), a public agency insurance mutual;
566 or
567 (k) except as provided in Chapter 6b, Guaranteed Asset Protection Waiver Act, a
568 guaranteed asset protection waiver.

569 (4) A transaction described in Subsection (3)(e) is subject to taxation under Section
570 31A-3-301.
571 (5) (a) After a hearing, the commissioner may order an insurer of certain group or
572 blanket contracts to transfer the Utah portion of the business otherwise exempted under
573 Subsection (3)(h) to an authorized insurer if the contracts have been written by an unauthorized
574 insurer.
575 (b) If the commissioner finds that the conditions required for the exemption of a group
576 or blanket insurer are not satisfied or that adequate protection to residents of this state is not
577 provided, the commissioner may require:
578 (i) the insurer to be authorized to do business in this state; or
579 (ii) that any of the insurer's transactions be subject to this title.
580 (c) Subsection (3)(h) does not apply to blanket accident and health insurance.
581 (6) (a) As used in Subsection (3)(i) and this Subsection (6):
582 (i) "manufacturer's or seller's service contract" means a service contract:
583 (A) made available by:
584 (I) a manufacturer of a product;
585 (II) a seller of a product; or
586 (III) an affiliate of a manufacturer or seller of a product;
587 (B) made available:
588 (I) on one or more specific products; or
589 (II) on products that are components of a system; and
590 (C) under which the person described in Subsection (6)(a)(i)(A) is liable for services to
591 be provided under the service contract including, if the manufacturer's or seller's service
592 contract designates, providing parts and labor;
593 (ii) "manufacturer's or seller's warranty" means the guaranty of:
594 (A) (I) the manufacturer of a product;
595 (II) a seller of a product; or

596 (III) an affiliate of a manufacturer or seller of a product;
597 (B) (I) on one or more specific products; or
598 (II) on products that are components of a system; and
599 (C) under which the person described in Subsection (6)(a)(ii)(A) is liable for services
600 to be provided under the warranty, including, if the manufacturer's or seller's warranty
601 designates, providing parts and labor; and
602 (iii) "service contract" means the same as that term is defined in Section 31A-6a-101.
603 (b) A manufacturer's or seller's warranty may be designated as:
604 (i) a warranty;
605 (ii) a guaranty; or
606 (iii) a term similar to a term described in Subsection (6)(b)(i) or (ii).
607 (c) This title does not apply to:
608 (i) a manufacturer's or seller's warranty;
609 (ii) a manufacturer's or seller's service contract paid for with consideration that is in
610 addition to the consideration paid for the product itself; and
611 (iii) a service contract that is not a manufacturer's or seller's warranty or manufacturer's
612 or seller's service contract if:
613 (A) the service contract is paid for with consideration that is in addition to the
614 consideration paid for the product itself;
615 (B) the service contract is for the repair or maintenance of goods;
616 (C) the [~~cost~~] purchase price of the product is [~~equal to an amount determined in~~
617 ~~accordance with Subsection (6)(e); and~~] $3,700 or less;
618 (D) the product is not a motor vehicle[~~.~~]; and
619 (E) the product is not the subject of a home warranty service contract.
620 (d) This title does not apply to a manufacturer's or seller's warranty or service contract
621 paid for with consideration that is in addition to the consideration paid for the product itself
622 regardless of whether the manufacturer's or seller's warranty or service contract is sold:

623 (i) at the time of the purchase of the product; or
624 (ii) at a time other than the time of the purchase of the product.
625 [~~(c) (i) For fiscal year 2001-02, the amount described in Subsection (6)(c)(iii)(C) shall~~
626 ~~be equal to $3,700 or less.~~]
627 [~~(ii) For each fiscal year after fiscal year 2001-02, the commissioner shall annually~~
628 ~~determine whether the amount described in Subsection (6)(c)(iii)(C) should be adjusted in~~
629 ~~accordance with changes in the Consumer Price Index published by the United States Bureau~~
630 ~~of Labor Statistics selected by the commissioner by rule, between:~~]
631 [~~(A) the Consumer Price Index for the February immediately preceding the adjustment;~~
632 ~~and~~]
633 [~~(B) the Consumer Price Index for February 2001.~~]
634 [~~(iii) If under Subsection (6)(e)(ii) the commissioner determines that an adjustment~~
635 ~~should be made, the commissioner shall make the adjustment by rule.~~]
636 (7) (a) For purposes of this Subsection (7), "public agency insurance mutual" means an
637 entity formed by two or more political subdivisions or public agencies of the state:
638 (i) under Title 11, Chapter 13, Interlocal Cooperation Act; and
639 (ii) for the purpose of providing for the political subdivisions or public agencies:
640 (A) subject to Subsection (7)(b), insurance coverage; or
641 (B) risk management.
642 (b) Notwithstanding Subsection (7)(a)(ii)(A), a public agency insurance mutual may
643 not provide health insurance unless the public agency insurance mutual provides the health
644 insurance using:
645 (i) a third party administrator licensed under Chapter 25, Third Party Administrators;
646 (ii) an admitted insurer; or
647 (iii) a program authorized by Title 49, Chapter 20, Public Employees' Benefit and
648 Insurance Program Act.
649 (c) Except for this Subsection (7), a public agency insurance mutual is exempt from

650 this title.
651 (d) A public agency insurance mutual is considered to be a governmental entity and
652 political subdivision of the state with all of the rights, privileges, and immunities of a
653 governmental entity or political subdivision of the state including all the rights and benefits of
654 Title 63G, Chapter 7, Governmental Immunity Act of Utah.
655 Section 5. Section **31A-1-301** is amended to read:
656 **31A-1-301. Definitions.**
657 As used in this title, unless otherwise specified:
658 (1) (a) "Accident and health insurance" means insurance to provide protection against
659 economic losses resulting from:
660 (i) a medical condition including:
661 (A) a medical care expense; or
662 (B) the risk of disability;
663 (ii) accident; or
664 (iii) sickness.
665 (b) "Accident and health insurance":
666 (i) includes a contract with disability contingencies including:
667 (A) an income replacement contract;
668 (B) a health care contract;
669 (C) an expense reimbursement contract;
670 (D) a credit accident and health contract;
671 (E) a continuing care contract; and
672 (F) a long-term care contract; and
673 (ii) may provide:
674 (A) hospital coverage;
675 (B) surgical coverage;
676 (C) medical coverage;

677 (D) loss of income coverage;
678 (E) prescription drug coverage;
679 (F) dental coverage; or
680 (G) vision coverage.
681 (c) "Accident and health insurance" does not include workers' compensation insurance.
682 (d) For purposes of a national licensing registry, "accident and health insurance" is the
683 same as "accident and health or sickness insurance."
684 (2) "Actuary" is as defined by the commissioner by rule, made in accordance with Title
685 63G, Chapter 3, Utah Administrative Rulemaking Act.
686 (3) "Administrator" means the same as that term is defined in Subsection [~~(178)~~] (179).
687 (4) "Adult" means an individual who has attained the age of at least 18 years.
688 (5) "Affiliate" means a person who controls, is controlled by, or is under common
689 control with, another person. A corporation is an affiliate of another corporation, regardless of
690 ownership, if substantially the same group of individuals manage the corporations.
691 (6) "Agency" means:
692 (a) a person other than an individual, including a sole proprietorship by which an
693 individual does business under an assumed name; and
694 (b) an insurance organization licensed or required to be licensed under Section
695 31A-23a-301, 31A-25-207, or 31A-26-209.
696 (7) "Alien insurer" means an insurer domiciled outside the United States.
697 (8) "Amendment" means an endorsement to an insurance policy or certificate.
698 (9) "Annuity" means an agreement to make periodical payments for a period certain or
699 over the lifetime of one or more individuals if the making or continuance of all or some of the
700 series of the payments, or the amount of the payment, is dependent upon the continuance of
701 human life.
702 (10) "Application" means a document:
703 (a) (i) completed by an applicant to provide information about the risk to be insured;

704 and
705 (ii) that contains information that is used by the insurer to evaluate risk and decide
706 whether to:
707 (A) insure the risk under:
708 (I) the coverage as originally offered; or
709 (II) a modification of the coverage as originally offered; or
710 (B) decline to insure the risk; or
711 (b) used by the insurer to gather information from the applicant before issuance of an
712 annuity contract.
713 (11) "Articles" or "articles of incorporation" means:
714 (a) the original articles;
715 (b) a special law;
716 (c) a charter;
717 (d) an amendment;
718 (e) restated articles;
719 (f) articles of merger or consolidation;
720 (g) a trust instrument;
721 (h) another constitutive document for a trust or other entity that is not a corporation;
722 and
723 (i) an amendment to an item listed in Subsections (11)(a) through (h).
724 (12) "Bail bond insurance" means a guarantee that a person will attend court when
725 required, up to and including surrender of the person in execution of a sentence imposed under
726 Subsection 77-20-7(1), as a condition to the release of that person from confinement.
727 (13) "Binder" means the same as that term is defined in Section 31A-21-102.
728 (14) "Blanket insurance policy" means a group policy covering a defined class of
729 persons:
730 (a) without individual underwriting or application; and

731 (b) that is determined by definition without designating each person covered.
732 (15) "Board," "board of trustees," or "board of directors" means the group of persons
733 with responsibility over, or management of, a corporation, however designated.
734 (16) "Bona fide office" means a physical office in this state:
735 (a) that is open to the public;
736 (b) that is staffed during regular business hours on regular business days; and
737 (c) at which the public may appear in person to obtain services.
738 (17) "Business entity" means:
739 (a) a corporation;
740 (b) an association;
741 (c) a partnership;
742 (d) a limited liability company;
743 (e) a limited liability partnership; or
744 (f) another legal entity.
745 (18) "Business of insurance" means the same as that term is defined in Subsection (94).
746 (19) "Business plan" means the information required to be supplied to the
747 commissioner under Subsections 31A-5-204(2)(i) and (j), including the information required
748 when these subsections apply by reference under:
749 (a) Section 31A-8-205; or
750 (b) Subsection 31A-9-205(2).
751 (20) (a) "Bylaws" means the rules adopted for the regulation or management of a
752 corporation's affairs, however designated.
753 (b) "Bylaws" includes comparable rules for a trust or other entity that is not a
754 corporation.
755 (21) "Captive insurance company" means:
756 (a) an insurer:
757 (i) owned by another organization; and

758 (ii) whose exclusive purpose is to insure risks of the parent organization and an
759 affiliated company; or
760 (b) in the case of a group or association, an insurer:
761 (i) owned by the insureds; and
762 (ii) whose exclusive purpose is to insure risks of:
763 (A) a member organization;
764 (B) a group member; or
765 (C) an affiliate of:
766 (I) a member organization; or
767 (II) a group member.
768 (22) "Casualty insurance" means liability insurance.
769 (23) "Certificate" means evidence of insurance given to:
770 (a) an insured under a group insurance policy; or
771 (b) a third party.
772 (24) "Certificate of authority" is included within the term "license."
773 (25) "Claim," unless the context otherwise requires, means a request or demand on an
774 insurer for payment of a benefit according to the terms of an insurance policy.
775 (26) "Claims-made coverage" means an insurance contract or provision limiting
776 coverage under a policy insuring against legal liability to claims that are first made against the
777 insured while the policy is in force.
778 (27) (a) "Commissioner" or "commissioner of insurance" means Utah's insurance
779 commissioner.
780 (b) When appropriate, the terms listed in Subsection (27)(a) apply to the equivalent
781 supervisory official of another jurisdiction.
782 (28) (a) "Continuing care insurance" means insurance that:
783 (i) provides board and lodging;
784 (ii) provides one or more of the following:

785 (A) a personal service;
786 (B) a nursing service;
787 (C) a medical service; or
788 (D) any other health-related service; and
789 (iii) provides the coverage described in this Subsection (28)(a) under an agreement
790 effective:
791 (A) for the life of the insured; or
792 (B) for a period in excess of one year.
793 (b) Insurance is continuing care insurance regardless of whether or not the board and
794 lodging are provided at the same location as a service described in Subsection (28)(a)(ii).
795 (29) (a) "Control," "controlling," "controlled," or "under common control" means the
796 direct or indirect possession of the power to direct or cause the direction of the management
797 and policies of a person. This control may be:
798 (i) by contract;
799 (ii) by common management;
800 (iii) through the ownership of voting securities; or
801 (iv) by a means other than those described in Subsections (29)(a)(i) through (iii).
802 (b) There is no presumption that an individual holding an official position with another
803 person controls that person solely by reason of the position.
804 (c) A person having a contract or arrangement giving control is considered to have
805 control despite the illegality or invalidity of the contract or arrangement.
806 (d) There is a rebuttable presumption of control in a person who directly or indirectly
807 owns, controls, holds with the power to vote, or holds proxies to vote 10% or more of the
808 voting securities of another person.
809 (30) "Controlled insurer" means a licensed insurer that is either directly or indirectly
810 controlled by a producer.
811 (31) "Controlling person" means a person that directly or indirectly has the power to

812 direct or cause to be directed, the management, control, or activities of a reinsurance
813 intermediary.
814 (32) "Controlling producer" means a producer who directly or indirectly controls an
815 insurer.
816 (33) "Corporate governance annual disclosure" means a report an insurer or insurance
817 group files in accordance with the requirements of Chapter 16b, Corporate Governance Annual
818 Disclosure Act.
819 (34) (a) "Corporation" means an insurance corporation, except when referring to:
820 (i) a corporation doing business:
821 (A) as:
822 (I) an insurance producer;
823 (II) a surplus lines producer;
824 (III) a limited line producer;
825 (IV) a consultant;
826 (V) a managing general agent;
827 (VI) a reinsurance intermediary;
828 (VII) a third party administrator; or
829 (VIII) an adjuster; and
830 (B) under:
831 (I) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and
832 Reinsurance Intermediaries;
833 (II) Chapter 25, Third Party Administrators; or
834 (III) Chapter 26, Insurance Adjusters; or
835 (ii) a noninsurer that is part of a holding company system under Chapter 16, Insurance
836 Holding Companies.
837 (b) "Mutual" or "mutual corporation" means a mutual insurance corporation.
838 (c) "Stock corporation" means a stock insurance corporation.

839 (35) (a) "Creditable coverage" has the same meaning as provided in federal regulations
840 adopted pursuant to the Health Insurance Portability and Accountability Act.
841 (b) "Creditable coverage" includes coverage that is offered through a public health plan
842 such as:
843 (i) the Primary Care Network Program under a Medicaid primary care network
844 demonstration waiver obtained subject to Section 26-18-3;
845 (ii) the Children's Health Insurance Program under Section 26-40-106; or
846 (iii) the Ryan White Program Comprehensive AIDS Resources Emergency Act, Pub. L.
847 No. 101-381, and Ryan White HIV/AIDS Treatment Modernization Act of 2006, Pub. L. No.
848 109-415.
849 (36) "Credit accident and health insurance" means insurance on a debtor to provide
850 indemnity for payments coming due on a specific loan or other credit transaction while the
851 debtor has a disability.
852 (37) (a) "Credit insurance" means insurance offered in connection with an extension of
853 credit that is limited to partially or wholly extinguishing that credit obligation.
854 (b) "Credit insurance" includes:
855 (i) credit accident and health insurance;
856 (ii) credit life insurance;
857 (iii) credit property insurance;
858 (iv) credit unemployment insurance;
859 (v) guaranteed automobile protection insurance;
860 (vi) involuntary unemployment insurance;
861 (vii) mortgage accident and health insurance;
862 (viii) mortgage guaranty insurance; and
863 (ix) mortgage life insurance.
864 (38) "Credit life insurance" means insurance on the life of a debtor in connection with
865 an extension of credit that pays a person if the debtor dies.

866 (39) "Creditor" means a person, including an insured, having a claim, whether:
867 (a) matured;
868 (b) unmatured;
869 (c) liquidated;
870 (d) unliquidated;
871 (e) secured;
872 (f) unsecured;
873 (g) absolute;
874 (h) fixed; or
875 (i) contingent.
876 (40) "Credit property insurance" means insurance:
877 (a) offered in connection with an extension of credit; and
878 (b) that protects the property until the debt is paid.
879 (41) "Credit unemployment insurance" means insurance:
880 (a) offered in connection with an extension of credit; and
881 (b) that provides indemnity if the debtor is unemployed for payments coming due on a:
882 (i) specific loan; or
883 (ii) credit transaction.
884 (42) (a) "Crop insurance" means insurance providing protection against damage to
885 crops from unfavorable weather conditions, fire or lightning, flood, hail, insect infestation,
886 disease, or other yield-reducing conditions or perils that is:
887 (i) provided by the private insurance market; or
888 (ii) subsidized by the Federal Crop Insurance Corporation.
889 (b) "Crop insurance" includes multiperil crop insurance.
890 (43) (a) "Customer service representative" means a person that provides an insurance
891 service and insurance product information:
892 (i) for the customer service representative's:

893 (A) producer;
894 (B) surplus lines producer; or
895 (C) consultant employer; and
896 (ii) to the customer service representative's employer's:
897 (A) customer;
898 (B) client; or
899 (C) organization.
900 (b) A customer service representative may only operate within the scope of authority of
901 the customer service representative's producer, surplus lines producer, or consultant employer.
902 (44) "Deadline" means a final date or time:
903 (a) imposed by:
904 (i) statute;
905 (ii) rule; or
906 (iii) order; and
907 (b) by which a required filing or payment must be received by the department.
908 (45) "Deemer clause" means a provision under this title under which upon the
909 occurrence of a condition precedent, the commissioner is considered to have taken a specific
910 action. If the statute so provides, a condition precedent may be the commissioner's failure to
911 take a specific action.
912 (46) "Degree of relationship" means the number of steps between two persons
913 determined by counting the generations separating one person from a common ancestor and
914 then counting the generations to the other person.
915 (47) "Department" means the Insurance Department.
916 (48) "Director" means a member of the board of directors of a corporation.
917 (49) "Disability" means a physiological or psychological condition that partially or
918 totally limits an individual's ability to:
919 (a) perform the duties of:

920 (i) that individual's occupation; or
921 (ii) an occupation for which the individual is reasonably suited by education, training,
922 or experience; or
923 (b) perform two or more of the following basic activities of daily living:
924 (i) eating;
925 (ii) toileting;
926 (iii) transferring;
927 (iv) bathing; or
928 (v) dressing.
929 (50) "Disability income insurance" means the same as that term is defined in
930 Subsection (85).
931 (51) "Domestic insurer" means an insurer organized under the laws of this state.
932 (52) "Domiciliary state" means the state in which an insurer:
933 (a) is incorporated;
934 (b) is organized; or
935 (c) in the case of an alien insurer, enters into the United States.
936 (53) (a) "Eligible employee" means:
937 (i) an employee who:
938 (A) works on a full-time basis; and
939 (B) has a normal work week of 30 or more hours; or
940 (ii) a person described in Subsection (53)(b).
941 (b) "Eligible employee" includes:
942 (i) an owner who:
943 (A) works on a full-time basis; [~~and~~]
944 (B) has a normal work week of 30 or more hours; and
945 <u>(C) employs at least one common employee; and</u>
946 (ii) if the individual is included under a health benefit plan of a small employer:

947 (A) a sole proprietor;
948 (B) a partner in a partnership; or
949 (C) an independent contractor.
950 (c) "Eligible employee" does not include, unless eligible under Subsection (53)(b):
951 (i) an individual who works on a temporary or substitute basis for a small employer;
952 (ii) an employer's spouse who does not meet the requirements of Subsection (53)(a)(i);
953 or
954 (iii) a dependent of an employer who does not meet the requirements of Subsection
955 (53)(a)(i).
956 (54) "Employee" means:
957 (a) an individual employed by an employer; and
958 (b) an owner who meets the requirements of Subsection (53)(b)(i).
959 (55) "Employee benefits" means one or more benefits or services provided to:
960 (a) an employee; or
961 (b) a dependent of an employee.
962 (56) (a) "Employee welfare fund" means a fund:
963 (i) established or maintained, whether directly or through a trustee, by:
964 (A) one or more employers;
965 (B) one or more labor organizations; or
966 (C) a combination of employers and labor organizations; and
967 (ii) that provides employee benefits paid or contracted to be paid, other than income
968 from investments of the fund:
969 (A) by or on behalf of an employer doing business in this state; or
970 (B) for the benefit of a person employed in this state.
971 (b) "Employee welfare fund" includes a plan funded or subsidized by a user fee or tax
972 revenues.
973 (57) "Endorsement" means a written agreement attached to a policy or certificate to

974 modify the policy or certificate coverage.
975 (58) (a) "Enrollee" means:
976 (i) a policyholder;
977 (ii) a certificate holder;
978 (iii) a subscriber; or
979 (iv) a covered individual:
980 (A) who has entered into a contract with an organization for health care; or
981 (B) on whose behalf an arrangement for health care has been made.
982 (b) "Enrollee" includes an insured.
983 (59) "Enrollment date," with respect to a health benefit plan, means:
984 (a) the first day of coverage; or
985 (b) if there is a waiting period, the first day of the waiting period.
986 (60) "Enterprise risk" means an activity, circumstance, event, or series of events
987 involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a
988 material adverse effect upon the financial condition or liquidity of the insurer or its insurance
989 holding company system as a whole, including anything that would cause:
990 (a) the insurer's risk-based capital to fall into an action or control level as set forth in
991 Sections 31A-17-601 through 31A-17-613; or
992 (b) the insurer to be in hazardous financial condition set forth in Section 31A-27a-101.
993 (61) (a) "Escrow" means:
994 (i) a transaction that effects the sale, transfer, encumbering, or leasing of real property,
995 when a person not a party to the transaction, and neither having nor acquiring an interest in the
996 title, performs, in accordance with the written instructions or terms of the written agreement
997 between the parties to the transaction, any of the following actions:
998 (A) the explanation, holding, or creation of a document; or
999 (B) the receipt, deposit, and disbursement of money;
1000 (ii) a settlement or closing involving:

1001 (A) a mobile home;
1002 (B) a grazing right;
1003 (C) a water right; or
1004 (D) other personal property authorized by the commissioner.
1005 (b) "Escrow" does not include:
1006 (i) the following notarial acts performed by a notary within the state:
1007 (A) an acknowledgment;
1008 (B) a copy certification;
1009 (C) jurat; and
1010 (D) an oath or affirmation;
1011 (ii) the receipt or delivery of a document; or
1012 (iii) the receipt of money for delivery to the escrow agent.
1013 (62) "Escrow agent" means an agency title insurance producer meeting the
1014 requirements of Sections 31A-4-107, 31A-14-211, and 31A-23a-204, who is acting through an
1015 individual title insurance producer licensed with an escrow subline of authority.
1016 (63) (a) "Excludes" is not exhaustive and does not mean that another thing is not also
1017 excluded.
1018 (b) The items listed in a list using the term "excludes" are representative examples for
1019 use in interpretation of this title.
1020 (64) "Exclusion" means for the purposes of accident and health insurance that an
1021 insurer does not provide insurance coverage, for whatever reason, for one of the following:
1022 (a) a specific physical condition;
1023 (b) a specific medical procedure;
1024 (c) a specific disease or disorder; or
1025 (d) a specific prescription drug or class of prescription drugs.
1026 (65) "Expense reimbursement insurance" means insurance:
1027 (a) written to provide a payment for an expense relating to hospital confinement

1028 resulting from illness or injury; and
1029 (b) written:
1030 (i) as a daily limit for a specific number of days in a hospital; and
1031 (ii) to have a one or two day waiting period following a hospitalization.
1032 (66) "Fidelity insurance" means insurance guaranteeing the fidelity of a person holding
1033 a position of public or private trust.
1034 (67) (a) "Filed" means that a filing is:
1035 (i) submitted to the department as required by and in accordance with applicable
1036 statute, rule, or filing order;
1037 (ii) received by the department within the time period provided in applicable statute,
1038 rule, or filing order; and
1039 (iii) accompanied by the appropriate fee in accordance with:
1040 (A) Section 31A-3-103; or
1041 (B) rule.
1042 (b) "Filed" does not include a filing that is rejected by the department because it is not
1043 submitted in accordance with Subsection (67)(a).
1044 (68) "Filing," when used as a noun, means an item required to be filed with the
1045 department including:
1046 (a) a policy;
1047 (b) a rate;
1048 (c) a form;
1049 (d) a document;
1050 (e) a plan;
1051 (f) a manual;
1052 (g) an application;
1053 (h) a report;
1054 (i) a certificate;

1055 (j) an endorsement;

1056 (k) an actuarial certification;

1057 (l) a licensee annual statement;

1058 (m) a licensee renewal application;

1059 (n) an advertisement;

1060 (o) a binder; or

1061 (p) an outline of coverage.

1062 (69) "First party insurance" means an insurance policy or contract in which the insurer

1063 agrees to pay a claim submitted to it by the insured for the insured's losses.

1064 (70) "Foreign insurer" means an insurer domiciled outside of this state, including an

1065 alien insurer.

1066 (71) (a) "Form" means one of the following prepared for general use:

1067 (i) a policy;

1068 (ii) a certificate;

1069 (iii) an application;

1070 (iv) an outline of coverage; or

1071 (v) an endorsement.

1072 (b) "Form" does not include a document specially prepared for use in an individual

1073 case.

1074 (72) "Franchise insurance" means an individual insurance policy provided through a

1075 mass marketing arrangement involving a defined class of persons related in some way other

1076 than through the purchase of insurance.

1077 (73) "General lines of authority" include:

1078 (a) the general lines of insurance in Subsection (74);

1079 (b) title insurance under one of the following sublines of authority:

1080 (i) title examination, including authority to act as a title marketing representative;

1081 (ii) escrow, including authority to act as a title marketing representative; and

1082 (iii) title marketing representative only;
1083 (c) surplus lines;
1084 (d) workers' compensation; and
1085 (e) another line of insurance that the commissioner considers necessary to recognize in
1086 the public interest.
1087 (74) "General lines of insurance" include:
1088 (a) accident and health;
1089 (b) casualty;
1090 (c) life;
1091 (d) personal lines;
1092 (e) property; and
1093 (f) variable contracts, including variable life and annuity.
1094 (75) "Group health plan" means an employee welfare benefit plan to the extent that the
1095 plan provides medical care:
1096 (a) (i) to an employee; or
1097 (ii) to a dependent of an employee; and
1098 (b) (i) directly;
1099 (ii) through insurance reimbursement; or
1100 (iii) through another method.
1101 (76) (a) "Group insurance policy" means a policy covering a group of persons that is
1102 issued:
1103 (i) to a policyholder on behalf of the group; and
1104 (ii) for the benefit of a member of the group who is selected under a procedure defined
1105 in:
1106 (A) the policy; or
1107 (B) an agreement that is collateral to the policy.
1108 (b) A group insurance policy may include a member of the policyholder's family or a

1109 dependent.

1110 (77) "Group-wide supervisor" means the commissioner or other regulatory official
1111 designated as the group-wide supervisor for an internationally active insurance group under
1112 Section 31A-16-108.6.

1113 (78) "Guaranteed automobile protection insurance" means insurance offered in
1114 connection with an extension of credit that pays the difference in amount between the
1115 insurance settlement and the balance of the loan if the insured automobile is a total loss.

1116 (79) (a) "Health benefit plan" means, except as provided in Subsection (79)(b), a
1117 policy, contract, certificate, or agreement offered or issued by a health carrier to provide,
1118 deliver, arrange for, pay for, or reimburse any of the costs of health care.

1119 (b) "Health benefit plan" does not include:

1120 (i) coverage only for accident or disability income insurance, or any combination
1121 thereof;

1122 (ii) coverage issued as a supplement to liability insurance;

1123 (iii) liability insurance, including general liability insurance and automobile liability
1124 insurance;

1125 (iv) workers' compensation or similar insurance;

1126 (v) automobile medical payment insurance;

1127 (vi) credit-only insurance;

1128 (vii) coverage for on-site medical clinics;

1129 (viii) other similar insurance coverage, specified in federal regulations issued pursuant
1130 to Pub. L. No. 104-191, under which benefits for health care services are secondary or
1131 incidental to other insurance benefits;

1132 (ix) the following benefits if they are provided under a separate policy, certificate, or
1133 contract of insurance or are otherwise not an integral part of the plan:

1134 (A) limited scope dental or vision benefits;

1135 (B) benefits for long-term care, nursing home care, home health care,

1136 community-based care, or any combination thereof; or

1137 (C) other similar limited benefits, specified in federal regulations issued pursuant to

1138 Pub. L. No. 104-191;

1139 (x) the following benefits if the benefits are provided under a separate policy,

1140 certificate, or contract of insurance, there is no coordination between the provision of benefits

1141 and any exclusion of benefits under any health plan, and the benefits are paid with respect to an

1142 event without regard to whether benefits are provided under any health plan:

1143 (A) coverage only for specified disease or illness; or

1144 (B) hospital indemnity or other fixed indemnity insurance; [~~and~~]

1145 (xi) the following if offered as a separate policy, certificate, or contract of insurance:

1146 (A) Medicare supplemental health insurance as defined under the Social Security Act,

1147 42 U.S.C. Sec. 1395ss(g)(1);

1148 (B) coverage supplemental to the coverage provided under United States Code, Title

1149 10, Chapter 55, Civilian Health and Medical Program of the Uniformed Services

1150 (CHAMPUS); or

1151 (C) similar supplemental coverage provided to coverage under a group health insurance

1152 plan[~~.~~];

1153 (xii) short-term, limited-duration insurance; and

1154 (xiii) student health insurance, except as required under 45 C.F.R. Sec. 147.145.

1155 (80) "Health care" means any of the following intended for use in the diagnosis,

1156 treatment, mitigation, or prevention of a human ailment or impairment:

1157 (a) a professional service;

1158 (b) a personal service;

1159 (c) a facility;

1160 (d) equipment;

1161 (e) a device;

1162 (f) supplies; or

1163 (g) medicine.
1164 (81) (a) "Health care insurance" or "health insurance" means insurance providing:
1165 (i) a health care benefit; or
1166 (ii) payment of an incurred health care expense.
1167 (b) "Health care insurance" or "health insurance" does not include accident and health
1168 insurance providing a benefit for:
1169 (i) replacement of income;
1170 (ii) short-term accident;
1171 (iii) fixed indemnity;
1172 (iv) credit accident and health;
1173 (v) supplements to liability;
1174 (vi) workers' compensation;
1175 (vii) automobile medical payment;
1176 (viii) no-fault automobile;
1177 (ix) equivalent self-insurance; or
1178 (x) a type of accident and health insurance coverage that is a part of or attached to
1179 another type of policy.
1180 (82) "Health care provider" means the same as that term is defined in Section
1181 78B-3-403.
1182 (83) "Health insurance exchange" means an exchange as defined in 45 C.F.R. Sec.
1183 155.20.
1184 (84) "Health Insurance Portability and Accountability Act" means the Health Insurance
1185 Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, as amended.
1186 (85) "Income replacement insurance" or "disability income insurance" means insurance
1187 written to provide payments to replace income lost from accident or sickness.
1188 (86) "Indemnity" means the payment of an amount to offset all or part of an insured
1189 loss.

1190 (87) "Independent adjuster" means an insurance adjuster required to be licensed under
1191 Section 31A-26-201 who engages in insurance adjusting as a representative of an insurer.
1192 (88) "Independently procured insurance" means insurance procured under Section
1193 31A-15-104.
1194 (89) "Individual" means a natural person.
1195 (90) "Inland marine insurance" includes insurance covering:
1196 (a) property in transit on or over land;
1197 (b) property in transit over water by means other than boat or ship;
1198 (c) bailee liability;
1199 (d) fixed transportation property such as bridges, electric transmission systems, radio
1200 and television transmission towers and tunnels; and
1201 (e) personal and commercial property floaters.
1202 (91) "Insolvency" or "insolvent" means that:
1203 (a) an insurer is unable to pay the insurer's obligations as the obligations are due;
1204 (b) an insurer's total adjusted capital is less than the insurer's mandatory control level
1205 RBC under Subsection 31A-17-601(8)(c); or
1206 (c) an insurer's admitted assets are less than the insurer's liabilities.
1207 (92) (a) "Insurance" means:
1208 (i) an arrangement, contract, or plan for the transfer of a risk or risks from one or more
1209 persons to one or more other persons; or
1210 (ii) an arrangement, contract, or plan for the distribution of a risk or risks among a
1211 group of persons that includes the person seeking to distribute that person's risk.
1212 (b) "Insurance" includes:
1213 (i) a risk distributing arrangement providing for compensation or replacement for
1214 damages or loss through the provision of a service or a benefit in kind;
1215 (ii) a contract of guaranty or suretyship entered into by the guarantor or surety as a
1216 business and not as merely incidental to a business transaction; and

1217 (iii) a plan in which the risk does not rest upon the person who makes an arrangement,
1218 but with a class of persons who have agreed to share the risk.
1219 (93) "Insurance adjuster" means a person who directs or conducts the investigation,
1220 negotiation, or settlement of a claim under an insurance policy other than life insurance or an
1221 annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.
1222 (94) "Insurance business" or "business of insurance" includes:
1223 (a) providing health care insurance by an organization that is or is required to be
1224 licensed under this title;
1225 (b) providing a benefit to an employee in the event of a contingency not within the
1226 control of the employee, in which the employee is entitled to the benefit as a right, which
1227 benefit may be provided either:
1228 (i) by a single employer or by multiple employer groups; or
1229 (ii) through one or more trusts, associations, or other entities;
1230 (c) providing an annuity:
1231 (i) including an annuity issued in return for a gift; and
1232 (ii) except an annuity provided by a person specified in Subsections 31A-22-1305(2)
1233 and (3);
1234 (d) providing the characteristic services of a motor club as outlined in Subsection
1235 (125);
1236 (e) providing another person with insurance;
1237 (f) making as insurer, guarantor, or surety, or proposing to make as insurer, guarantor,
1238 or surety, a contract or policy of title insurance;
1239 (g) transacting or proposing to transact any phase of title insurance, including:
1240 (i) solicitation;
1241 (ii) negotiation preliminary to execution;
1242 (iii) execution of a contract of title insurance;
1243 (iv) insuring; and

1244 (v) transacting matters subsequent to the execution of the contract and arising out of
1245 the contract, including reinsurance;
1246 (h) transacting or proposing a life settlement; and
1247 (i) doing, or proposing to do, any business in substance equivalent to Subsections
1248 (94)(a) through (h) in a manner designed to evade this title.
1249 (95) "Insurance consultant" or "consultant" means a person who:
1250 (a) advises another person about insurance needs and coverages;
1251 (b) is compensated by the person advised on a basis not directly related to the insurance
1252 placed; and
1253 (c) except as provided in Section 31A-23a-501, is not compensated directly or
1254 indirectly by an insurer or producer for advice given.
1255 (96) "Insurance group" means the persons that comprise an insurance holding company
1256 system.
1257 (97) "Insurance holding company system" means a group of two or more affiliated
1258 persons, at least one of whom is an insurer.
1259 (98) (a) "Insurance producer" or "producer" means a person licensed or required to be
1260 licensed under the laws of this state to sell, solicit, or negotiate insurance.
1261 (b) (i) "Producer for the insurer" means a producer who is compensated directly or
1262 indirectly by an insurer for selling, soliciting, or negotiating an insurance product of that
1263 insurer.
1264 (ii) "Producer for the insurer" may be referred to as an "agent."
1265 (c) (i) "Producer for the insured" means a producer who:
1266 (A) is compensated directly and only by an insurance customer or an insured; and
1267 (B) receives no compensation directly or indirectly from an insurer for selling,
1268 soliciting, or negotiating an insurance product of that insurer to an insurance customer or
1269 insured.
1270 (ii) "Producer for the insured" may be referred to as a "broker."

1271 (99) (a) "Insured" means a person to whom or for whose benefit an insurer makes a
1272 promise in an insurance policy and includes:
1273 (i) a policyholder;
1274 (ii) a subscriber;
1275 (iii) a member; and
1276 (iv) a beneficiary.
1277 (b) The definition in Subsection (99)(a):
1278 (i) applies only to this title;
1279 (ii) does not define the meaning of "insured" as used in an insurance policy or
1280 certificate; and
1281 (iii) includes an enrollee.
1282 (100) (a) "Insurer" means a person doing an insurance business as a principal
1283 including:
1284 (i) a fraternal benefit society;
1285 (ii) an issuer of a gift annuity other than an annuity specified in Subsections
1286 31A-22-1305(2) and (3);
1287 (iii) a motor club;
1288 (iv) an employee welfare plan;
1289 (v) a person purporting or intending to do an insurance business as a principal on that
1290 person's own account; and
1291 (vi) a health maintenance organization.
1292 (b) "Insurer" does not include a governmental entity.
1293 (101) "Interinsurance exchange" means the same as that term is defined in Subsection
1294 (160).
1295 (102) "Internationally active insurance group" means an insurance holding company
1296 system:
1297 (a) that includes an insurer registered under Section 31A-16-105;

1298 (b) that has premiums written in at least three countries;
1299 (c) whose percentage of gross premiums written outside the United States is at least
1300 10% of its total gross written premiums; and
1301 (d) that, based on a three-year rolling average, has:
1302 (i) total assets of at least $50,000,000,000; or
1303 (ii) total gross written premiums of at least $10,000,000,000.
1304 (103) "Involuntary unemployment insurance" means insurance:
1305 (a) offered in connection with an extension of credit; and
1306 (b) that provides indemnity if the debtor is involuntarily unemployed for payments
1307 coming due on a:
1308 (i) specific loan; or
1309 (ii) credit transaction.
1310 (104) [~~(a)~~] "Large employer," in connection with a health benefit plan, means an
1311 employer who, with respect to a calendar year and to a plan year:
1312 [~~(i)~~] (a) employed an average of at least 51 employees on business days during the
1313 preceding calendar year; and
1314 [~~(ii)~~] (b) employs at least one employee on the first day of the plan year.
1315 [~~(b) The number of employees shall be determined using the method set forth in 26~~
1316 ~~U.S.C. Sec. 4980H(c)(2).~~]
1317 (105) "Late enrollee," with respect to an employer health benefit plan, means an
1318 individual whose enrollment is a late enrollment.
1319 (106) "Late enrollment," with respect to an employer health benefit plan, means
1320 enrollment of an individual other than:
1321 (a) on the earliest date on which coverage can become effective for the individual
1322 under the terms of the plan; or
1323 (b) through special enrollment.
1324 (107) (a) Except for a retainer contract or legal assistance described in Section

1325 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for a
1326 specified legal expense.
1327 (b) "Legal expense insurance" includes an arrangement that creates a reasonable
1328 expectation of an enforceable right.
1329 (c) "Legal expense insurance" does not include the provision of, or reimbursement for,
1330 legal services incidental to other insurance coverage.
1331 (108) (a) "Liability insurance" means insurance against liability:
1332 (i) for death, injury, or disability of a human being, or for damage to property,
1333 exclusive of the coverages under:
1334 (A) medical malpractice insurance;
1335 (B) professional liability insurance; and
1336 (C) workers' compensation insurance;
1337 (ii) for a medical, hospital, surgical, and funeral benefit to a person other than the
1338 insured who is injured, irrespective of legal liability of the insured, when issued with or
1339 supplemental to insurance against legal liability for the death, injury, or disability of a human
1340 being, exclusive of the coverages under:
1341 (A) medical malpractice insurance;
1342 (B) professional liability insurance; and
1343 (C) workers' compensation insurance;
1344 (iii) for loss or damage to property resulting from an accident to or explosion of a
1345 boiler, pipe, pressure container, machinery, or apparatus;
1346 (iv) for loss or damage to property caused by:
1347 (A) the breakage or leakage of a sprinkler, water pipe, or water container; or
1348 (B) water entering through a leak or opening in a building; or
1349 (v) for other loss or damage properly the subject of insurance not within another kind
1350 of insurance as defined in this chapter, if the insurance is not contrary to law or public policy.
1351 (b) "Liability insurance" includes:

1352 (i) vehicle liability insurance;
1353 (ii) residential dwelling liability insurance; and
1354 (iii) making inspection of, and issuing a certificate of inspection upon, an elevator,
1355 boiler, machinery, or apparatus of any kind when done in connection with insurance on the
1356 elevator, boiler, machinery, or apparatus.
1357 (109) (a) "License" means authorization issued by the commissioner to engage in an
1358 activity that is part of or related to the insurance business.
1359 (b) "License" includes a certificate of authority issued to an insurer.
1360 (110) (a) "Life insurance" means:
1361 (i) insurance on a human life; and
1362 (ii) insurance pertaining to or connected with human life.
1363 (b) The business of life insurance includes:
1364 (i) granting a death benefit;
1365 (ii) granting an annuity benefit;
1366 (iii) granting an endowment benefit;
1367 (iv) granting an additional benefit in the event of death by accident;
1368 (v) granting an additional benefit to safeguard the policy against lapse; and
1369 (vi) providing an optional method of settlement of proceeds.
1370 (111) "Limited license" means a license that:
1371 (a) is issued for a specific product of insurance; and
1372 (b) limits an individual or agency to transact only for that product or insurance.
1373 (112) "Limited line credit insurance" includes the following forms of insurance:
1374 (a) credit life;
1375 (b) credit accident and health;
1376 (c) credit property;
1377 (d) credit unemployment;
1378 (e) involuntary unemployment;

1379 (f) mortgage life;
1380 (g) mortgage guaranty;
1381 (h) mortgage accident and health;
1382 (i) guaranteed automobile protection; and
1383 (j) another form of insurance offered in connection with an extension of credit that:
1384 (i) is limited to partially or wholly extinguishing the credit obligation; and
1385 (ii) the commissioner determines by rule should be designated as a form of limited line
1386 credit insurance.
1387 (113) "Limited line credit insurance producer" means a person who sells, solicits, or
1388 negotiates one or more forms of limited line credit insurance coverage to an individual through
1389 a master, corporate, group, or individual policy.
1390 (114) "Limited line insurance" includes:
1391 (a) bail bond;
1392 (b) limited line credit insurance;
1393 (c) legal expense insurance;
1394 (d) motor club insurance;
1395 (e) car rental related insurance;
1396 (f) travel insurance;
1397 (g) crop insurance;
1398 (h) self-service storage insurance;
1399 (i) guaranteed asset protection waiver;
1400 (j) portable electronics insurance; and
1401 (k) another form of limited insurance that the commissioner determines by rule should
1402 be designated a form of limited line insurance.
1403 (115) "Limited lines authority" includes the lines of insurance listed in Subsection
1404 (114).
1405 (116) "Limited lines producer" means a person who sells, solicits, or negotiates limited

1406 lines insurance.
1407 (117) (a) "Long-term care insurance" means an insurance policy or rider advertised,
1408 marketed, offered, or designated to provide coverage:
1409 (i) in a setting other than an acute care unit of a hospital;
1410 (ii) for not less than 12 consecutive months for a covered person on the basis of:
1411 (A) expenses incurred;
1412 (B) indemnity;
1413 (C) prepayment; or
1414 (D) another method;
1415 (iii) for one or more necessary or medically necessary services that are:
1416 (A) diagnostic;
1417 (B) preventative;
1418 (C) therapeutic;
1419 (D) rehabilitative;
1420 (E) maintenance; or
1421 (F) personal care; and
1422 (iv) that may be issued by:
1423 (A) an insurer;
1424 (B) a fraternal benefit society;
1425 (C) (I) a nonprofit health hospital; and
1426 (II) a medical service corporation;
1427 (D) a prepaid health plan;
1428 (E) a health maintenance organization; or
1429 (F) an entity similar to the entities described in Subsections (117)(a)(iv)(A) through (E)
1430 to the extent that the entity is otherwise authorized to issue life or health care insurance.
1431 (b) "Long-term care insurance" includes:
1432 (i) any of the following that provide directly or supplement long-term care insurance:

1433 (A) a group or individual annuity or rider; or
1434 (B) a life insurance policy or rider;
1435 (ii) a policy or rider that provides for payment of benefits on the basis of:
1436 (A) cognitive impairment; or
1437 (B) functional capacity; or
1438 (iii) a qualified long-term care insurance contract.
1439 (c) "Long-term care insurance" does not include:
1440 (i) a policy that is offered primarily to provide basic Medicare supplement coverage;
1441 (ii) basic hospital expense coverage;
1442 (iii) basic medical/surgical expense coverage;
1443 (iv) hospital confinement indemnity coverage;
1444 (v) major medical expense coverage;
1445 (vi) income replacement or related asset-protection coverage;
1446 (vii) accident only coverage;
1447 (viii) coverage for a specified:
1448 (A) disease; or
1449 (B) accident;
1450 (ix) limited benefit health coverage; or
1451 (x) a life insurance policy that accelerates the death benefit to provide the option of a
1452 lump sum payment:
1453 (A) if the following are not conditioned on the receipt of long-term care:
1454 (I) benefits; or
1455 (II) eligibility; and
1456 (B) the coverage is for one or more the following qualifying events:
1457 (I) terminal illness;
1458 (II) medical conditions requiring extraordinary medical intervention; or
1459 (III) permanent institutional confinement.

1460 (118) "Managed care organization" means a person:
1461 (a) licensed as a health maintenance organization under Chapter 8, Health Maintenance
1462 Organizations and Limited Health Plans; or
1463 (b) (i) licensed under:
1464 (A) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
1465 (B) Chapter 7, Nonprofit Health Service Insurance Corporations; or
1466 (C) Chapter 14, Foreign Insurers; and
1467 (ii) that requires an enrollee to use, or offers incentives, including financial incentives,
1468 for an enrollee to use, network providers.
1469 (119) "Medical malpractice insurance" means insurance against legal liability incident
1470 to the practice and provision of a medical service other than the practice and provision of a
1471 dental service.
1472 (120) "Member" means a person having membership rights in an insurance
1473 corporation.
1474 (121) "Minimum capital" or "minimum required capital" means the capital that must be
1475 constantly maintained by a stock insurance corporation as required by statute.
1476 (122) "Mortgage accident and health insurance" means insurance offered in connection
1477 with an extension of credit that provides indemnity for payments coming due on a mortgage
1478 while the debtor has a disability.
1479 (123) "Mortgage guaranty insurance" means surety insurance under which a mortgagee
1480 or other creditor is indemnified against losses caused by the default of a debtor.
1481 (124) "Mortgage life insurance" means insurance on the life of a debtor in connection
1482 with an extension of credit that pays if the debtor dies.
1483 (125) "Motor club" means a person:
1484 (a) licensed under:
1485 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
1486 (ii) Chapter 11, Motor Clubs; or

1487 (iii) Chapter 14, Foreign Insurers; and

1488 (b) that promises for an advance consideration to provide for a stated period of time

1489 one or more:

1490 (i) legal services under Subsection 31A-11-102(1)(b);

1491 (ii) bail services under Subsection 31A-11-102(1)(c); or

1492 (iii) (A) trip reimbursement;

1493 (B) towing services;

1494 (C) emergency road services;

1495 (D) stolen automobile services;

1496 (E) a combination of the services listed in Subsections (125)(b)(iii)(A) through (D); or

1497 (F) other services given in Subsections 31A-11-102(1)(b) through (f).

1498 (126) "Mutual" means a mutual insurance corporation.

1499 (127) "Network plan" means health care insurance:

1500 (a) that is issued by an insurer; and

1501 (b) under which the financing and delivery of medical care is provided, in whole or in

1502 part, through a defined set of providers under contract with the insurer, including the financing

1503 and delivery of an item paid for as medical care.

1504 (128) "Network provider" means a health care provider who has an agreement with a

1505 managed care organization to provide health care services to an enrollee with an expectation of

1506 receiving payment, other than coinsurance, copayments, or deductibles, directly from the

1507 managed care organization.

1508 (129) "Nonparticipating" means a plan of insurance under which the insured is not

1509 entitled to receive a dividend representing a share of the surplus of the insurer.

1510 (130) "Ocean marine insurance" means insurance against loss of or damage to:

1511 (a) ships or hulls of ships;

1512 (b) goods, freight, cargoes, merchandise, effects, disbursements, profits, money,

1513 securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia

1514 interests, or other cargoes in or awaiting transit over the oceans or inland waterways;
1515 (c) earnings such as freight, passage money, commissions, or profits derived from
1516 transporting goods or people upon or across the oceans or inland waterways; or
1517 (d) a vessel owner or operator as a result of liability to employees, passengers, bailors,
1518 owners of other vessels, owners of fixed objects, customs or other authorities, or other persons
1519 in connection with maritime activity.
1520 (131) "Order" means an order of the commissioner.
1521 (132) "ORSA guidance manual" means the current version of the Own Risk and
1522 Solvency Assessment Guidance Manual developed and adopted by the National Association of
1523 Insurance Commissioners and as amended from time to time.
1524 (133) "ORSA summary report" means a confidential high-level summary of an insurer
1525 or insurance group's own risk and solvency assessment.
1526 (134) "Outline of coverage" means a summary that explains an accident and health
1527 insurance policy.
1528 (135) "Own risk and solvency assessment" means an insurer or insurance group's
1529 confidential internal assessment:
1530 (a) (i) of each material and relevant risk associated with the insurer or insurance group;
1531 (ii) of the insurer or insurance group's current business plan to support each risk
1532 described in Subsection (135)(a)(i); and
1533 (iii) of the sufficiency of capital resources to support each risk described in Subsection
1534 (135)(a)(i); and
1535 (b) that is appropriate to the nature, scale, and complexity of an insurer or insurance
1536 group.
1537 (136) "Participating" means a plan of insurance under which the insured is entitled to
1538 receive a dividend representing a share of the surplus of the insurer.
1539 (137) "Participation," as used in a health benefit plan, means a requirement relating to
1540 the minimum percentage of eligible employees that must be enrolled in relation to the total

1541 number of eligible employees of an employer reduced by each eligible employee who
1542 voluntarily declines coverage under the plan because the employee:
1543 (a) has other group health care insurance coverage; or
1544 (b) receives:
1545 (i) Medicare, under the Health Insurance for the Aged Act, Title XVIII of the Social
1546 Security Amendments of 1965; or
1547 (ii) another government health benefit.
1548 (138) "Person" includes:
1549 (a) an individual;
1550 (b) a partnership;
1551 (c) a corporation;
1552 (d) an incorporated or unincorporated association;
1553 (e) a joint stock company;
1554 (f) a trust;
1555 (g) a limited liability company;
1556 (h) a reciprocal;
1557 (i) a syndicate; or
1558 (j) another similar entity or combination of entities acting in concert.
1559 (139) "Personal lines insurance" means property and casualty insurance coverage sold
1560 for primarily noncommercial purposes to:
1561 (a) an individual; or
1562 (b) a family.
1563 (140) "Plan sponsor" means the same as that term is defined in 29 U.S.C. Sec.
1564 1002(16)(B).
1565 (141) "Plan year" means:
1566 (a) the year that is designated as the plan year in:
1567 (i) the plan document of a group health plan; or

1568 (ii) a summary plan description of a group health plan;
1569 (b) if the plan document or summary plan description does not designate a plan year or
1570 there is no plan document or summary plan description:
1571 (i) the year used to determine deductibles or limits;
1572 (ii) the policy year, if the plan does not impose deductibles or limits on a yearly basis;
1573 or
1574 (iii) the employer's taxable year if:
1575 (A) the plan does not impose deductibles or limits on a yearly basis; and
1576 (B) (I) the plan is not insured; or
1577 (II) the insurance policy is not renewed on an annual basis; or
1578 (c) in a case not described in Subsection (141)(a) or (b), the calendar year.
1579 (142) (a) "Policy" means a document, including an attached endorsement or application
1580 that:
1581 (i) purports to be an enforceable contract; and
1582 (ii) memorializes in writing some or all of the terms of an insurance contract.
1583 (b) "Policy" includes a service contract issued by:
1584 (i) a motor club under Chapter 11, Motor Clubs;
1585 (ii) a service contract provided under Chapter 6a, Service Contracts; and
1586 (iii) a corporation licensed under:
1587 (A) Chapter 7, Nonprofit Health Service Insurance Corporations; or
1588 (B) Chapter 8, Health Maintenance Organizations and Limited Health Plans.
1589 (c) "Policy" does not include:
1590 (i) a certificate under a group insurance contract; or
1591 (ii) a document that does not purport to have legal effect.
1592 (143) "Policyholder" means a person who controls a policy, binder, or oral contract by
1593 ownership, premium payment, or otherwise.
1594 (144) "Policy illustration" means a presentation or depiction that includes

1595 nonguaranteed elements of a policy of life insurance over a period of years.

1596 (145) "Policy summary" means a synopsis describing the elements of a life insurance
1597 policy.

1598 (146) "PPACA" means the Patient Protection and Affordable Care Act, Pub. L. No.
1599 111-148 and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, and
1600 related federal regulations and guidance.

1601 (147) "Preexisting condition," with respect to health care insurance:

1602 (a) means a condition that was present before the effective date of coverage, whether or
1603 not medical advice, diagnosis, care, or treatment was recommended or received before that day;
1604 and

1605 (b) does not include a condition indicated by genetic information unless an actual
1606 diagnosis of the condition by a physician has been made.

1607 (148) (a) "Premium" means the monetary consideration for an insurance policy.

1608 (b) "Premium" includes, however designated:

1609 (i) an assessment;

1610 (ii) a membership fee;

1611 (iii) a required contribution; or

1612 (iv) monetary consideration.

1613 (c) (i) "Premium" does not include consideration paid to a third party administrator for
1614 the third party administrator's services.

1615 (ii) "Premium" includes an amount paid by a third party administrator to an insurer for
1616 insurance on the risks administered by the third party administrator.

1617 (149) "Principal officers" for a corporation means the officers designated under
1618 Subsection 31A-5-203(3).

1619 (150) "Proceeding" includes an action or special statutory proceeding.

1620 (151) "Professional liability insurance" means insurance against legal liability incident
1621 to the practice of a profession and provision of a professional service.

1622 (152) (a) Except as provided in Subsection (152)(b), "property insurance" means
1623 insurance against loss or damage to real or personal property of every kind and any interest in
1624 that property:
1625 (i) from all hazards or causes; and
1626 (ii) against loss consequential upon the loss or damage including vehicle
1627 comprehensive and vehicle physical damage coverages.
1628 (b) "Property insurance" does not include:
1629 (i) inland marine insurance; and
1630 (ii) ocean marine insurance.
1631 (153) "Qualified long-term care insurance contract" or "federally tax qualified
1632 long-term care insurance contract" means:
1633 (a) an individual or group insurance contract that meets the requirements of Section
1634 7702B(b), Internal Revenue Code; or
1635 (b) the portion of a life insurance contract that provides long-term care insurance:
1636 (i) (A) by rider; or
1637 (B) as a part of the contract; and
1638 (ii) that satisfies the requirements of Sections 7702B(b) and (e), Internal Revenue
1639 Code.
1640 (154) "Qualified United States financial institution" means an institution that:
1641 (a) is:
1642 (i) organized under the laws of the United States or any state; or
1643 (ii) in the case of a United States office of a foreign banking organization, licensed
1644 under the laws of the United States or any state;
1645 (b) is regulated, supervised, and examined by a United States federal or state authority
1646 having regulatory authority over a bank or trust company; and
1647 (c) meets the standards of financial condition and standing that are considered
1648 necessary and appropriate to regulate the quality of a financial institution whose letters of credit

1649 will be acceptable to the commissioner as determined by:
1650 (i) the commissioner by rule; or
1651 (ii) the Securities Valuation Office of the National Association of Insurance
1652 Commissioners.
1653 (155) (a) "Rate" means:
1654 (i) the cost of a given unit of insurance; or
1655 (ii) for property or casualty insurance, that cost of insurance per exposure unit either
1656 expressed as:
1657 (A) a single number; or
1658 (B) a pure premium rate, adjusted before the application of individual risk variations
1659 based on loss or expense considerations to account for the treatment of:
1660 (I) expenses;
1661 (II) profit; and
1662 (III) individual insurer variation in loss experience.
1663 (b) "Rate" does not include a minimum premium.
1664 (156) (a) Except as provided in Subsection (156)(b), "rate service organization" means
1665 a person who assists an insurer in rate making or filing by:
1666 (i) collecting, compiling, and furnishing loss or expense statistics;
1667 (ii) recommending, making, or filing rates or supplementary rate information; or
1668 (iii) advising about rate questions, except as an attorney giving legal advice.
1669 (b) "Rate service organization" does not mean:
1670 (i) an employee of an insurer;
1671 (ii) a single insurer or group of insurers under common control;
1672 (iii) a joint underwriting group; or
1673 (iv) an individual serving as an actuarial or legal consultant.
1674 (157) "Rating manual" means any of the following used to determine initial and
1675 renewal policy premiums:

1676 (a) a manual of rates;
1677 (b) a classification;
1678 (c) a rate-related underwriting rule; and
1679 (d) a rating formula that describes steps, policies, and procedures for determining
1680 initial and renewal policy premiums.
1681 (158) (a) "Rebate" means a licensee paying, allowing, giving, or offering to pay, allow,
1682 or give, directly or indirectly:
1683 (i) a refund of premium or portion of premium;
1684 (ii) a refund of commission or portion of commission;
1685 (iii) a refund of all or a portion of a consultant fee; or
1686 (iv) providing services or other benefits not specified in an insurance or annuity
1687 contract.
1688 (b) "Rebate" does not include:
1689 (i) a refund due to termination or changes in coverage;
1690 (ii) a refund due to overcharges made in error by the licensee; or
1691 (iii) savings or wellness benefits as provided in the contract by the licensee.
1692 (159) "Received by the department" means:
1693 (a) the date delivered to and stamped received by the department, if delivered in
1694 person;
1695 (b) the post mark date, if delivered by mail;
1696 (c) the delivery service's post mark or pickup date, if delivered by a delivery service;
1697 (d) the received date recorded on an item delivered, if delivered by:
1698 (i) facsimile;
1699 (ii) email; or
1700 (iii) another electronic method; or
1701 (e) a date specified in:
1702 (i) a statute;

1703 (ii) a rule; or
1704 (iii) an order.
1705 (160) "Reciprocal" or "interinsurance exchange" means an unincorporated association
1706 of persons:
1707 (a) operating through an attorney-in-fact common to all of the persons; and
1708 (b) exchanging insurance contracts with one another that provide insurance coverage
1709 on each other.
1710 (161) "Reinsurance" means an insurance transaction where an insurer, for
1711 consideration, transfers any portion of the risk it has assumed to another insurer. In referring to
1712 reinsurance transactions, this title sometimes refers to:
1713 (a) the insurer transferring the risk as the "ceding insurer"; and
1714 (b) the insurer assuming the risk as the:
1715 (i) "assuming insurer"; or
1716 (ii) "assuming reinsurer."
1717 (162) "Reinsurer" means a person licensed in this state as an insurer with the authority
1718 to assume reinsurance.
1719 (163) "Residential dwelling liability insurance" means insurance against liability
1720 resulting from or incident to the ownership, maintenance, or use of a residential dwelling that is
1721 a detached single family residence or multifamily residence up to four units.
1722 (164) (a) "Retrocession" means reinsurance with another insurer of a liability assumed
1723 under a reinsurance contract.
1724 (b) A reinsurer "retrocedes" when the reinsurer reinsures with another insurer part of a
1725 liability assumed under a reinsurance contract.
1726 (165) "Rider" means an endorsement to:
1727 (a) an insurance policy; or
1728 (b) an insurance certificate.
1729 (166) "Secondary medical condition" means a complication related to an exclusion

1730 from coverage in accident and health insurance.
1731 (167) (a) "Security" means a:
1732 (i) note;
1733 (ii) stock;
1734 (iii) bond;
1735 (iv) debenture;
1736 (v) evidence of indebtedness;
1737 (vi) certificate of interest or participation in a profit-sharing agreement;
1738 (vii) collateral-trust certificate;
1739 (viii) preorganization certificate or subscription;
1740 (ix) transferable share;
1741 (x) investment contract;
1742 (xi) voting trust certificate;
1743 (xii) certificate of deposit for a security;
1744 (xiii) certificate of interest of participation in an oil, gas, or mining title or lease or in
1745 payments out of production under such a title or lease;
1746 (xiv) commodity contract or commodity option;
1747 (xv) certificate of interest or participation in, temporary or interim certificate for,
1748 receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed
1749 in Subsections (167)(a)(i) through (xiv); or
1750 (xvi) another interest or instrument commonly known as a security.
1751 (b) "Security" does not include:
1752 (i) any of the following under which an insurance company promises to pay money in a
1753 specific lump sum or periodically for life or some other specified period:
1754 (A) insurance;
1755 (B) an endowment policy; or
1756 (C) an annuity contract; or

1757 (ii) a burial certificate or burial contract.
1758 (168) "Securityholder" means a specified person who owns a security of a person,
1759 including:
1760 (a) common stock;
1761 (b) preferred stock;
1762 (c) debt obligations; and
1763 (d) any other security convertible into or evidencing the right of any of the items listed
1764 in this Subsection (168).
1765 (169) (a) "Self-insurance" means an arrangement under which a person provides for
1766 spreading its own risks by a systematic plan.
1767 (b) Except as provided in this Subsection (169), "self-insurance" does not include an
1768 arrangement under which a number of persons spread their risks among themselves.
1769 (c) "Self-insurance" includes:
1770 (i) an arrangement by which a governmental entity undertakes to indemnify an
1771 employee for liability arising out of the employee's employment; and
1772 (ii) an arrangement by which a person with a managed program of self-insurance and
1773 risk management undertakes to indemnify its affiliates, subsidiaries, directors, officers, or
1774 employees for liability or risk that is related to the relationship or employment.
1775 (d) "Self-insurance" does not include an arrangement with an independent contractor.
1776 (170) "Sell" means to exchange a contract of insurance:
1777 (a) by any means;
1778 (b) for money or its equivalent; and
1779 (c) on behalf of an insurance company.
1780 (171) "Short-term care insurance" means an insurance policy or rider advertised,
1781 marketed, offered, or designed to provide coverage that is similar to long-term care insurance,
1782 but that provides coverage for less than 12 consecutive months for each covered person.
1783 (172) "Short-term [~~limited duration health~~], limited-duration insurance" means a health

1784 benefit product that:
1785 (a) after taking into account any renewals or extensions, has a total duration of no more
1786 than 36 months; and
1787 (b) has an expiration date specified in the contract that is less than 12 months after the
1788 original effective date of coverage under the health benefit product.
1789 (173) "Significant break in coverage" means a period of 63 consecutive days during
1790 each of which an individual does not have creditable coverage.
1791 (174) (a) "Small employer" means, in connection with a health benefit plan and with
1792 respect to a calendar year and to a plan year, an employer who:
1793 (i) (A) employed at least one but not more than 50 eligible employees on business days
1794 during the preceding calendar year; or
1795 (B) if the employer did not exist for the entirety of the preceding calendar year,
1796 reasonably expects to employ an average of at least one but not more than 50 eligible
1797 employees on business days during the current calendar year;
1798 (ii) employs at least one employee on the first day of the plan year; and
1799 (iii) for an employer who has common ownership with one or more other employers, is
1800 treated as a single employer under 26 U.S.C. Sec. 414(b), (c), (m), or (o).
1801 (b) "Small employer" does not include a sole proprietor that does not employ at least
1802 one employee.
1803 (175) "Special enrollment period," in connection with a health benefit plan, has the
1804 same meaning as provided in federal regulations adopted pursuant to the Health Insurance
1805 Portability and Accountability Act.
1806 (176) (a) "Subsidiary" of a person means an affiliate controlled by that person either
1807 directly or indirectly through one or more affiliates or intermediaries.
1808 (b) "Wholly owned subsidiary" of a person is a subsidiary of which all of the voting
1809 shares are owned by that person either alone or with its affiliates, except for the minimum
1810 number of shares the law of the subsidiary's domicile requires to be owned by directors or

1811 others.

1812 (177) Subject to Subsection (91)(b), "surety insurance" includes:

1813 (a) a guarantee against loss or damage resulting from the failure of a principal to pay or

1814 perform the principal's obligations to a creditor or other obligee;

1815 (b) bail bond insurance; and

1816 (c) fidelity insurance.

1817 (178) (a) "Surplus" means the excess of assets over the sum of paid-in capital and

1818 liabilities.

1819 (b) (i) "Permanent surplus" means the surplus of an insurer or organization that is

1820 designated by the insurer or organization as permanent.

1821 (ii) Sections 31A-5-211, 31A-7-201, 31A-8-209, 31A-9-209, and 31A-14-205 require

1822 that insurers or organizations doing business in this state maintain specified minimum levels of

1823 permanent surplus.

1824 (iii) Except for assessable mutuals, the minimum permanent surplus requirement is the

1825 same as the minimum required capital requirement that applies to stock insurers.

1826 (c) "Excess surplus" means:

1827 (i) for a life insurer, accident and health insurer, health organization, or property and

1828 casualty insurer as defined in Section 31A-17-601, the lesser of:

1829 (A) that amount of an insurer's or health organization's total adjusted capital that

1830 exceeds the product of:

1831 (I) 2.5; and

1832 (II) the sum of the insurer's or health organization's minimum capital or permanent

1833 surplus required under Section 31A-5-211, 31A-9-209, or 31A-14-205; or

1834 (B) that amount of an insurer's or health organization's total adjusted capital that

1835 exceeds the product of:

1836 (I) 3.0; and

1837 (II) the authorized control level RBC as defined in Subsection 31A-17-601(8)(a); and

1838 (ii) for a monoline mortgage guaranty insurer, financial guaranty insurer, or title insurer
1839 that amount of an insurer's paid-in-capital and surplus that exceeds the product of:
1840 (A) 1.5; and
1841 (B) the insurer's total adjusted capital required by Subsection 31A-17-609(1).
1842 (179) "Third party administrator" or "administrator" means a person who collects
1843 charges or premiums from, or who, for consideration, adjusts or settles claims of residents of
1844 the state in connection with insurance coverage, annuities, or service insurance coverage,
1845 except:
1846 (a) a union on behalf of its members;
1847 (b) a person administering a:
1848 (i) pension plan subject to the federal Employee Retirement Income Security Act of
1849 1974;
1850 (ii) governmental plan as defined in Section 414(d), Internal Revenue Code; or
1851 (iii) nonelecting church plan as described in Section 410(d), Internal Revenue Code;
1852 (c) an employer on behalf of the employer's employees or the employees of one or
1853 more of the subsidiary or affiliated corporations of the employer;
1854 (d) an insurer licensed under the following, but only for a line of insurance for which
1855 the insurer holds a license in this state:
1856 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
1857 (ii) Chapter 7, Nonprofit Health Service Insurance Corporations;
1858 (iii) Chapter 8, Health Maintenance Organizations and Limited Health Plans;
1859 (iv) Chapter 9, Insurance Fraternals; or
1860 (v) Chapter 14, Foreign Insurers;
1861 (e) a person:
1862 (i) licensed or exempt from licensing under:
1863 (A) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and
1864 Reinsurance Intermediaries; or

1865 (B) Chapter 26, Insurance Adjusters; and
1866 (ii) whose activities are limited to those authorized under the license the person holds
1867 or for which the person is exempt; or
1868 (f) an institution, bank, or financial institution:
1869 (i) that is:
1870 (A) an institution whose deposits and accounts are to any extent insured by a federal
1871 deposit insurance agency, including the Federal Deposit Insurance Corporation or National
1872 Credit Union Administration; or
1873 (B) a bank or other financial institution that is subject to supervision or examination by
1874 a federal or state banking authority; and
1875 (ii) that does not adjust claims without a third party administrator license.
1876 (180) "Title insurance" means the insuring, guaranteeing, or indemnifying of an owner
1877 of real or personal property or the holder of liens or encumbrances on that property, or others
1878 interested in the property against loss or damage suffered by reason of liens or encumbrances
1879 upon, defects in, or the unmarketability of the title to the property, or invalidity or
1880 unenforceability of any liens or encumbrances on the property.
1881 (181) "Total adjusted capital" means the sum of an insurer's or health organization's
1882 statutory capital and surplus as determined in accordance with:
1883 (a) the statutory accounting applicable to the annual financial statements required to be
1884 filed under Section 31A-4-113; and
1885 (b) another item provided by the RBC instructions, as RBC instructions is defined in
1886 Section 31A-17-601.
1887 (182) (a) "Trustee" means "director" when referring to the board of directors of a
1888 corporation.
1889 (b) "Trustee," when used in reference to an employee welfare fund, means an
1890 individual, firm, association, organization, joint stock company, or corporation, whether acting
1891 individually or jointly and whether designated by that name or any other, that is charged with

1892 or has the overall management of an employee welfare fund.
1893 (183) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted insurer"
1894 means an insurer:
1895 (i) not holding a valid certificate of authority to do an insurance business in this state;
1896 or
1897 (ii) transacting business not authorized by a valid certificate.
1898 (b) "Admitted insurer" or "authorized insurer" means an insurer:
1899 (i) holding a valid certificate of authority to do an insurance business in this state; and
1900 (ii) transacting business as authorized by a valid certificate.
1901 (184) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.
1902 (185) "Vehicle liability insurance" means insurance against liability resulting from or
1903 incident to ownership, maintenance, or use of a land vehicle or aircraft, exclusive of a vehicle
1904 comprehensive or vehicle physical damage coverage under Subsection (152).
1905 (186) "Voting security" means a security with voting rights, and includes a security
1906 convertible into a security with a voting right associated with the security.
1907 (187) "Waiting period" for a health benefit plan means the period that must pass before
1908 coverage for an individual, who is otherwise eligible to enroll under the terms of the health
1909 benefit plan, can become effective.
1910 (188) "Workers' compensation insurance" means:
1911 (a) insurance for indemnification of an employer against liability for compensation
1912 based on:
1913 (i) a compensable accidental injury; and
1914 (ii) occupational disease disability;
1915 (b) employer's liability insurance incidental to workers' compensation insurance and
1916 written in connection with workers' compensation insurance; and
1917 (c) insurance assuring to a person entitled to workers' compensation benefits the
1918 compensation provided by law.

1919 Section 6. Section **31A-2-104** is amended to read:

1920 **31A-2-104. Other employees -- Insurance fraud investigators.**

1921 (1) The department shall employ [~~a chief examiner and such other~~] professional,

1922 technical, and clerical employees as necessary to carry out the duties of the department.

1923 (2) An insurance fraud investigator employed [~~pursuant to~~] in accordance with

1924 Subsection (1) may as [~~approved by~~] the commissioner approves:

1925 (a) be designated a law enforcement officer, as defined in Section 53-13-103; and

1926 (b) be eligible for retirement benefits under the Public Safety Employee's Retirement

1927 System.

1928 Section 7. Section **31A-2-110** is amended to read:

1929 **31A-2-110. Official seal and signature.**

1930 (1) (a) Any statutory or common-law requirement that an official seal be affixed is

1931 satisfied by the signature of the commissioner.

1932 (b) However, the commissioner may adopt and use a seal bearing the words

1933 "Commissioner of Insurance for Utah," an impression of which shall be filed with the Division

1934 of Archives.

1935 (2) Any signature of the commissioner may be in [~~facsimile~~] a format that affixes an

1936 exact copy of the signature, unless specifically required to be handwritten.

1937 Section 8. Section **31A-2-212** is amended to read:

1938 **31A-2-212. Miscellaneous duties.**

1939 (1) Upon issuance of an order limiting, suspending, or revoking a person's authority to

1940 do business in Utah, and when the commissioner begins a proceeding against an insurer under

1941 Chapter 27a, Insurer Receivership Act, the commissioner:

1942 (a) shall notify by mail the producers of the person or insurer of whom the

1943 commissioner has record; and

1944 (b) may publish notice of the order or proceeding in any manner the commissioner

1945 considers necessary to protect the rights of the public.

1946 (2) (a) When required for evidence in a legal proceeding, the commissioner shall
1947 furnish a certificate of authority of a licensee to transact the business of insurance in Utah on
1948 any particular date.
1949 (b) The court or other officer shall receive [~~the~~] a certificate of authority described in
1950 this Subsection (2) in lieu of the commissioner's testimony.
1951 (3) (a) On the request of an insurer authorized to do a surety business, the
1952 commissioner shall furnish a copy of the insurer's certificate of authority to a designated public
1953 officer in this state who requires that certificate of authority before accepting a bond.
1954 (b) The public officer described in Subsection (3)(a) shall file the certificate of
1955 authority furnished under Subsection (3)(a).
1956 (c) After a certified copy of a certificate of authority is furnished to a public officer, it
1957 is not necessary, while the certificate of authority remains effective, to attach a copy of it to any
1958 instrument of suretyship filed with that public officer.
1959 (d) Whenever the commissioner revokes the certificate of authority or begins a
1960 proceeding under Chapter 27a, Insurer Receivership Act, against an insurer authorized to do a
1961 surety business, the commissioner shall immediately give notice of that action to each public
1962 officer who is sent a certified copy under this Subsection (3).
1963 (4) (a) The commissioner shall immediately notify every judge and clerk of the courts
1964 of record in the state when:
1965 (i) an authorized insurer doing a surety business:
1966 (A) files a petition for receivership; or
1967 (B) is in receivership; or
1968 (ii) the commissioner has reason to believe that the authorized insurer doing surety
1969 business:
1970 (A) is in financial difficulty; or
1971 (B) has unreasonably failed to carry out any of [~~its~~] the authorized insurer's contracts.
1972 (b) Upon the receipt of the notice required by this Subsection (4), it is the duty of the

1973 judges and clerks to notify and require a person that files with the court a bond on which the
1974 authorized insurer doing surety business is surety to immediately file a new bond with a new
1975 surety.
1976 [~~(5) (a) The commissioner shall report to the Legislature in accordance with Section~~
1977 ~~63N-11-106 before adopting a rule authorized by Subsection (5)(b).~~]
1978 [~~(b)~~] (5) (a) The commissioner shall require an insurer that issues, sells, renews, or
1979 offers health insurance coverage in this state to comply with PPACA and administrative rules
1980 adopted by the commissioner related to regulation of health benefit plans, including:
1981 (i) lifetime and annual limits;
1982 (ii) prohibition of rescissions;
1983 (iii) coverage of preventive health services;
1984 (iv) coverage for a child or dependent;
1985 (v) pre-existing condition limitations;
1986 (vi) insurer transparency of consumer information including plan disclosures, uniform
1987 coverage documents, and standard definitions;
1988 (vii) premium rate reviews;
1989 (viii) essential health benefits;
1990 (ix) provider choice;
1991 (x) waiting periods;
1992 (xi) appeals processes;
1993 (xii) rating restrictions;
1994 (xiii) uniform applications and notice provisions;
1995 (xiv) certification and regulation of qualified health plans; and
1996 (xv) network adequacy standards.
1997 [~~(c)~~] (b) The commissioner shall preserve state control over:
1998 (i) the health insurance market in the state;
1999 (ii) qualified health plans offered in the state; and

2000 (iii) the conduct of navigators, producers, and in-person assisters operating in the state.

2001 [(d) If the state enters into an agreement with the United States Department of Health
2002 and Human Services in which the state operates health insurance plan management, the
2003 commissioner may:]

2004 [(i) for fiscal year 2014, hire one temporary and two permanent full-time employees to
2005 be funded through the department's existing budget; and]

2006 [(ii) for fiscal year 2015, hire two permanent full-time employees funded through the
2007 Insurance Department Restricted Account, subject to appropriations from the Legislature and
2008 approval by the governor.]

2009 Section 9. Section **31A-2-218** is amended to read:

2010 **31A-2-218. Strategic plan for health system reform.**

2011 The commissioner and the department shall:

2012 [(1) work with the Governor's Office of Economic Development, the Department of
2013 Health, the Department of Workforce Services, and the Legislature to develop health system
2014 reform in accordance with the strategic plan described in Title 63N, Chapter 11, Health System
2015 Reform Act;]

2016 [(2) work with health insurers in accordance with Section 31A-22-635 to develop
2017 standards for health insurance applications and compatible electronic systems;]

2018 [(3)] (1) facilitate a private sector method for the collection of health insurance
2019 premium payments made for a single policy by multiple payers, including the policyholder, one
2020 or more employers of one or more individuals covered by the policy, government programs,
2021 and others by educating employers and insurers about collection services available through
2022 private vendors, including financial institutions;

2023 [(4)] (2) encourage health insurers to develop products that:

2024 (a) encourage health care providers to follow best practice protocols;

2025 (b) incorporate other health care quality improvement mechanisms; and

2026 (c) incorporate rewards and incentives for healthy lifestyles and behaviors as permitted

2027 by the Health Insurance Portability and Accountability Act;
2028 [(5)] (3) involve the Office of Consumer Health Assistance created in Section
2029 31A-2-216, as necessary, to accomplish the requirements of this section; and
2030 [(6)] (4) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking
2031 Act, make rules, as necessary, to implement Subsections (1) and (2)[, (3), and (4)].
2032 Section 10. Section **31A-2-309** is amended to read:
2033 **31A-2-309. Service of process through state officer.**
2034 (1) The commissioner, or the lieutenant governor when the subject proceeding is
2035 brought by the state, is the agent for receipt of service of a summons, notice, order, pleading, or
2036 other legal process relating to a Utah court or administrative agency upon the following:
2037 (a) an insurer authorized to do business in this state, while authorized to do business in
2038 this state, and thereafter in a proceeding arising from or related to a transaction having a
2039 connection with this state;
2040 (b) a surplus lines insurer for a proceeding arising out of a contract of insurance that is
2041 subject to the surplus lines law, or out of a certificate, cover note, or other confirmation of that
2042 type of insurance;
2043 (c) an unauthorized insurer or other person assisting an unauthorized insurer under
2044 Subsection 31A-15-102(1) by doing an act specified in Subsection 31A-15-102(2), for a
2045 proceeding arising out of a transaction that is subject to the unauthorized insurance law;
2046 (d) a nonresident producer, consultant, adjuster, or third party administrator, while
2047 authorized to do business in this state, and thereafter in a proceeding arising from or related to
2048 a transaction having a connection with this state; and
2049 (e) a reinsurer submitting to the commissioner's jurisdiction under Subsection
2050 31A-17-404[(9)](11).
2051 (2) The following is considered to have irrevocably appointed the commissioner and
2052 lieutenant governor as that person's agents in accordance with Subsection (1):
2053 (a) a licensed insurer by applying for and receiving a certificate of authority;

2054 (b) a surplus lines insurer by entering into a contract subject to the surplus lines law;
2055 (c) an unauthorized insurer by doing in this state an act prohibited by Section
2056 31A-15-103; and
2057 (d) a nonresident producer, consultant, adjuster, and third party administrator.
2058 (3) The commissioner and lieutenant governor are also agents for an executor,
2059 administrator, personal representative, receiver, trustee, or other successor in interest of a
2060 person specified under Subsection (1).
2061 (4) A litigant serving process on the commissioner or lieutenant governor under this
2062 section shall pay the fee applicable under Section 31A-3-103.
2063 (5) The right to substituted service under this section does not limit the right to serve a
2064 summons, notice, order, pleading, demand, or other process upon a person in another manner
2065 provided by law.
2066 Section 11. Section **31A-2-403** is amended to read:
2067 **31A-2-403. Title and Escrow Commission created.**
2068 (1) (a) Subject to Subsection (1)(b), there is created within the department the Title and
2069 Escrow Commission that is comprised of five members appointed by the governor with the
2070 consent of the Senate as follows:
2071 (i) except as provided in Subsection [~~(1)(c)~~] (1)(d), two members shall be employees of
2072 a title insurer;
2073 (ii) two members shall:
2074 (A) be employees of a Utah agency title insurance producer;
2075 (B) be or have been licensed under the title insurance line of authority;
2076 (C) as of the day on which the member is appointed, be or have been licensed with the
2077 title examination or escrow subline of authority for at least five years; and
2078 (D) as of the day on which the member is appointed, not be from the same county as
2079 another member appointed under this Subsection (1)(a)(ii); and
2080 (iii) one member shall be a member of the general public from any county in the state.

2081 (b) No more than one commission member may be appointed from a single company
2082 or an affiliate or subsidiary of the company.
2083 (c) No more than two commission members may be employees of an entity operating
2084 under an affiliated business arrangement, as defined in Section 31A-23a-1001.
2085 [(c)] (d) If the governor is unable to identify more than one individual who is an
2086 employee of a title insurer and willing to serve as a member of the commission, the
2087 commission shall include the following members in lieu of the members described in
2088 Subsection (1)(a)(i):
2089 (i) one member who is an employee of a title insurer; and
2090 (ii) one member who is an employee of a Utah agency title insurance producer.
2091 (2) (a) Subject to Subsection (2)(c), a commission member shall file with the
2092 commissioner a disclosure of any position of employment or ownership interest that the
2093 commission member has with respect to a person that is subject to the jurisdiction of the
2094 commissioner.
2095 (b) The disclosure statement required by this Subsection (2) shall be:
2096 (i) filed by no later than the day on which the person begins that person's appointment;
2097 and
2098 (ii) amended when a significant change occurs in any matter required to be disclosed
2099 under this Subsection (2).
2100 (c) A commission member is not required to disclose an ownership interest that the
2101 commission member has if the ownership interest is in a publicly traded company or held as
2102 part of a mutual fund, trust, or similar investment.
2103 (3) (a) Except as required by Subsection (3)(b), as terms of current commission
2104 members expire, the governor shall appoint each new commission member to a four-year term
2105 ending on June 30.
2106 (b) Notwithstanding the requirements of Subsection (3)(a), the governor shall, at the
2107 time of appointment, adjust the length of terms to ensure that the terms of the commission

2108 members are staggered so that approximately half of the members appointed under Subsection
2109 (1)(a)(i) and half of the members appointed under Subsection (1)(a)(ii) are appointed every two
2110 years.
2111 (c) A commission member may not serve more than one consecutive term.
2112 (d) When a vacancy occurs in the membership for any reason, the governor, with the
2113 consent of the Senate, shall appoint a replacement for the unexpired term.
2114 (e) Notwithstanding the other provisions of this Subsection (3), a commission member
2115 serves until a successor is appointed by the governor with the consent of the Senate.
2116 (4) A commission member may not receive compensation or benefits for the
2117 commission member's service, but may receive per diem and travel expenses in accordance
2118 with:
2119 (a) Section 63A-3-106;
2120 (b) Section 63A-3-107; and
2121 (c) rules made by the Division of Finance pursuant to Sections 63A-3-106 and
2122 63A-3-107.
2123 (5) Members of the commission shall annually select one commission member to serve
2124 as chair.
2125 (6) (a) (i) Except as provided in Subsection (6)(b), the commission shall meet at least
2126 monthly.
2127 (ii) (A) The commissioner shall, with the concurrence of the chair of the commission,
2128 designate at least one monthly meeting per quarter as an in-person meeting.
2129 (B) Notwithstanding Section 52-4-207, a commission member shall physically attend a
2130 meeting designated as an in-person meeting under Subsection (6)(a)(ii)(A) and may not attend
2131 through electronic means. A commission member may attend any other commission meeting,
2132 subcommittee meeting, or emergency meeting by electronic means in accordance with Section
2133 52-4-207.
2134 (b) (i) Except as provided in Subsection (6)(b)(ii), the commissioner may, with the

2135 concurrence of the chair of the commission, cancel a monthly meeting of the commission if,
2136 due to the number or nature of pending title insurance matters, the monthly meeting is not
2137 necessary.

2138 (ii) The commissioner may not cancel a monthly meeting designated as an in-person
2139 meeting under Subsection (6)(a)(ii)(A).

2140 (c) The commissioner may call additional meetings:

2141 (i) at the commissioner's discretion;

2142 (ii) upon the request of the chair of the commission; or

2143 (iii) upon the written request of three or more commission members.

2144 (d) (i) Three commission members constitute a quorum for the transaction of business.

2145 (ii) The action of a majority of the commission members when a quorum is present is
2146 the action of the commission.

2147 (7) The commissioner shall staff the commission.

2148 Section 12. Section **31A-6a-101** is amended to read:

2149 **31A-6a-101. Definitions.**

2150 As used in this chapter:

2151 (1) "Home warranty service contract" means a service contract that requires a person to
2152 repair or replace a component, system, or appliance of a home or make indemnification to the
2153 contract holder for the repair or replacement of a component, system, or appliance of the home:

2154 (a) upon mechanical or operational failure of the component, system, or appliance;

2155 (b) for a predetermined fee; and

2156 (c) if:

2157 (i) the person is not the builder, seller, or lessor of the home that is the subject of the
2158 contract; and

2159 (ii) the failure described in Subsection (1)(a) occurs within a specified period of time.

2160 [~~(1)~~] (2) (a) "Incidental cost" means a cost, incurred by a warranty holder in relation to
2161 a vehicle protection product warranty, that is in addition to the cost of purchasing the warranty.

2162 (b) "Incidental cost" includes an insurance policy deductible, a rental vehicle charge,
2163 the difference between the actual value of the stolen vehicle at the time of theft and the cost of
2164 a replacement vehicle, sales tax, a registration fee, a transaction fee, a mechanical inspection
2165 fee, or damage a theft causes to a vehicle.
2166 [~~(2)~~] (3) "Mechanical breakdown insurance" means a policy, contract, or agreement
2167 issued by an insurance company that has complied with either Chapter 5, Domestic Stock and
2168 Mutual Insurance Corporations, or Chapter 14, Foreign Insurers, that undertakes to perform or
2169 provide repair or replacement service on goods or property, or indemnification for repair or
2170 replacement service, for the operational or structural failure of the goods or property due to a
2171 defect in materials, workmanship, or normal wear and tear.
2172 [~~(3)~~] (4) "Nonmanufacturers' parts" means replacement parts not made for or by the
2173 original manufacturer of the goods commonly referred to as "after market parts."
2174 [~~(4)~~] (5) (a) "Road hazard" means a hazard that is encountered while driving a motor
2175 vehicle.
2176 (b) "Road hazard" includes potholes, rocks, wood debris, metal parts, glass, plastic,
2177 curbs, or composite scraps.
2178 [~~(5)~~] (6) (a) "Service contract" means a contract or agreement to perform or reimburse
2179 for the repair or maintenance of goods or property, for their operational or structural failure due
2180 to a defect in materials, workmanship, normal wear and tear, power surge or interruption, or
2181 accidental damage from handling, with or without additional provision for incidental payment
2182 of indemnity under limited circumstances, including towing, providing a rental car, providing
2183 emergency road service, and covering food spoilage.
2184 (b) "Service contract" does not include:
2185 (i) mechanical breakdown insurance; or
2186 (ii) a prepaid contract of limited duration that provides for scheduled maintenance
2187 only, regardless of whether the contract is executed before, on, or after May 9, 2017.
2188 (c) "Service contract" includes any contract or agreement to perform or reimburse the

2189 service contract holder for any one or more of the following services:

2190 (i) the repair or replacement of tires, wheels, or both on a motor vehicle damaged as a

2191 result of coming into contact with a road hazard;

2192 (ii) the removal of dents, dings, or creases on a motor vehicle that can be repaired using

2193 the process of paintless dent removal without affecting the existing paint finish and without

2194 replacing vehicle body panels, sanding, bonding, or painting;

2195 (iii) the repair of chips or cracks in or the replacement of a motor vehicle windshield as

2196 a result of damage caused by a road hazard, that is primary to the coverage offered by the motor

2197 vehicle owner's motor vehicle insurance policy; or

2198 (iv) the replacement of a motor vehicle key or key-fob if the key or key-fob becomes

2199 inoperable, lost, or stolen, except that the replacement of lost or stolen property is limited to

2200 only the replacement of a lost or stolen motor vehicle key or key-fob.

2201 [~~(6)~~] (7) "Service contract holder" or "contract holder" means a person who purchases a

2202 service contract.

2203 [~~(7)~~] (8) "Service contract provider" means a person who issues, makes, provides,

2204 administers, sells or offers to sell a service contract, or who is contractually obligated to

2205 provide service under a service contract.

2206 [~~(8)~~] (9) "Service contract reimbursement policy" or "reimbursement insurance policy"

2207 means a policy of insurance providing coverage for all obligations and liabilities incurred by

2208 the service contract provider or warrantor under the terms of the service contract or vehicle

2209 protection product warranty issued by the provider or warrantor.

2210 [~~(9)~~] (10) (a) "Vehicle protection product" means a device or system that is:

2211 (i) installed on or applied to a motor vehicle; and

2212 (ii) designed to:

2213 (A) prevent the theft of the vehicle; or

2214 (B) if the vehicle is stolen, aid in the recovery of the vehicle.

2215 (b) "Vehicle protection product" includes:

2216 (i) a vehicle protection product warranty;
2217 (ii) an alarm system;
2218 (iii) a body part marking product;
2219 (iv) a steering lock;
2220 (v) a window etch product;
2221 (vi) a pedal and ignition lock;
2222 (vii) a fuel and ignition kill switch; and
2223 (viii) an electronic, radio, or satellite tracking device.
2224 [~~(10)~~] (11) "Vehicle protection product warranty" means a written agreement by a
2225 warrantor that provides that if the vehicle protection product fails to prevent the theft of the
2226 motor vehicle, or aid in the recovery of the motor vehicle within a time period specified in the
2227 warranty, not exceeding 30 days after the day on which the motor vehicle is reported stolen, the
2228 warrantor will reimburse the warranty holder for incidental costs specified in the warranty, not
2229 exceeding $5,000, or in a specified fixed amount not exceeding $5,000.
2230 (12) "Vehicle service contract" means a service contract for the repair or maintenance
2231 of a vehicle:
2232 (a) for operational or structural failure because of a defect in materials, workmanship,
2233 normal wear and tear, or accidental damage from handling; and
2234 (b) with or without additional provision for incidental payment of indemnity under
2235 limited circumstances, including towing, providing a rental car, or providing emergency road
2236 service.
2237 [~~(11)~~] (13) "Warrantor" means a person who is contractually obligated to the warranty
2238 holder under the terms of a vehicle protection product warranty.
2239 [~~(12)~~] (14) "Warranty holder" means the person who purchases a vehicle protection
2240 product, any authorized transferee or assignee of the purchaser, or any other person legally
2241 assuming the purchaser's rights under the vehicle protection product warranty.
2242 Section 13. Section **31A-6a-103** is amended to read:

2243 **31A-6a-103. Requirements for doing business.**
2244 (1) A service contract or vehicle protection product warranty may not be issued, sold,
2245 or offered for sale in this state unless the service contract or vehicle protection product
2246 warranty is insured under a reimbursement insurance policy issued by:
2247 (a) an insurer authorized to do business in this state; or
2248 (b) a recognized surplus lines carrier.
2249 (2) (a) A service contract or vehicle protection product warranty may not be issued,
2250 sold, or offered for sale unless the service contract provider or warrantor completes the
2251 registration process described in this Subsection (2).
2252 (b) To register, a service contract provider or warrantor shall submit to the department
2253 the following:
2254 (i) an application for registration;
2255 (ii) a fee established in accordance with Section 31A-3-103;
2256 (iii) a copy of any service contract or vehicle protection product warranty that the
2257 service contract provider or warrantor offers in this state; and
2258 (iv) a copy of the service contract provider's or warrantor's reimbursement insurance
2259 policy.
2260 (c) A service provider or warrantor shall submit the information described in
2261 Subsection (2)(b) no less than 30 days before the day on which the service provider or
2262 warrantor issues, sells, offers for sale, or uses a service contract, vehicle protection product
2263 warranty, or reimbursement insurance policy in this state.
2264 (d) A service provider or warrantor shall file any modification of the terms of a service
2265 contract, vehicle protection product warranty, or reimbursement insurance policy 30 days
2266 before the day on which it is used in this state.
2267 (e) A person complying with this chapter is not required to comply with:
2268 (i) Subsections 31A-21-201(1) and 31A-23a-402(3); or
2269 (ii) Chapter 19a, Utah Rate Regulation Act.

2270 (f) (i) Each year before March 1, a service provider shall pay an annual registration fee
2271 established in accordance with Section 31A-3-103.
2272 (ii) If a service provider does not pay the annual registration fee described in this
2273 Subsection (2)(f) before March 1:
2274 (A) the service provider's registration is expired; and
2275 (B) the service provider may apply for registration in accordance with this Subsection
2276 (2).
2277 (3) (a) Premiums collected on a service contract are not subject to premium taxes.
2278 (b) Premiums collected by an issuer of a reimbursement insurance policy are subject to
2279 premium taxes.
2280 (4) A person marketing, selling, or offering to sell a service contract or vehicle
2281 protection product warranty for a service contract provider or warrantor that complies with this
2282 chapter is exempt from the licensing requirements of this title.
2283 (5) A service contract provider or warrantor complying with this chapter is not required
2284 to comply with:
2285 (a) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
2286 (b) Chapter 7, Nonprofit Health Service Insurance Corporations;
2287 (c) Chapter 8, Health Maintenance Organizations and Limited Health Plans;
2288 (d) Chapter 9, Insurance Fraternals;
2289 (e) Chapter 10, Annuities;
2290 (f) Chapter 11, Motor Clubs;
2291 (g) Chapter 12, State Risk Management Fund;
2292 (h) Chapter 14, Foreign Insurers;
2293 (i) Chapter 19a, Utah Rate Regulation Act;
2294 (j) Chapter 25, Third Party Administrators; and
2295 (k) Chapter 28, Guaranty Associations.
2296 Section 14. Section **31A-6a-104** is amended to read:

2297 **31A-6a-104. Required disclosures.**
2298 (1) A reimbursement insurance policy insuring a service contract or a vehicle
2299 protection product warranty that is issued, sold, or offered for sale in this state shall
2300 conspicuously state that, upon failure of the service contract provider or warrantor to perform
2301 under the contract, the issuer of the policy shall:
2302 (a) pay on behalf of the service contract provider or warrantor any sums the service
2303 contract provider or warrantor is legally obligated to pay according to the service contract
2304 provider's or warrantor's contractual obligations under the service contract or a vehicle
2305 protection product warranty issued or sold by the service contract provider or warrantor; or
2306 (b) provide the service which the service contract provider is legally obligated to
2307 perform, according to the service contract provider's contractual obligations under the service
2308 contract issued or sold by the service contract provider.
2309 (2) (a) A service contract may not be issued, sold, or offered for sale in this state unless
2310 the service contract contains the following statements in substantially the following form:
2311 (i) "Obligations of the provider under this service contract are guaranteed under a
2312 service contract reimbursement insurance policy. Should the provider fail to pay or provide
2313 service on any claim within 60 days after proof of loss has been filed, the contract holder is
2314 entitled to make a claim directly against the Insurance Company.";
2315 (ii) "This service contract or warranty is subject to limited regulation by the Utah
2316 Insurance Department. To file a complaint, contact the Utah Insurance Department."; and
2317 (iii) A service contract or reimbursement insurance policy may not be issued, sold, or
2318 offered for sale in this state unless the contract contains a statement in substantially the
2319 following form, "Coverage afforded under this contract is not guaranteed by the Property and
2320 Casualty Guaranty Association."
2321 (b) A vehicle protection product warranty may not be issued, sold, or offered for sale in
2322 this state unless the vehicle protection product warranty contains the following statements in
2323 substantially the following form:

2324 (i) "Obligations of the warrantor under this vehicle protection product warranty are
2325 guaranteed under a reimbursement insurance policy. Should the warrantor fail to pay on any
2326 claim within 60 days after proof of loss has been filed, the warranty holder is entitled to make a
2327 claim directly against the Insurance Company.";
2328 (ii) "This vehicle protection product warranty is subject to limited regulation by the
2329 Utah Insurance Department. To file a complaint, contact the Utah Insurance Department."; and
2330 (iii) as applicable:
2331 (A) "The warrantor under this vehicle protection product warranty will reimburse the
2332 warranty holder as specified in the warranty upon the theft of the vehicle."; or
2333 (B) "The warrantor under this vehicle protection product warranty will reimburse the
2334 warranty holder as specified in the warranty and at the end of the time period specified in the
2335 warranty if, following the theft of the vehicle, the stolen vehicle is not recovered within a time
2336 period specified in the warranty, not to exceed 30 days after the day on which the vehicle is
2337 reported stolen."
2338 (c) A vehicle protection product warranty, or reimbursement insurance policy, may not
2339 be issued, sold, or offered for sale in this state unless the warranty contains a statement in
2340 substantially the following form, "Coverage afforded under this warranty is not guaranteed by
2341 the Property and Casualty Guaranty Association."
2342 (3) (a) A service contract and a vehicle protection product warranty shall:
2343 [~~(a)~~] (i) conspicuously state the name, address, and a toll free claims service telephone
2344 number of the reimbursement insurer;
2345 [~~(b) (i)~~] (ii) (A) identify the service contract provider, the seller, and the service
2346 contract holder; or
2347 [~~(ii)~~] (B) identify the warrantor, the seller, and the warranty holder;
2348 [~~(c)~~] (iii) conspicuously state the total purchase price and the terms under which the
2349 service contract or warranty is to be paid;
2350 [~~(d)~~] (iv) conspicuously state the existence of any deductible amount;

2351 [(e)] (v) specify the merchandise, service to be provided, and any limitation, exception,
2352 or exclusion;
2353 [(f)] (vi) state a term, restriction, or condition governing the transferability of the
2354 service contract or warranty; and
2355 [(g)] (vii) state a term, restriction, or condition that governs cancellation of the service
2356 contract as provided in Sections 31A-21-303 through 31A-21-305 by either the contract holder
2357 or service contract provider.
2358 (b) Beginning January 1, 2021, a service contract shall contain a conspicuous statement
2359 in substantially the following form: "Purchase of this product is optional and is not required in
2360 order to finance, lease, or purchase a motor vehicle."
2361 (4) If prior approval of repair work is required[, a service] under a home protection
2362 service contract or a vehicle service contract, the contract shall conspicuously state the
2363 procedure for obtaining prior approval and for making a claim, including:
2364 (a) a toll free telephone number for claim service; and
2365 (b) a procedure for obtaining reimbursement for emergency repairs performed outside
2366 of normal business hours.
2367 (5) A preexisting condition clause in a service contract shall specifically state which
2368 preexisting condition is excluded from coverage.
2369 (6) (a) Except as provided in Subsection (6)(c), a service contract shall state the
2370 conditions upon which the use of a nonmanufacturers' part is allowed.
2371 (b) A condition described in Subsection (6)(a) shall comply with applicable state and
2372 federal laws.
2373 (c) This Subsection (6) does not apply to:
2374 (i) a home warranty service contract[.]; or
2375 (ii) a service contract that does not impose an obligation to provide parts.
2376 (7) This section applies to a vehicle protection product warranty, except for the
2377 requirements of Subsections (3)(d) and (g), (4), (5), and (6). The department may make rules

2378 in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement
2379 the application of this section to a vehicle protection product warranty.
2380 (8) (a) As used in this Subsection (8), "conspicuous statement" means a disclosure that:
2381 (i) appears in all-caps, bold, and 14-point font; and
2382 (ii) provides a space to be initialed by the consumer:
2383 (A) immediately below the printed disclosure; and
2384 (B) at or before the time the consumer purchases the vehicle protection product.
2385 (b) A vehicle protection product warranty shall contain a conspicuous statement in
2386 substantially the following form: "Purchase of this product is optional and is not required in
2387 order to finance, lease, or purchase a motor vehicle."
2388 (9) If a vehicle protection product warranty states that the warrantor will reimburse the
2389 warranty holder for incidental costs, the vehicle protection product warranty shall state how
2390 incidental costs paid under the warranty are calculated.
2391 (10) If a vehicle protection product warranty states that the warrantor will reimburse
2392 the warranty holder in a fixed amount, the vehicle protection product warranty shall state the
2393 fixed amount.
2394 Section 15. Section **31A-8-211** is amended to read:
2395 **31A-8-211. Deposit.**
2396 (1) Except as provided in Subsection (2), each health maintenance organization
2397 authorized in this state shall maintain a deposit with the commissioner under Section
2398 31A-2-206 in an amount equal to the sum of:
2399 (a) $100,000; and
2400 (b) 50% of the greater of:
2401 (i) $900,000;
2402 (ii) 2% of the annual premium revenues as reported on the most recent annual financial
2403 statement filed with the commissioner; or
2404 (iii) an amount equal to the sum of three months uncovered health care expenditures as

2405 reported on the most recent financial statement filed with the commissioner.
2406 (2) (a) [~~After a hearing the~~] The commissioner may exempt a health maintenance
2407 organization from the deposit requirement of Subsection (1) if:
2408 (i) the commissioner determines that the enrollees' interests are adequately protected;
2409 (ii) the health maintenance organization has been continuously authorized to do
2410 business in this state for at least five years; and
2411 (iii) the health maintenance organization has $5,000,000 surplus in excess of the health
2412 maintenance organization's company action level RBC as defined in Subsection
2413 31A-17-601(8)(b).
2414 (b) The commissioner may rescind an exemption given under Subsection (2)(a).
2415 (3) (a) Each limited health plan authorized in this state shall maintain a deposit with
2416 the commissioner under Section 31A-2-206 in an amount equal to the minimum capital or
2417 permanent surplus plus 50% of the greater of:
2418 (i) .5 times minimum required capital or minimum permanent surplus; or
2419 (ii) (A) during the first year of operation, 10% of the limited health plan's projected
2420 uncovered expenditures for the first year of operation;
2421 (B) during the second year of operation, 12% of the limited health plan's projected
2422 uncovered expenditures for the second year of operation;
2423 (C) during the third year of operation, 14% of the limited health plan's projected
2424 uncovered expenditures for the third year of operation;
2425 (D) during the fourth year of operation, 18% of the limited health plan's projected
2426 uncovered expenditures during the fourth year of operation; or
2427 (E) during the fifth year of operation, and during all subsequent years, 20% of the
2428 limited health plan's projected uncovered expenditures for the previous 12 months.
2429 (b) Projections of future uncovered expenditures shall be established in a manner that
2430 is approved by the commissioner.
2431 (4) A deposit required by this section may be counted toward the minimum capital or

2432 minimum permanent surplus required under Section 31A-8-209.
2433 Section 16. Section **31A-17-404** is amended to read:
2434 **31A-17-404. Credit allowed a domestic ceding insurer against reserves for**
2435 **reinsurance.**
2436 (1) A domestic ceding insurer is allowed credit for reinsurance as either an asset or a
2437 reduction from liability for reinsurance ceded only if the reinsurer meets the requirements of
2438 Subsection (3), (4), (5), (6), (7), [~~or~~] (8), or (9) subject to the following:
2439 (a) Credit is allowed under Subsection (3), (4), or (5) only with respect to a cession of a
2440 kind or class of business that the assuming insurer is licensed or otherwise permitted to write or
2441 assume:
2442 (i) in its state of domicile; or
2443 (ii) in the case of a United States branch of an alien assuming insurer, in the state
2444 through which it is entered and licensed to transact insurance or reinsurance.
2445 (b) Credit is allowed under Subsection (5) or (6) only if the applicable requirements of
2446 Subsection [~~(9)~~] (11) are met.
2447 (2) A domestic ceding insurer is allowed credit for reinsurance ceded:
2448 (a) only if the reinsurance is payable in a manner consistent with Section 31A-22-1201;
2449 (b) only to the extent that the accounting:
2450 (i) is consistent with the terms of the reinsurance contract; and
2451 (ii) clearly reflects:
2452 (A) the amount and nature of risk transferred; and
2453 (B) liability, including contingent liability, of the ceding insurer;
2454 (c) only to the extent the reinsurance contract shifts insurance policy risk from the
2455 ceding insurer to the assuming reinsurer in fact and not merely in form; and
2456 (d) only if the reinsurance contract contains a provision placing on the reinsurer the
2457 credit risk of all dealings with intermediaries regarding the reinsurance contract.
2458 (3) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an

2459 assuming insurer that is licensed to transact insurance or reinsurance in this state.
2460 (4) (a) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an
2461 assuming insurer that is accredited by the commissioner as a reinsurer in this state.
2462 (b) An insurer is accredited as a reinsurer if the insurer:
2463 (i) files with the commissioner evidence of the insurer's submission to this state's
2464 jurisdiction;
2465 (ii) submits to the commissioner's authority to examine the insurer's books and records;
2466 (iii) (A) is licensed to transact insurance or reinsurance in at least one state; or
2467 (B) in the case of a United States branch of an alien assuming insurer, is entered
2468 through and licensed to transact insurance or reinsurance in at least one state;
2469 (iv) files annually with the commissioner a copy of the insurer's:
2470 (A) annual statement filed with the insurance department of its state of domicile; and
2471 (B) most recent audited financial statement; and
2472 (v) (A) (I) has not had its accreditation denied by the commissioner within 90 days [~~of~~]
2473 after the day on which the insurer submits the information required by this Subsection (4); and
2474 (II) maintains a surplus with regard to policyholders in an amount not less than
2475 $20,000,000; or
2476 (B) (I) has its accreditation approved by the commissioner; and
2477 (II) maintains a surplus with regard to policyholders in an amount less than
2478 $20,000,000.
2479 (c) Credit may not be allowed a domestic ceding insurer if the assuming insurer's
2480 accreditation is revoked by the commissioner after a notice and hearing.
2481 (5) (a) A domestic ceding insurer is allowed a credit if:
2482 (i) the reinsurance is ceded to an assuming insurer that is:
2483 (A) domiciled in a state meeting the requirements of Subsection (5)(a)(ii); or
2484 (B) in the case of a United States branch of an alien assuming insurer, is entered
2485 through a state meeting the requirements of Subsection (5)(a)(ii);

2486 (ii) the state described in Subsection (5)(a)(i) employs standards regarding credit for
2487 reinsurance substantially similar to those applicable under this section; and
2488 (iii) the assuming insurer or United States branch of an alien assuming insurer:
2489 (A) maintains a surplus with regard to policyholders in an amount not less than
2490 $20,000,000; and
2491 (B) submits to the authority of the commissioner to examine its books and records.
2492 (b) The requirements of Subsections (5)(a)(i) and (ii) do not apply to reinsurance ceded
2493 and assumed pursuant to a pooling arrangement among insurers in the same holding company
2494 system.
2495 (6) (a) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an
2496 assuming insurer that maintains a trust fund:
2497 (i) created in accordance with rules made by the commissioner pursuant to Title 63G,
2498 Chapter 3, Utah Administrative Rulemaking Act; and
2499 (ii) in a qualified United States financial institution for the payment of a valid claim of:
2500 (A) a United States ceding insurer of the assuming insurer;
2501 (B) an assign of the United States ceding insurer; and
2502 (C) a successor in interest to the United States ceding insurer.
2503 (b) To enable the commissioner to determine the sufficiency of the trust fund described
2504 in Subsection (6)(a), the assuming insurer shall:
2505 (i) report annually to the commissioner information substantially the same as that
2506 required to be reported on the National Association of Insurance Commissioners Annual
2507 Statement form by a licensed insurer; and
2508 (ii) (A) submit to examination of its books and records by the commissioner; and
2509 (B) pay the cost of an examination.
2510 (c) (i) Credit for reinsurance may not be granted under this Subsection (6) unless the
2511 form of the trust and any amendment to the trust is approved by:
2512 (A) the commissioner of the state where the trust is domiciled; or

2513 (B) the commissioner of another state who, pursuant to the terms of the trust
2514 instrument, accepts principal regulatory oversight of the trust.
2515 (ii) The form of the trust and an amendment to the trust shall be filed with the
2516 commissioner of every state in which a ceding insurer beneficiary of the trust is domiciled.
2517 (iii) The trust instrument shall provide that a contested claim is valid and enforceable
2518 upon the final order of a court of competent jurisdiction in the United States.
2519 (iv) The trust shall vest legal title to its assets in its one or more trustees for the benefit
2520 of:
2521 (A) a United States ceding insurer of the assuming insurer;
2522 (B) an assign of the United States ceding insurer; or
2523 (C) a successor in interest to the United States ceding insurer.
2524 (v) The trust and the assuming insurer are subject to examination as determined by the
2525 commissioner.
2526 (vi) The trust shall remain in effect for as long as the assuming insurer has an
2527 outstanding obligation due under a reinsurance agreement subject to the trust.
2528 (vii) No later than February 28 of each year, the trustee of the trust shall:
2529 (A) report to the commissioner in writing the balance of the trust;
2530 (B) list the trust's investments at the end of the preceding calendar year; and
2531 (C) (I) certify the date of termination of the trust, if so planned; or
2532 (II) certify that the trust will not expire [~~prior to~~] <u>before</u> the following December 31.
2533 (d) The following requirements apply to the following categories of assuming insurer:
2534 (i) For a single assuming insurer:
2535 (A) the trust fund shall consist of funds in trust in an amount not less than the assuming
2536 insurer's liabilities attributable to reinsurance ceded by United States ceding insurers; and
2537 (B) the assuming insurer shall maintain a trusteed surplus of not less than $20,000,000,
2538 except as provided in Subsection (6)(d)(ii).
2539 (ii) (A) At any time after the assuming insurer has permanently discontinued

2540 underwriting new business secured by the trust for at least three full years, the commissioner
2541 with principal regulatory oversight of the trust may authorize a reduction in the required
2542 trusteed surplus, but only after a finding, based on an assessment of the risk, that the new
2543 required surplus level is adequate for the protection of United States ceding insurers,
2544 policyholders, and claimants in light of reasonably foreseeable adverse loss development.
2545 (B) The risk assessment may involve an actuarial review, including an independent
2546 analysis of reserves and cash flows, and shall consider all material risk factors, including, when
2547 applicable, the lines of business involved, the stability of the incurred loss estimates, and the
2548 effect of the surplus requirements on the assuming insurer's liquidity or solvency.
2549 (C) The minimum required trusteed surplus may not be reduced to an amount less than
2550 30% of the assuming insurer's liabilities attributable to reinsurance ceded by United States
2551 ceding insurers covered by the trust.
2552 (iii) For a group acting as assuming insurer, including incorporated and individual
2553 unincorporated underwriters:
2554 (A) for reinsurance ceded under a reinsurance agreement with an inception,
2555 amendment, or renewal date on or after August 1, 1995, the trust shall consist of a trusteed
2556 account in an amount not less than the respective underwriters' several liabilities attributable to
2557 business ceded by the one or more United States domiciled ceding insurers to an underwriter of
2558 the group;
2559 (B) for reinsurance ceded under a reinsurance agreement with an inception date on or
2560 before July 31, 1995, and not amended or renewed after July 31, 1995, notwithstanding the
2561 other provisions of this chapter, the trust shall consist of a trusteed account in an amount not
2562 less than the respective underwriters' several insurance and reinsurance liabilities attributable to
2563 business written in the United States;
2564 (C) in addition to a trust described in Subsection (6)(d)(iii)(A) or (B), the group shall
2565 maintain in trust a trusteed surplus of which $100,000,000 is held jointly for the benefit of the
2566 one or more United States domiciled ceding insurers of a member of the group for all years of

2567 account;

2568 (D) the incorporated members of the group:

2569 (I) may not be engaged in a business other than underwriting as a member of the group;

2570 and

2571 (II) are subject to the same level of regulation and solvency control by the group's

2572 domiciliary regulator as are the unincorporated members; and

2573 (E) within 90 days after the day on which the group's financial statements are due to be

2574 filed with the group's domiciliary regulator, the group shall provide to the commissioner:

2575 (I) an annual certification by the group's domiciliary regulator of the solvency of each

2576 underwriter member; or

2577 (II) if a certification is unavailable, a financial statement, prepared by an independent

2578 public accountant, of each underwriter member of the group.

2579 (iv) For a group of incorporated underwriters under common administration, the group

2580 shall:

2581 (A) have continuously transacted an insurance business outside the United States for at

2582 least three years immediately preceding the day on which the group makes application for

2583 accreditation;

2584 (B) maintain aggregate policyholders' surplus of at least $10,000,000,000;

2585 (C) maintain a trust fund in an amount not less than the group's several liabilities

2586 attributable to business ceded by the one or more United States domiciled ceding insurers to a

2587 member of the group pursuant to a reinsurance contract issued in the name of the group;

2588 (D) in addition to complying with the other provisions of this Subsection (6)(d)(iv),

2589 maintain a joint trusteed surplus of which $100,000,000 is held jointly for the benefit of the one

2590 or more United States domiciled ceding insurers of a member of the group as additional

2591 security for these liabilities; and

2592 (E) within 90 days after the day on which the group's financial statements are due to be

2593 filed with the group's domiciliary regulator, make available to the commissioner:

2594 (I) an annual certification of each underwriter member's solvency by the member's
2595 domiciliary regulator; and
2596 (II) a financial statement of each underwriter member of the group prepared by an
2597 independent public accountant.
2598 [~~(7) If reinsurance is ceded to an assuming insurer not meeting the requirements of~~
2599 ~~Subsection (3), (4), (5), or (6), a domestic ceding insurer is allowed credit only as to the~~
2600 ~~insurance of a risk located in a jurisdiction where the reinsurance is required by applicable law~~
2601 ~~or regulation of that jurisdiction.~~]
2602 [~~(8)~~] (7) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an
2603 assuming insurer that secures its obligations in accordance with this Subsection [~~(8)~~] (7):
2604 (a) The insurer shall be certified by the commissioner as a reinsurer in this state.
2605 (b) To be eligible for certification, the assuming insurer shall:
2606 (i) be domiciled and licensed to transact insurance or reinsurance in a qualified
2607 jurisdiction, as determined by the commissioner pursuant to Subsection [~~(8)~~] (7)(d);
2608 (ii) maintain minimum capital and surplus, or its equivalent, in an amount to be
2609 determined by the commissioner pursuant to rules made in accordance with Title 63G, Chapter
2610 3, Utah Administrative Rulemaking Act;
2611 (iii) maintain financial strength ratings from two or more rating agencies considered
2612 acceptable by the commissioner pursuant to rules made in accordance with Title 63G, Chapter
2613 3, Utah Administrative Rulemaking Act; and
2614 (iv) agree to:
2615 (A) submit to the jurisdiction of this state;
2616 (B) appoint the commissioner as its agent for service of process in this state;
2617 (C) provide security for 100% of the assuming insurer's liabilities attributable to
2618 reinsurance ceded by United States ceding insurers if it resists enforcement of a final United
2619 States judgment;
2620 (D) agree to meet applicable information filing requirements as determined by the

2621 commissioner including an application for certification, a renewal and on an ongoing basis; and
2622 (E) any other requirements for certification considered relevant by the commissioner.
2623 (c) An association, including incorporated and individual unincorporated underwriters,
2624 may be a certified reinsurer. To be eligible for certification, in addition to satisfying
2625 requirements of Subsections [~~(8)~~] (7)(a) and (b), the association:
2626 (i) shall satisfy its minimum capital and surplus requirements through the capital and
2627 surplus equivalents, net of liabilities, of the association and its members, which shall include a
2628 joint central fund that may be applied to any unsatisfied obligation of the association or any of
2629 its members in an amount determined by the commissioner to provide adequate protection;
2630 (ii) may not have incorporated members of the association engaged in any business
2631 other than underwriting as a member of the association;
2632 (iii) shall be subject to the same level of regulation and solvency control of the
2633 incorporated members of the association by the association's domiciliary regulator as are the
2634 unincorporated members; and
2635 (iv) within 90 days after its financial statements are due to be filed with the
2636 association's domiciliary regulator provide:
2637 (A) to the commissioner an annual certification by the association's domiciliary
2638 regulator of the solvency of each underwriter member; or
2639 (B) if a certification is unavailable, financial statements prepared by independent
2640 public accountants, of each underwriter member of the association.
2641 (d) The commissioner shall create and publish a list of qualified jurisdictions under
2642 which an assuming insurer licensed and domiciled in the jurisdiction is eligible to be
2643 considered for certification by the commissioner as a certified reinsurer.
2644 (i) To determine whether the domiciliary jurisdiction of a non-United States assuming
2645 insurer is eligible to be recognized as a qualified jurisdiction, the commissioner:
2646 (A) shall evaluate the appropriateness and effectiveness of the reinsurance supervisory
2647 system of the jurisdiction, both initially and on an ongoing basis;

2648 (B) shall consider the rights, the benefits, and the extent of reciprocal recognition
2649 afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the
2650 United States;
2651 (C) shall require the qualified jurisdiction to share information and cooperate with the
2652 commissioner with respect to all certified reinsurers domiciled within that jurisdiction; and
2653 (D) may not recognize a jurisdiction as a qualified jurisdiction if the commissioner has
2654 determined that the jurisdiction does not adequately and promptly enforce final United States
2655 judgments and arbitration awards.
2656 (ii) The commissioner may consider additional factors in determining a qualified
2657 jurisdiction.
2658 (iii) A list of qualified jurisdictions shall be published through the National
2659 Association of Insurance Commissioners' Committee Process and the commissioner shall:
2660 (A) consider this list in determining qualified jurisdictions; and
2661 (B) if the commissioner approves a jurisdiction as qualified that does not appear on the
2662 National Association of Insurance Commissioner's list of qualified jurisdictions, provide
2663 thoroughly documented justification in accordance with criteria to be developed by rule made
2664 in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
2665 (iv) United States jurisdictions that meet the requirement for accreditation under the
2666 National Association of Insurance Commissioners' financial standards and accreditation
2667 program shall be recognized as qualified jurisdictions.
2668 (v) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction,
2669 the commissioner may suspend the reinsurer's certification indefinitely, in lieu of revocation.
2670 (e) The commissioner shall:
2671 (i) assign a rating to each certified reinsurer, giving due consideration to the financial
2672 strength ratings that have been assigned by rating agencies considered acceptable to the
2673 commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative
2674 Rulemaking Act; and

2675 (ii) publish a list of all certified reinsurers and their ratings.

2676 (f) A certified reinsurer shall secure obligations assumed from United States ceding
2677 insurers under this Subsection [~~(8)~~] (7) at a level consistent with its rating, as specified in rules
2678 made by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative
2679 Rulemaking Act.

2680 (i) For a domestic ceding insurer to qualify for full financial statement credit for
2681 reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a
2682 form acceptable to the commissioner and consistent with Section 31A-17-404.1, or in a
2683 multibeneficiary trust in accordance with Subsections (5), (6), and [~~(7)~~] (9), except as
2684 otherwise provided in this Subsection [~~(8)~~] (7).

2685 (ii) If a certified reinsurer maintains a trust to fully secure its obligations subject to
2686 Subsections (5), (6), and [~~(7)~~] (9), and chooses to secure its obligations incurred as a certified
2687 reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate
2688 trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a
2689 certified reinsurer with reduced security as permitted by this Subsection [~~(8)~~] (7) or comparable
2690 laws of other United States jurisdictions and for its obligations subject to Subsections (5), (6),
2691 and [~~(7)~~] (9).

2692 (iii) It shall be a condition to the grant of certification under this Subsection [~~(8)~~] (7)
2693 that the certified reinsurer shall have bound itself:

2694 (A) by the language of the trust and agreement with the commissioner with principal
2695 regulatory oversight of the trust account; and

2696 (B) upon termination of the trust account, to fund, out of the remaining surplus of the
2697 trust, any deficiency of any other trust account.

2698 (iv) The minimum trusteed surplus requirements provided in Subsections (5), (6), and
2699 [~~(7)~~] (9) are not applicable with respect to a multibeneficiary trust maintained by a certified
2700 reinsurer for the purpose of securing obligations incurred under this Subsection [~~(8)~~] (7),
2701 except that the trust shall maintain a minimum trusteed surplus of $10,000,000.

2702 (v) With respect to obligations incurred by a certified reinsurer under this Subsection
2703 [~~(8)~~] (7), if the security is insufficient, the commissioner:
2704 (A) shall reduce the allowable credit by an amount proportionate to the deficiency; and
2705 (B) may impose further reductions in allowable credit upon finding that there is a
2706 material risk that the certified reinsurer's obligations will not be paid in full when due.
2707 (vi) For purposes of this Subsection [~~(8)~~] (7), a certified reinsurer whose certification
2708 has been terminated for any reason shall be treated as a certified reinsurer required to secure
2709 100% of its obligations.
2710 (A) As used in this Subsection [~~(8)~~] (7), the term "terminated" refers to revocation,
2711 suspension, voluntary surrender, and inactive status.
2712 (B) If the commissioner continues to assign a higher rating as permitted by other
2713 provisions of this section, the requirement under this Subsection [~~(8)~~] (7)(f)(vi) does not apply
2714 to a certified reinsurer in inactive status or to a reinsurer whose certification has been
2715 suspended.
2716 (g) If an applicant for certification has been certified as a reinsurer in a National
2717 Association of Insurance Commissioners' accredited jurisdiction, the commissioner may:
2718 (i) defer to that jurisdiction's certification;
2719 (ii) defer to the rating assigned by that jurisdiction; and
2720 (iii) consider such reinsurer to be a certified reinsurer in this state.
2721 (h) (i) A certified reinsurer that ceases to assume new business in this state may request
2722 to maintain its certification in inactive status in order to continue to qualify for a reduction in
2723 security for its in-force business.
2724 (ii) An inactive certified reinsurer shall continue to comply with all applicable
2725 requirements of this Subsection [~~(8)~~] (7).
2726 (iii) The commissioner shall assign a rating to a reinsurer that qualifies under this
2727 Subsection [~~(8)~~] (7)(h), that takes into account, if relevant, the reasons why the reinsurer is not
2728 assuming new business.

2729 (8) (a) As used in this Subsection (8):
2730 (i) "Covered agreement" means an agreement entered into pursuant to Dodd-Frank
2731 Wall Street Reform and Consumer Protection Act, 31 U.S.C. Sections 313 and 314, that is
2732 currently in effect or in a period of provisional application and addresses the elimination, under
2733 specified conditions, of collateral requirements as a condition for entering into any reinsurance
2734 agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to
2735 recognize credit for reinsurance.
2736 (ii) "Reciprocal jurisdiction" means a jurisdiction that is:
2737 (A) a non-United States jurisdiction that is subject to an in-force covered agreement
2738 with the United States, each within its legal authority, or, in the case of a covered agreement
2739 between the United States and European Union, is a member state of the European Union;
2740 (B) a United States jurisdiction that meets the requirements for accreditation under the
2741 National Association of Insurance Commissioners' financial standards and accreditation
2742 program; or
2743 (C) a qualified jurisdiction, as determined by the commissioner in accordance with
2744 Subsection (7)(d), that is not otherwise described in this Subsection (8)(a)(ii) and meets certain
2745 additional requirements, consistent with the terms and conditions of in-force covered
2746 agreements, as specified by the commissioner in rule made in accordance with Title 63G,
2747 Chapter 3, Utah Administrative Rulemaking Act.
2748 (b) (i) Credit shall be allowed when the reinsurance is ceded to an assuming insurer
2749 meeting each of the conditions set forth in this Subsection (8)(b).
2750 (ii) The assuming insurer must have its head office or be domiciled in, as applicable,
2751 and be licensed in a reciprocal jurisdiction.
2752 (iii) (A) The assuming insurer must have and maintain, on an ongoing basis, minimum
2753 capital and surplus, or its equivalent, calculated according to the methodology of its
2754 domiciliary jurisdiction, in an amount to be set forth in regulation.
2755 (B) If the assuming insurer is an association, including incorporated and individual

2756 unincorporated underwriters, it must have and maintain, on an ongoing basis, minimum capital
2757 and surplus equivalents (net of liabilities), calculated according to the methodology applicable
2758 in its domiciliary jurisdiction, and a central fund containing a balance in amounts to be set forth
2759 in regulation.
2760 (iv) (A) The assuming insurer must have and maintain, on an ongoing basis, a
2761 minimum solvency or capital ration, as applicable, which will be set forth in regulation.
2762 (B) If the assuming insurer is an association, including incorporated and individual
2763 unincorporated underwriters, it must have and maintain, on an ongoing basis, a minimum
2764 solvency or capital ratio in the reciprocal jurisdiction where the assuming insurer has its head
2765 office or is domiciled, as applicable, and is also licensed.
2766 (v) The assuming insurer must agree and provide adequate assurance to the
2767 commissioner, in a form specified by the commissioner by rule made in accordance with Title
2768 63G, Chapter 3, Utah Administrative Rulemaking Act, as follows:
2769 (A) the assuming insurer must provide prompt written notice and explanation to the
2770 commissioner if it falls below the minimum requirements set forth in Subsections (8)(c) or (d),
2771 or if any regulatory action is taken against it for serious noncompliance with applicable law;
2772 (B) the assuming insurer must consent in writing to the jurisdiction of the courts of this
2773 state and to the appointment of the commissioner as agent for service of process, however the
2774 commissioner may require that consent for service of process be provided to the commissioner
2775 and included in each reinsurance agreement and nothing in this provision shall limit, or in any
2776 way alter, the capacity of parties to a reinsurance agreement to agree to alternative dispute
2777 resolution mechanisms, except to the extent such agreements are unenforceable under
2778 applicable insolvency or delinquency laws;
2779 (C) the assuming insurer must consent in writing to pay all final judgments, wherever
2780 enforcement is sought, obtained by a ceding insurer or its legal successor, that have been
2781 declared enforceable in the jurisdiction where the judgment was obtained;
2782 (D) each reinsurance agreement must include a provision requiring the assuming

2783 insurer to provide security in an amount equal to 100% of the assuming insurer's liabilities
2784 attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists
2785 enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it
2786 was obtained or a properly enforceable arbitration award, whether obtained by the ceding
2787 insurer or by its legal successor on behalf of its resolution estate; and
2788 (E) the assuming insurer must confirm that it is not presently participating in any
2789 solvent scheme of arrangement which involved this state's ceding insurers, and agree to notify
2790 the ceding insurer and the commissioner and to provide security:
2791 (I) in an amount equal to 100% of the assuming insurer's liabilities to the ceding
2792 insurer, should the assuming insurer enter into such a solvent scheme of arrangement; and
2793 (II) in a form consistent with the provisions of Subsections (7) and (10) and as
2794 specified by the commissioner in regulation.
2795 (vi) The assuming insurer or its legal successor must provide, if requested by the
2796 commissioner, on behalf of itself and any legal predecessors, certain documentation to the
2797 commissioner, as specified by the commissioner by rule made in accordance with Title 63G,
2798 Chapter 3, Utah Administrative Rulemaking Act.
2799 (vii) The assuming insurer must maintain a practice of prompt payment of claims under
2800 reinsurance agreements, pursuant to criteria set forth in rule made in accordance with Title
2801 63G, Chapter 3, Utah Administrative Rulemaking Act.
2802 (viii) The assuming insurer's supervisory authority must confirm to the commissioner
2803 on an annual basis, as of the preceding December 31 or at the annual date otherwise statutorily
2804 reported to the reciprocal jurisdiction, that the assuming insurer complies with the requirements
2805 set forth in Subsections (8)(c) and (d).
2806 (ix) Nothing in this provision precludes an assuming insurer from providing the
2807 commissioner with information on a voluntary basis.
2808 (c) (i) The commissioner shall timely create and publish a list of reciprocal
2809 jurisdictions.

2810 (ii) (A) A list of reciprocal jurisdictions is published through the National Association
2811 of Insurance Commissioners' Committee Process.
2812 (B) The commissioner's list of reciprocal jurisdictions shall include any reciprocal
2813 jurisdiction as defined in this Subsection (8), and shall consider any other reciprocal
2814 jurisdictions in accordance with the criteria developed under rule made in accordance with
2815 Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
2816 (iii) (A) The commissioner may remove a jurisdiction from the list of reciprocal
2817 jurisdictions upon a determination that the jurisdiction no longer meets the requirements of a
2818 reciprocal jurisdiction, in accordance with a process set forth in rule made in accordance with
2819 Title 63G, Chapter 3, Utah Administrative Rulemaking Act, except that the commissioner shall
2820 not remove from the list a reciprocal jurisdiction.
2821 (B) Upon removal of a reciprocal jurisdiction from this list, credit for reinsurance
2822 ceded to an assuming insurer which has its home office or is domiciled in that jurisdiction shall
2823 be allowed, if otherwise allowed under this chapter.
2824 (d) (i) The commissioner shall timely create and publish a list of assuming insurers that
2825 have satisfied the conditions set forth in this subsection and to which cessions shall be granted
2826 credit in accordance with this Subsection (8).
2827 (ii) The commissioner may add an assuming insurer to such list if a National
2828 Association of Insurance Commissioners accredited jurisdiction has added such assuming
2829 insurer to a list of such assuming insurers or if, upon initial eligibility, the assuming insurer
2830 submits the information to the commissioner as required under this Subsection (8) and
2831 complies with any additional requirements that the commissioner may impose by rule made in
2832 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, except to the
2833 extent that they conflict with an applicable covered agreement.
2834 (e) (i) If the commissioner determines that an assuming insurer no longer meets one or
2835 more of the requirements under this Subsection (8), the commissioner may revoke or suspend
2836 the eligibility of the assuming insurer for recognition under this Subsection (8) in accordance

2837 with procedures established in rule made in accordance with Title 63G, Chapter 3, Utah
2838 Administrative Rulemaking Act.
2839 (ii) (A) While an assuming insurer's eligibility is suspended, no reinsurance agreement
2840 issued, amended, or renewed after the effective date of the suspension qualifies for credit
2841 except to the extent that the assuming insurer's obligations under the contract are secured in
2842 accordance with Subsection (10).
2843 (B) If an assuming insurer's eligibility is revoked, no credit for reinsurance may be
2844 granted after the effective date of the revocation with respect to any reinsurance agreements
2845 entered into by the assuming insurer, including reinsurance agreements entered into prior to the
2846 date of revocation, except to the extent that the assuming insurer's obligations under the
2847 contract are secured in a form acceptable to the commissioner and consistent with the
2848 provisions of Subsection (10).
2849 (f) If subject to a legal process of rehabilitation, liquidation, or conservation, as
2850 applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by
2851 the court in which the proceedings are pending, may obtain an order requiring that the
2852 assuming insurer post security for all outstanding ceded liabilities.
2853 (g) Nothing in this Subsection (8) limits or in any way alters the capacity of parties to a
2854 reinsurance agreement to agree on requirements for security or other terms in that reinsurance
2855 agreement, except as expressly prohibited by this chapter or other applicable law or regulation.
2856 (h) (i) Credit may be taken under this Subsection (8) only for reinsurance agreements
2857 entered into, amended, or renewed on or after the effective date of the statute adding this
2858 Subsection (8), and only with respect to losses incurred and reserves reported on or after the
2859 later of:
2860 (A) the date on which the assuming insurer has met all eligibility requirements
2861 pursuant to Subsection (8)(b); and
2862 (B) the effective date of the new reinsurance agreement, amendment or renewal.
2863 (ii) This Subsection (8) does not alter or impair a ceding insurer's right to take credit

2864 for reinsurance, to the extent that credit is not available under this Subsection (8), as long as the
2865 reinsurance qualifies for credit under any other applicable provision of this chapter.
2866 (iii) Nothing in this Subsection (8) authorizes an assuming insurer to withdraw or
2867 reduce the security provided under any reinsurance agreement except as permitted by the terms
2868 of the agreement.
2869 (iv) Nothing in this Subsection (8) limits, or in any way alters, the capacity of parties to
2870 any reinsurance agreement to renegotiate the agreement.
2871 (9) If reinsurance is ceded to an assuming insurer not meeting the requirements of
2872 Subsection (3), (4), (5), (6), (7), or (8), a domestic ceding insurer is allowed credit only as to
2873 the insurance of a risk located in a jurisdiction where the reinsurance is required by applicable
2874 law or regulation of that jurisdiction.
2875 (10) (a) An asset or a reduction from liability for the reinsurance ceded by a domestic
2876 insurer to an assuming insurer not meeting the requirements of Subsection (3), (4), (5), (6), (7),
2877 or (8) shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer.
2878 (b) The commissioner may adopt by rule made in accordance with Title 63G, Chapter
2879 3, Utah Administrative Rulemaking Act, specific additional requirements relating to or setting
2880 forth:
2881 (i) the valuation of assets or reserve credits;
2882 (ii) the amount and forms of security supporting reinsurance arrangements; and
2883 (iii) the circumstances pursuant to which credit will be reduced or eliminated.
2884 (c) (i) The reduction shall be in the amount of funds held by or on behalf of the ceding
2885 insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with
2886 the assuming insurer as security for the payment of obligations thereunder, if the security is:
2887 (A) held in the United States subject to withdrawal solely by, and under the exclusive
2888 control of, the ceding insurer; or
2889 (B) in the case of a trust, held in a qualified United States financial institution.
2890 (ii) The security described in this Subsection (10)(c) may be in the form of:

2891 (A) cash;

2892 (B) securities listed by the Securities Valuation Office of the National Association of
2893 Insurance Commissioners, including those deemed exempt from filing as defined by the
2894 Purposes and Procedures Manual of the Securities Valuation Office, and qualifying as admitted
2895 assets;

2896 (C) clean, irrevocable, unconditional letters of credit, issued or confirmed by a
2897 qualified United States financial institution effective no later than December 31 of the year for
2898 which the filing is being made, and in the possession of, or in trust for, the ceding insurer on or
2899 before the filing date of its annual statement;

2900 (D) letters of credit meeting applicable standards of issuer acceptability as of the dates
2901 of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's
2902 subsequent failure to meet applicable standards of issuer acceptability, continue to be
2903 acceptable as security until their expiration, extension, renewal, modification or amendment,
2904 whichever first occurs; or

2905 (E) any other form of security acceptable to the commissioner.

2906 [(9)] (11) Reinsurance credit may not be allowed a domestic ceding insurer unless the
2907 assuming insurer under the reinsurance contract submits to the jurisdiction of Utah courts by:

2908 (a) (i) being an admitted insurer; and

2909 (ii) submitting to jurisdiction under Section 31A-2-309;

2910 (b) having irrevocably appointed the commissioner as the domestic ceding insurer's
2911 agent for service of process in an action arising out of or in connection with the reinsurance,
2912 which appointment is made under Section 31A-2-309; or

2913 (c) agreeing in the reinsurance contract:

2914 (i) that if the assuming insurer fails to perform its obligations under the terms of the
2915 reinsurance contract, the assuming insurer, at the request of the ceding insurer, shall:

2916 (A) submit to the jurisdiction of a court of competent jurisdiction in a state of the
2917 United States;

2918 (B) comply with all requirements necessary to give the court jurisdiction; and
2919 (C) abide by the final decision of the court or of an appellate court in the event of an
2920 appeal; and
2921 (ii) to designate the commissioner or a specific attorney licensed to practice law in this
2922 state as its attorney upon whom may be served lawful process in an action, suit, or proceeding
2923 instituted by or on behalf of the ceding company.
2924 [~~(10)~~] (12) Submitting to the jurisdiction of Utah courts under Subsection [~~(9)~~] (11)
2925 does not override a duty or right of a party under the reinsurance contract, including a
2926 requirement that the parties arbitrate their disputes.
2927 [~~(11)~~] (13) If an assuming insurer does not meet the requirements of Subsection (3),
2928 (4), [~~or~~] (5), or (8), the credit permitted by Subsection (6) or [~~(8)~~] (7) may not be allowed
2929 unless the assuming insurer agrees in the trust instrument to the following conditions:
2930 (a) (i) Notwithstanding any other provision in the trust instrument, if an event
2931 described in Subsection [~~(11)~~] (13)(a)(ii) occurs the trustee shall comply with:
2932 (A) an order of the commissioner with regulatory oversight over the trust; or
2933 (B) an order of a court of competent jurisdiction directing the trustee to transfer to the
2934 commissioner with regulatory oversight all of the assets of the trust fund.
2935 (ii) This Subsection [~~(11)~~] (13)(a) applies if:
2936 (A) the trust fund is inadequate because the trust contains an amount less than the
2937 amount required by Subsection (6)(d); or
2938 (B) the grantor of the trust is:
2939 (I) declared insolvent; or
2940 (II) placed into receivership, rehabilitation, liquidation, or similar proceeding under the
2941 laws of its state or country of domicile.
2942 (b) The assets of a trust fund described in Subsection [~~(11)~~] (13)(a) shall be distributed
2943 by and a claim shall be filed with and valued by the commissioner with regulatory oversight in
2944 accordance with the laws of the state in which the trust is domiciled that are applicable to the

2945 liquidation of a domestic insurance company.

2946 (c) If the commissioner with regulatory oversight determines that the assets of the trust
2947 fund, or any part of the assets, are not necessary to satisfy the claims of the one or more United
2948 States ceding insurers of the grantor of the trust, the assets, or a part of the assets, shall be
2949 returned by the commissioner with regulatory oversight to the trustee for distribution in
2950 accordance with the trust instrument.

2951 (d) A grantor shall waive any right otherwise available to it under United States law
2952 that is inconsistent with this Subsection [~~(11)~~] (13).

2953 [~~(12)~~] (14) If an accredited or certified reinsurer ceases to meet the requirements for
2954 accreditation or certification, the commissioner may suspend or revoke the reinsurer's
2955 accreditation or certification.

2956 (a) The commissioner shall give the reinsurer notice and opportunity for hearing.

2957 (b) The suspension or revocation may not take effect until after the commissioner's
2958 order after a hearing, unless:

2959 (i) the reinsurer waives its right to hearing;

2960 (ii) the commissioner's order is based on:

2961 (A) regulatory action by the reinsurer's domiciliary jurisdiction; or

2962 (B) the voluntary surrender or termination of the reinsurer's eligibility to transact
2963 insurance or reinsurance business in its domiciliary jurisdiction or primary certifying state
2964 under Subsection [~~(8)~~] (7)(g); or

2965 (iii) the commissioner's finding that an emergency requires immediate action and a
2966 court of competent jurisdiction has not stayed the commissioner's action.

2967 (c) While a reinsurer's accreditation or certification is suspended, no reinsurance
2968 contract issued or renewed after the effective date of the suspension qualifies for credit except
2969 to the extent that the reinsurer's obligations under the contract are secured in accordance with
2970 Section 31A-17-404.1.

2971 (d) If a reinsurer's accreditation or certification is revoked, no credit for reinsurance

2972 may be granted after the effective date of the revocation except to the extent that the reinsurer's
2973 obligations under the contract are secured in accordance with Subsection [~~(8)~~] (7)(f) or Section
2974 31A-17-404.1.
2975 [~~(13)~~] (15) (a) A ceding insurer shall take steps to manage its reinsurance recoverables
2976 proportionate to its own book of business.
2977 (b) (i) A domestic ceding insurer shall notify the commissioner within 30 days after
2978 reinsurance recoverables from any single assuming insurer, or group of affiliated assuming
2979 insurers:
2980 (A) exceeds 50% of the domestic ceding insurer's last reported surplus to
2981 policyholders; or
2982 (B) after it is determined that reinsurance recoverables from any single assuming
2983 insurer, or group of affiliated assuming insurers, is likely to exceed 50% of the domestic ceding
2984 insurer's last reported surplus to policyholders.
2985 (ii) The notification required by Subsection [~~(13)~~] (15)(b)(i) shall demonstrate that the
2986 exposure is safely managed by the domestic ceding insurer.
2987 (c) A ceding insurer shall take steps to diversify its reinsurance program.
2988 (d) (i) A domestic ceding insurer shall notify the commissioner within 30 days after
2989 ceding or being likely to cede more than 20% of the ceding insurer's gross written premium in
2990 the prior calendar year to any:
2991 (A) single assuming insurer; or
2992 (B) group of affiliated assuming insurers.
2993 (ii) The notification shall demonstrate that the exposure is safely managed by the
2994 domestic ceding insurer.
2995 Section 17. Section **31A-17-404.3** is amended to read:
2996 **31A-17-404.3. Rules.**
2997 (1) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and
2998 this chapter, the commissioner may make rules prescribing:

2999 (a) the form of a letter of credit required under this chapter;
3000 (b) the requirements for a trust or trust instrument required by this chapter;
3001 (c) the procedures for licensing and accrediting;
3002 (d) minimum capital and surplus requirements;
3003 (e) additional requirements relating to calculation of credit allowed a domestic ceding
3004 insurer against reserves for reinsurance under Section 31A-17-404; and
3005 (f) additional requirements relating to calculation of asset reduction from liability for
3006 reinsurance ceded by a domestic insurer to other ceding insurers under Section 31A-17-404.1.
3007 (2) A rule made pursuant to Subsection (1)(e) or (f) may apply to reinsurance relating
3008 to:
3009 (a) a life insurance policy with guaranteed nonlevel gross premiums or guaranteed
3010 nonlevel benefits;
3011 (b) a universal life insurance policy with provisions resulting in the ability of a
3012 policyholder to keep a policy in force over a secondary guarantee period;
3013 (c) a variable annuity with guaranteed death or living benefits;
3014 (d) a long-term care insurance policy; or
3015 (e) such other life and health insurance or annuity product as to which the National
3016 Association of Insurance Commissioners adopts model regulatory requirements with respect
3017 for credit for reinsurance.
3018 (3) A rule adopted pursuant to Subsection (1)(e) or (f) may apply to a treaty containing:
3019 (a) a policy issued on or after January 1, 2015; and
3020 (b) a policy issued before January 1, 2015, if risk pertaining to the policy is ceded in
3021 connection with the treaty, either in whole or in part, on or after January 1, 2015.
3022 (4) A rule adopted pursuant to Subsection (1)(e) or (f) may require the ceding insurer,
3023 in calculating the amounts or forms of security required to be held under rules made under this
3024 section, to use the Valuation Manual adopted by the National Association of Insurance
3025 Commissioners under Section 11B(1) of the National Association of Insurance Commissioners

3026 Standard Valuation Law, including all amendments adopted by the National Association of
3027 Insurance Commissioners and in effect on the date as of which the calculation is made, to the
3028 extent applicable.
3029 (5) A rule adopted pursuant to Subsection (1)(e) or (f) may not apply to cessions to an
3030 assuming insurer that:
3031 (a) meets the conditions established in Subsection 31A-17-404(8);
3032 [~~(a)~~] (b) is certified in this state [~~or, if this state has not adopted provisions~~
3033 ~~substantially equivalent to Section 2E of the Credit for Reinsurance Model Law, certified in a~~
3034 ~~minimum of five other states~~]; or
3035 [~~(b)~~] (c) maintains at least $250,000,000 in capital and surplus when determined in
3036 accordance with the National Association of Insurance Commissioners Accounting Practices
3037 and Procedures Manual, including all amendments thereto adopted by the National Association
3038 of Insurance Commissioners, excluding the impact of any permitted or prescribed practices and
3039 is:
3040 (i) licensed in at least 26 states; or
3041 (ii) licensed in at least 10 states, and licensed or accredited in a total of at least 35
3042 states.
3043 (6) The authority to adopt rules pursuant to Subsection (1)(e) or (f) does not otherwise
3044 limit the commissioner's general authority to make rules pursuant to Subsection (1).
3045 Section 18. Section **31A-17-601** is amended to read:
3046 **31A-17-601. Definitions.**
3047 As used in this part:
3048 (1) "Adjusted RBC report" means an RBC report that has been adjusted by the
3049 commissioner in accordance with Subsection 31A-17-602(5).
3050 (2) "Corrective order" means an order issued by the commissioner specifying
3051 corrective action that the commissioner determines is required.
3052 (3) "Health organization" means:

3053 (a) an entity that is authorized under Chapter 7, Nonprofit Health Service Insurance
3054 Corporations, or Chapter 8, Health Maintenance Organizations and Limited Health Plans; and
3055 (b) that is:
3056 (i) a health maintenance organization;
3057 (ii) a limited health service organization;
3058 (iii) a dental or vision plan;
3059 (iv) a hospital, medical, and dental indemnity or service corporation; or
3060 (v) other managed care organization.
3061 (4) "Life or accident and health insurer" means:
3062 (a) an insurance company licensed to write life insurance, disability insurance, or both;
3063 or
3064 (b) a licensed property casualty insurer writing only disability insurance.
3065 (5) "Property and casualty insurer" means any insurance company licensed to write
3066 lines of insurance other than life but does not include a monoline mortgage guaranty insurer,
3067 financial guaranty insurer, or title insurer.
3068 (6) "RBC" means risk-based capital.
3069 (7) "RBC instructions" means the RBC report including the National Association of
3070 Insurance Commissioner's risk-based capital instructions [~~adopted by the department by rule~~]
3071 that govern the year for which an RBC report is prepared.
3072 (8) "RBC level" means an insurer's or health organization's authorized control level
3073 RBC, company action level RBC, mandatory control level RBC, or regulatory action level
3074 RBC.
3075 (a) "Authorized control level RBC" means the number determined under the risk-based
3076 capital formula in accordance with the RBC instructions;
3077 (b) "Company action level RBC" means the product of 2.0 and its authorized control
3078 level RBC;
3079 (c) "Mandatory control level RBC" means the product of .70 and the authorized control

3080 level RBC; and
3081 (d) "Regulatory action level RBC" means the product of 1.5 and its authorized control
3082 level RBC.
3083 (9) (a) "RBC plan" means a comprehensive financial plan containing the elements
3084 specified in Subsection 31A-17-603(2).
3085 (b) Notwithstanding Subsection (9)(a), the plan is a "revised RBC plan" if:
3086 (i) the commissioner rejects the RBC plan; and
3087 (ii) the plan is revised by the insurer or health organization, with or without the
3088 commissioner's recommendation.
3089 (10) "RBC report" means the report required in Section 31A-17-602.
3090 Section 19. Section **31A-19a-404** is amended to read:
3091 **31A-19a-404. Designated rate service organization.**
3092 (1) For purposes of workers' compensation insurance, the commissioner shall designate
3093 one rate service organization to:
3094 (a) develop and administer the uniform statistical plan, uniform classification plan, and
3095 uniform experience rating plan filed with and approved by the commissioner;
3096 (b) assist the commissioner in gathering, compiling, and reporting relevant statistical
3097 information on an aggregate basis;
3098 (c) develop and file manual rules, subject to the approval of the commissioner, that are
3099 reasonably related to the recording and reporting of data pursuant to the uniform statistical
3100 plan, uniform experience rating plan, and the uniform classification plan; and
3101 (d) develop and file the [~~prospective~~] <u>advisory</u> loss costs pursuant to Section
3102 31A-19a-406.
3103 (2) The uniform experience rating plan shall:
3104 (a) contain reasonable eligibility standards;
3105 (b) provide adequate incentives for loss prevention; and
3106 (c) provide for sufficient premium differentials so as to encourage safety.

3107 (3) Each workers' compensation insurer, directly or through its selected rate service
3108 organization, shall:
3109 (a) record and report its workers' compensation experience to the designated rate
3110 service organization as set forth in the uniform statistical plan approved by the commissioner;
3111 and
3112 (b) adhere to a uniform classification plan and uniform experience rating plan filed
3113 with the commissioner by the rate service organization designated by the commissioner[; and].
3114 [(c) adhere to the prospective loss costs filed by the designated rate service
3115 organization.]
3116 (4) The commissioner may adopt rules for:
3117 (a) the development and administration by the designated rate service organization of
3118 the:
3119 (i) uniform statistical plan;
3120 (ii) uniform experience rating plan; and
3121 (iii) uniform classification plan;
3122 (b) the recording and reporting of statistical data and experience rating data by the
3123 various insurers writing workers' compensation insurance;
3124 (c) the selection, retention, and termination of the designated rate service organization;
3125 and
3126 (d) providing for the equitable sharing and recovery of the expense of the designated
3127 rate service organization to develop, maintain, and provide the plans, services, and filings that
3128 are used by the various insurers writing workers' compensation insurance.
3129 (5) (a) Notwithstanding Subsection (3), an insurer may develop directly or through its
3130 selected rate service organization subclassifications of the uniform classification system upon
3131 which a rate may be made.
3132 (b) A subclassification shall be filed with the commissioner 30 days before its use.
3133 (c) The commissioner shall disapprove subclassifications if the insurer fails to

3134 demonstrate that the data produced by the subclassifications can be reported consistently with
3135 the uniform statistical plan and uniform classification plan.
3136 (6) Notwithstanding Subsection (3), an insurer may, directly or though its selected rate
3137 service organization, develop its own experience modifications based on the uniform statistical
3138 plan, uniform classification plan, and uniform rating plan filed by the rate service organization
3139 designated by the commissioner under Subsection (1).
3140 Section 20. Section **31A-19a-405** is amended to read:
3141 **31A-19a-405. Filing of rates and other rating information.**
3142 (1) (a) All workers' compensation rates, supplementary rate information, and supporting
3143 information shall be filed at least 30 days before the effective date of the rate or information.
3144 (b) Notwithstanding Subsection (1)(a), on application by the filer, the commissioner
3145 may authorize an earlier effective date.
3146 (2) The loss and loss adjustment expense factors included in the rates filed under
3147 Subsection (1) shall be:
3148 (a) the [~~prospective~~] advisory loss costs filed by the designated rate service
3149 organization under Section 31A-19a-406[~~.~~]; or
3150 (b) a percent modification of the advisory loss costs filed by the designated rate service
3151 organization under Section 31A-19a-406.
3152 (3) A modification filed under Subsection (2)(b) shall be accompanied by adequate
3153 support as required by Part 2, General Rate Regulation.
3154 Section 21. Section **31A-19a-406** is amended to read:
3155 **31A-19a-406. Filing requirements for designated rate service organization.**
3156 (1) The rate service organization designated under Section 31A-19a-404 shall file with
3157 the commissioner the following items proposed for use in this state at least 30 calendar days
3158 before the [~~date they~~] day on which the items are distributed to members, subscribers, or
3159 others:
3160 (a) each [~~prospective~~] advisory loss cost with its supporting information;

3161 (b) the uniform classification plan and rating manual;

3162 (c) the uniform experience rating plan manual;

3163 (d) the uniform statistical plan manual; and

3164 (e) each change, amendment, or modification of any of the items listed in Subsections

3165 (1)(a) through (d).

3166 (2) (a) If the commissioner believes that [~~prospective~~] advisory loss costs filed violate

3167 the excessive, inadequate, or unfair discriminatory standard in Section 31A-19a-201 or any

3168 other applicable requirement of this part, the commissioner may require that the rate service

3169 organization file additional supporting information.

3170 (b) If, after reviewing the supporting information, the commissioner determines that

3171 the [~~prospective~~] advisory loss costs violate these requirements, the commissioner may:

3172 (i) require that adjustments to the [~~prospective~~] advisory loss costs be made; or

3173 (ii) call a hearing for any purpose regarding the filing.

3174 Section 22. Section **31A-21-201** is amended to read:

3175 **31A-21-201. Filing of forms.**

3176 (1) (a) Except as exempted under Subsections 31A-21-101(2) through (6), a form may

3177 not be used, sold, or offered for sale until the form is filed with the commissioner.

3178 (b) A form is considered filed with the commissioner when the commissioner receives:

3179 (i) the form;

3180 (ii) the applicable filing fee as prescribed under Section 31A-3-103; and

3181 (iii) the applicable transmittal forms as required by the commissioner.

3182 (2) In filing a form for use in this state the insurer is responsible for assuring that the

3183 form is in compliance with this title and rules adopted by the commissioner.

3184 (3) (a) The commissioner may prohibit the use of a form at any time upon a finding

3185 that:

3186 (i) the form:

3187 (A) is inequitable;

3188 (B) is unfairly discriminatory;
3189 (C) is misleading;
3190 (D) is deceptive;
3191 (E) is obscure;
3192 (F) is unfair;
3193 (G) encourages misrepresentation; or
3194 (H) is not in the public interest;
3195 (ii) the form provides benefits or contains another provision that endangers the solidity
3196 of the insurer;
3197 (iii) except for a life or accident and health insurance policy form, the form is an
3198 insurance policy or application for an insurance policy, that fails to conspicuously, as defined
3199 by rule, provide:
3200 (A) the exact name of the insurer; and
3201 (B) the state of domicile of the insurer filing the insurance policy or application for the
3202 insurance policy;
3203 [(iii)] (iv) except an application required by Section 31A-22-635, [the form is an
3204 insurance policy or application for an insurance policy] the form is a life or accident and health
3205 insurance policy form that fails to conspicuously, as defined by rule, provide:
3206 (A) the exact name of the insurer;
3207 (B) the state of domicile of the insurer filing the insurance policy or application for the
3208 insurance policy; and
3209 (C) for a life insurance [and annuity insurance] policy only, the address of the
3210 administrative office of the insurer filing the [insurance policy or application for the insurance
3211 policy] form;
3212 [(iv)] (v) the form violates a statute or a rule adopted by the commissioner; or
3213 [(v)] (vi) the form is otherwise contrary to law.
3214 (b) (i) When the commissioner prohibits the use of a form under Subsection (3)(a), the

3215 commissioner may order that, on or before a date not less than 15 days after the order, the use
3216 of the form be discontinued.
3217 (ii) Once use of a form is prohibited, the form may not be used until appropriate
3218 changes are filed with and reviewed by the commissioner.
3219 (iii) When the commissioner prohibits the use of a form under Subsection (3)(a), the
3220 commissioner may require the insurer to disclose contract deficiencies to the existing
3221 policyholders.
3222 (c) If the commissioner prohibits use of a form under this Subsection (3), the
3223 prohibition shall:
3224 (i) be in writing;
3225 (ii) constitute an order; and
3226 (iii) state the reasons for the prohibition.
3227 (4) (a) If, after a hearing, the commissioner determines that it is in the public interest,
3228 the commissioner may require by rule or order that a form be subject to the commissioner's
3229 approval before its use.
3230 (b) The rule or order described in Subsection (4)(a) shall prescribe the filing
3231 procedures for a form if the procedures are different from the procedures stated in this section.
3232 (c) The type of form that under Subsection (4)(a) the commissioner may require
3233 approval of before use includes:
3234 (i) a form for a particular class of insurance;
3235 (ii) a form for a specific line of insurance;
3236 (iii) a specific type of form; or
3237 (iv) a form for a specific market segment.
3238 (5) (a) An insurer shall maintain a complete and accurate record of the following for
3239 the time period described in Subsection (5)(b):
3240 (i) a form:
3241 (A) filed under this section for use; or

3242 (B) that is in use; and
3243 (ii) a document filed under this section with a form described in Subsection (5)(a)(i).
3244 (b) The insurer shall maintain a record required under Subsection (5)(a) for the balance
3245 of the current year, plus five years from:
3246 (i) the last day on which the form is used; or
3247 (ii) the last day an insurance policy that is issued using the form is in effect.
3248 Section 23. Section **31A-21-301** is amended to read:
3249 **31A-21-301. Clauses required to be in a prominent position.**
3250 (1) The following portions of insurance policies shall appear conspicuously in the
3251 policy:
3252 (a) as required by [~~Subsection~~] Subsections 31A-21-201(3)(a)(iii) and (iv):
3253 (i) the exact name of the insurer;
3254 (ii) the state of domicile of the insurer; and
3255 (iii) for life insurance and annuity policies only, the address of the administrative office
3256 of the insurer;
3257 (b) information that two or more insurers under Subsection (1)(a) undertake only
3258 several liability, as required by Section 31A-21-306;
3259 (c) if a policy is assessable, a statement of that;
3260 (d) a statement that benefits are variable, as required by Section 31A-22-411; however,
3261 the methods of calculation need not be in a prominent position;
3262 (e) the right to return a life or accident and health insurance policy under Sections
3263 31A-22-423 and 31A-22-606; and
3264 (f) the beginning and ending dates of insurance protection.
3265 (2) Each clause listed in Subsection (1) shall be displayed conspicuously and separately
3266 from any other clause.
3267 Section 24. Section **31A-21-313** is amended to read:
3268 **31A-21-313. Limitation of actions.**

3269 (1) (a) An action on a written policy or contract of first party insurance shall be
3270 commenced within three years after the inception of the loss.
3271 (b) The inception of the loss on a fidelity bond is the date the insurer first denies all or
3272 part of a claim made under the fidelity bond.
3273 (2) Except as provided in Subsection (1) or elsewhere in this title, the law applicable to
3274 limitation of actions in Title 78B, Chapter 2, Statutes of Limitations, applies to actions on
3275 insurance policies.
3276 (3) An insurance policy may not:
3277 (a) limit the time for beginning an action on the policy to a time less than that
3278 authorized by statute;
3279 (b) prescribe in what court an action may be brought on the policy; or
3280 (c) provide that no action may be brought, subject to permissible arbitration provisions
3281 in contracts.
3282 (4) (a) Unless by verified complaint it is alleged that prejudice to the complainant will
3283 arise from a delay in bringing suit against an insurer, which prejudice is other than the delay
3284 itself, no action may be brought against an insurer on an insurance policy to compel payment
3285 under the policy until the earlier of:
3286 [(a)] (i) 60 days after proof of loss has been furnished as required under the policy;
3287 [(b)] (ii) waiver by the insurer of proof of loss; or
3288 [(c)] (iii) (A) the insurer's denial of full payment[.]; or
3289 (B) for an accident and health insurance policy, the insurer's denial of payment.
3290 (b) Under an accident and health insurance policy, an insurer may not require the
3291 completion of an appeals process that exceeds the provisions in 29 C.F.R. Sec. 2560.503-1 to
3292 bring suit under this Subsection (4).
3293 (5) The period of limitation is tolled during the period in which the parties conduct an
3294 appraisal or arbitration procedure prescribed by the insurance policy, by law, or as agreed to by
3295 the parties.

3296 Section 25. Section **31A-22-205** is enacted to read:

3297 **31A-22-205. Applicability of restatement of law.**

3298 (1) A restatement of the law of liability insurance is not the law or public policy of this

3299 state if the statement of law is inconsistent or in conflict with:

3300 (a) the Constitution of the United States;

3301 (b) the Utah Constitution;

3302 (c) a state statute;

3303 (d) state case law; or

3304 (e) state-adopted common law.

3305 (2) Nothing in this section precludes a court from referencing or considering a

3306 restatement or other legal treatise.

3307 Section 26. Section **31A-22-412** is amended to read:

3308 **31A-22-412. Assignment of life insurance rights.**

3309 (1) As used in this section, "final termination of a policy" means the day after which an

3310 insurer will not reinstate a policy without requiring:

3311 (a) evidence of insurability; or

3312 (b) written application.

3313 [~~(1)~~] (2) (a) Except as provided under Subsection [~~(3)~~] (4), the owner of any rights in a

3314 life insurance policy or annuity contract may assign any of those rights, including any right to

3315 designate a beneficiary and the rights secured under Sections 31A-22-517 through 31A-22-521

3316 and any other provision of this title.

3317 (b) An assignment, valid under general contract law, vests the assigned rights in the

3318 assignee, subject, so far as reasonably necessary for the protection of the insurer, to any

3319 provisions in the insurance policy or annuity contract inserted to protect the insurer against

3320 double payment or obligation.

3321 [~~(2)~~] (3) The rights of a beneficiary under a life insurance policy or annuity contract are

3322 subordinate to those of an assignee, unless the beneficiary was designated as an irrevocable

3323 beneficiary prior to the assignment.

3324 [(3)] (4) Assignment of insurance rights may be expressly prohibited by an annuity

3325 contract which provides annuities as retirement benefits related to employment contracts.

3326 [(4)] (5) (a) [When] After July 1, 1986, when a life insurance policy or annuity is[,

3327 after July 1, 1986,] assigned in writing as security for an indebtedness, the insurer shall[, in any

3328 case in which it has received written notice of the assignment, the name and address of the

3329 assignee, and a request for cancellation notice by the assignee,] mail to the assignee a copy of

3330 any cancellation notice sent with respect to the policy[.], if the insurer has received:

3331 (i) written notice of the assignment;

3332 (ii) the name and address of the assignee; and

3333 (iii) a request for assignment notice from the assignee.

3334 (b) An insurer shall mail the cancellation notice described in Subsection (5)(a):

3335 (i) [This notice shall be sent, postage] prepaid, and addressed to the assignee's address

3336 filed with the insured[. The notice shall be mailed];

3337 (ii) not less than 10 days [prior to] before the final termination of the policy; and

3338 (iii) each time the insured [has failed or refused] fails or refuses to transmit a premium

3339 payment to the insurer before the commencement of the policy's grace period.

3340 (c) The insurer may charge the insured directly or charge against the policy the

3341 reasonable cost of complying with this section, but in no event to exceed $5 for each notice.

3342 [As used in this section, "final termination of the policy" means the date after which the policy

3343 will not be reinstated by the insurer without requiring evidence of insurability or written

3344 application.]

3345 [(5)] (6) In lieu of providing notices to assignees of final termination of the policy

3346 under Subsection [(4)] (5), an insurer may provide an assignee with an identical copy of all

3347 notices sent to the owner of the life insurance policy, provided these notices comply with the

3348 other requirements of this title.

3349 Section 27. Section **31A-22-413** is amended to read:

3350 **31A-22-413. Designation of beneficiary.**
3351 (1) Subject to Subsection 31A-22-412[~~(2)~~](3), no life insurance policy or annuity
3352 contract may restrict the right of a policyholder or certificate holder:
3353 (a) to make an irrevocable designation of beneficiary effective immediately or at some
3354 subsequent time; or
3355 (b) if the designation of beneficiary is not explicitly irrevocable, to change the
3356 beneficiary without the consent of the previously designated beneficiary. Subsection
3357 75-6-201(1)(c) applies to designations by will or by separate writing.
3358 (2) (a) An insurer may prescribe formalities to be complied with for the change of
3359 beneficiaries, but those formalities may only be designed for the protection of the insurer.
3360 Notwithstanding Section 75-2-804, the insurer discharges its obligation under the insurance
3361 policy or certificate of insurance if it pays the properly designated beneficiary unless it has
3362 actual notice of either an assignment or a change in beneficiary designation made pursuant to
3363 Subsection (1)(b).
3364 (b) The insurer has actual notice if the formalities prescribed by the policy are
3365 complied with, or if the change in beneficiary has been requested in the form prescribed by the
3366 insurer and delivered to an agent representing the insurer at least three days prior to payment to
3367 the earlier properly designated beneficiary.
3368 Section 28. Section **31A-22-430** is enacted to read:
3369 **31A-22-430. Policy notification.**
3370 (1) (a) An insurer that delivers or issues for delivery an individual life insurance policy
3371 in this state shall notify the applicant for the policy, in writing at the time of application for the
3372 policy, of an applicant's right to designate a third party to receive notice of lapse or cancellation
3373 of the policy based on nonpayment of premium.
3374 (b) An applicant may make a designation described in Subsection (1)(a) at the time of
3375 application for the policy, or at any time the policy is in force, by submitting a written notice to
3376 the insurer containing the name and address of the third-party designee.

3377 (2) An insurer shall transmit a copy of a notice of lapse or cancellation of the policy
3378 based on nonpayment of premium to a third party designated in accordance with this section in
3379 addition to the transmission of the notice of lapse or cancellation of the policy to the
3380 policyholder.
3381 (3) The designation of a third party under this section does not constitute acceptance of
3382 any liability on the part of the third party or insurer for a service provided to the policyholder.
3383 Section 29. Section **31A-22-505** is amended to read:
3384 **31A-22-505. Association groups.**
3385 (1) A policy is subject to the requirements of this section if the policy is issued as
3386 policyholder to an association or to the trustees of a fund established, created, or maintained for
3387 the benefit of members of one or more associations:
3388 (a) with a minimum membership of 100 persons;
3389 (b) with a constitution and bylaws;
3390 (c) having a shared [~~or common purpose that is not primarily a business or customer~~
3391 ~~relationship; and~~] substantial common purpose that:
3392 (i) is the same profession, trade, occupation, or similar; or
3393 (ii) is by some common economic or representation of interest or genuine
3394 organizational relationship unrelated to the provision of benefits; and
3395 (d) that has been in active existence for at least two years.
3396 (2) The policy may insure members and employees of the association, employees of the
3397 members, one or more of the preceding entities, or all of any classes of these named entities for
3398 the benefit of persons other than the employees' employer, or any officials, representatives,
3399 trustees, or agents of the employer or association.
3400 (3) (a) The premiums shall be paid by:
3401 (i) the policyholder from funds contributed by the associations[~~, by~~];
3402 (ii) employer members, from funds contributed by the covered persons[~~,~~]; or
3403 (iii) from any combination of [~~these~~] Subsections (3)(a)(i) and (ii).

3404 (b) Except as provided under Section 31A-22-512, a policy on which no part of the
3405 premium is contributed by the covered persons, specifically for their insurance, is required to
3406 insure all eligible persons.
3407 Section 30. Section **31A-22-610.5** is amended to read:
3408 **31A-22-610.5. Dependent coverage.**
3409 (1) As used in this section, "child" has the same meaning as defined in Section
3410 78B-12-102.
3411 (2) (a) Any individual or group accident and health insurance policy or managed care
3412 organization contract that provides coverage for a policyholder's or certificate holder's
3413 dependent:
3414 (i) may not terminate coverage of an unmarried dependent by reason of the dependent's
3415 age before the dependent's 26th birthday; and
3416 (ii) shall, upon application, provide coverage for all unmarried dependents up to age
3417 26.
3418 (b) The cost of coverage for unmarried dependents 19 to 26 years of age shall be
3419 included in the premium on the same basis as other dependent coverage.
3420 (c) This section does not prohibit the employer from requiring the employee to pay all
3421 or part of the cost of coverage for unmarried dependents.
3422 (d) An individual or group health insurance policy or managed care organization shall
3423 continue in force coverage for a dependent through the last day of the month in which the
3424 dependent ceases to be a dependent:
3425 (i) if premiums are paid; and
3426 (ii) notwithstanding Sections 31A-22-618.6 and 31A-22-618.7.
3427 (3) (a) When a parent is required by a court or administrative order to provide health
3428 insurance coverage for a child, an accident and health insurer may not deny enrollment of a
3429 child under the accident and health insurance plan of the child's parent on the grounds the
3430 child:

3431 (i) was born out of wedlock and is entitled to coverage under Subsection (4);
3432 (ii) was born out of wedlock and the custodial parent seeks enrollment for the child
3433 under the custodial parent's policy;
3434 (iii) is not claimed as a dependent on the parent's federal tax return; [~~or~~]
3435 (iv) does not reside with the parent; or
3436 (v) does not reside in the insurer's service area.
3437 (b) A child enrolled as required under Subsection (3)(a)(iv) is subject to the terms of
3438 the accident and health insurance plan contract pertaining to services received outside of an
3439 insurer's service area.
3440 (4) When a child has accident and health coverage through an insurer of a noncustodial
3441 parent, and when requested by the noncustodial or custodial parent, the insurer shall:
3442 (a) provide information to the custodial parent as necessary for the child to obtain
3443 benefits through that coverage, but the insurer or employer, or the agents or employees of either
3444 of them, are not civilly or criminally liable for providing information in compliance with this
3445 Subsection (4)(a), whether the information is provided pursuant to a verbal or written request;
3446 (b) permit the custodial parent or the service provider, with the custodial parent's
3447 approval, to submit claims for covered services without the approval of the noncustodial
3448 parent; and
3449 (c) make payments on claims submitted in accordance with Subsection (4)(b) directly
3450 to the custodial parent, the child who obtained benefits, the provider, or the state Medicaid
3451 agency.
3452 (5) When a parent is required by a court or administrative order to provide health
3453 coverage for a child, and the parent is eligible for family health coverage, the insurer shall:
3454 (a) permit the parent to enroll, under the family coverage, a child who is otherwise
3455 eligible for the coverage without regard to an enrollment season restrictions;
3456 (b) if the parent is enrolled but fails to make application to obtain coverage for the
3457 child, enroll the child under family coverage upon application of the child's other parent, the

3458 state agency administering the Medicaid program, or the state agency administering 42 U.S.C.
3459 Sec. 651 through 669, the child support enforcement program; and
3460 (c) (i) when the child is covered by an individual policy, not disenroll or eliminate
3461 coverage of the child unless the insurer is provided satisfactory written evidence that:
3462 (A) the court or administrative order is no longer in effect; or
3463 (B) the child is or will be enrolled in comparable accident and health coverage through
3464 another insurer which will take effect not later than the effective date of disenrollment; or
3465 (ii) when the child is covered by a group policy, not disenroll or eliminate coverage of
3466 the child unless the employer is provided with satisfactory written evidence, which evidence is
3467 also provided to the insurer, that Subsection (8)(c)(i), (ii), or (iii) has happened.
3468 (6) An insurer may not impose requirements on a state agency that has been assigned
3469 the rights of an individual eligible for medical assistance under Medicaid and covered for
3470 accident and health benefits from the insurer that are different from requirements applicable to
3471 an agent or assignee of any other individual so covered.
3472 (7) Insurers may not reduce their coverage of pediatric vaccines below the benefit level
3473 in effect on May 1, 1993.
3474 (8) When a parent is required by a court or administrative order to provide health
3475 coverage, which is available through an employer doing business in this state, the employer
3476 shall:
3477 (a) permit the parent to enroll under family coverage any child who is otherwise
3478 eligible for coverage without regard to any enrollment season restrictions;
3479 (b) if the parent is enrolled but fails to make application to obtain coverage of the child,
3480 enroll the child under family coverage upon application by the child's other parent, by the state
3481 agency administering the Medicaid program, or the state agency administering 42 U.S.C. Sec.
3482 651 through 669, the child support enforcement program;
3483 (c) not disenroll or eliminate coverage of the child unless the employer is provided
3484 satisfactory written evidence that:

3485 (i) the court order is no longer in effect;

3486 (ii) the child is or will be enrolled in comparable coverage which will take effect no
3487 later than the effective date of disenrollment; or

3488 (iii) the employer has eliminated family health coverage for all of its employees; and

3489 (d) withhold from the employee's compensation the employee's share, if any, of
3490 premiums for health coverage and to pay this amount to the insurer.

3491 (9) An order issued under Section 62A-11-326.1 may be considered a "qualified
3492 medical support order" for the purpose of enrolling a dependent child in a group accident and
3493 health insurance plan as defined in Section 609(a), Federal Employee Retirement Income
3494 Security Act of 1974.

3495 (10) This section does not affect any insurer's ability to require as a precondition of any
3496 child being covered under any policy of insurance that:

3497 (a) the parent continues to be eligible for coverage;

3498 (b) the child shall be identified to the insurer with adequate information to comply with
3499 this section; and

3500 (c) the premium shall be paid when due.

3501 (11) This section applies to employee welfare benefit plans as defined in Section
3502 26-19-102.

3503 (12) (a) A policy that provides coverage to a child of a group member may not deny
3504 eligibility for coverage to a child solely because:

3505 (i) the child does not reside with the insured; or

3506 (ii) the child is solely dependent on a former spouse of the insured rather than on the
3507 insured.

3508 (b) A child who does not reside with the insured may be excluded on the same basis as
3509 a child who resides with the insured.

3510 Section 31. Section **31A-22-615.5** is amended to read:

3511 **31A-22-615.5. Insurance coverage for opioids -- Policies -- Reports.**

3512 (1) For purposes of this section:
3513 (a) "Health care provider" means an individual, other than a veterinarian, who:
3514 (i) is licensed to prescribe a controlled substance under Title 58, Chapter 37, Utah
3515 Controlled Substances Act; and
3516 (ii) possesses the authority, in accordance with the individual's scope of practice, to
3517 prescribe Schedule II controlled substances and Schedule III controlled substances that are
3518 applicable to opioids and benzodiazapines.
3519 (b) "Health insurer" means:
3520 (i) an insurer who offers health care insurance as that term is defined in Section
3521 31A-1-301;
3522 (ii) health benefits offered to state employees under Section 49-20-202; and
3523 (iii) a workers' compensation insurer:
3524 (A) authorized to provide workers' compensation insurance in the state; or
3525 (B) that is a self-insured employer as [~~defined~~] described in Section 34A-2-201.
3526 (c) "Opioid" has the same meaning as "opiate," as that term is defined in Section
3527 58-37-2.
3528 (d) "Prescribing policy" means a policy developed by a health insurer that includes
3529 evidence based guidelines for prescribing opioids, and may include the 2016 Center for Disease
3530 Control Guidelines for Prescribing Opioids for Chronic Pain, or the Utah Clinical Guidelines
3531 on Prescribing Opioids for the treatment of pain.
3532 (2) A health insurer that provides prescription drug coverage may enact a policy to
3533 minimize the risk of opioid addiction and overdose from:
3534 (a) chronic co-prescription of opioids with benzodiazapines and other sedating
3535 substances;
3536 (b) prescription of very high dose opioids in the primary care setting; and
3537 (c) the inadvertent transition of short-term opioids for an acute injury into long-term
3538 opioid dependence.

3539 (3) A health insurer that provides prescription drug coverage may enact policies to
3540 facilitate:
3541 (a) non-narcotic treatment alternatives for patients who have chronic pain; and
3542 (b) medication-assisted treatment for patients who have opioid dependence disorder.
3543 (4) The requirements of this section apply to insurance plans entered into or renewed
3544 on or after July 1, 2017.
3545 (5) (a) A health insurer subject to this section shall on or before [~~September 1, 2017~~]
3546 July 15, 2020, and before each [~~September 1~~] July 15 thereafter, submit a written report to the
3547 Utah Insurance Department regarding whether the insurer has adopted a policy and a general
3548 description of the policy.
3549 (b) The Utah Insurance Department shall, on or before October 1, 2017, and before
3550 each October 1 thereafter, submit a written summary of the information under Subsection (5)(a)
3551 to the Health and Human Services Interim Committee.
3552 (6) A health insurer subject to this section may share the policies developed under this
3553 section with other health insurers and the public.
3554 (7) This section sunsets in accordance with Section 63I-1-231.
3555 Section 32. Section **31A-22-2001** is enacted to read:
3556 **Part 20. Limited Long-Term Care Insurance Act**
3557 **31A-22-2001. Title.**
3558 This part is known as the "Limited Long-Term Care Insurance Act."
3559 Section 33. Section **31A-22-2002** is enacted to read:
3560 **31A-22-2002. Definitions.**
3561 As used in this part:
3562 (1) "Applicant" means:
3563 (a) when referring to an individual limited long-term care insurance policy, the person
3564 who seeks to contract for benefits; and
3565 (b) when referring to a group limited long-term care insurance policy, the proposed

3566 certificate holder.

3567 (2) "Elimination period" means the length of time between meeting the eligibility for

3568 benefit payment and receiving benefit payments from an insurer.

3569 (3) "Group limited long-term care insurance" means a limited long-term care insurance

3570 policy that is delivered or issued for delivery:

3571 (a) in this state; and

3572 (b) to an eligible group, as described under Subsection 31A-22-701(2).

3573 (4) (a) "Limited long-term care insurance" means an insurance:

3574 (i) policy, endorsement, or rider that is advertised, marketed, offered, or designed to

3575 provide coverage:

3576 (A) for less than 12 consecutive months for each covered person;

3577 (B) on an expense-incurred, indemnity, prepaid or other basis; and

3578 (C) for one or more necessary or medically necessary diagnostic, preventative,

3579 therapeutic, rehabilitative, maintenance, or personal care services that is provided in a setting

3580 other than an acute care unit of a hospital; or

3581 (ii) policy or rider that provides for payment of benefits based on cognitive impairment

3582 or the loss of functional capacity.

3583 (b) "Limited long-term care insurance" does not include an insurance policy that is

3584 offered primarily to provide:

3585 (i) basic Medicare supplement coverage;

3586 (ii) basic hospital expense coverage;

3587 (iii) basic medical-surgical expense coverage;

3588 (iv) hospital confinement indemnity coverage;

3589 (v) major medical expense coverage;

3590 (vi) disability income or related asset-protection coverage;

3591 (vii) accidental only coverage;

3592 (viii) specified disease or specified accident coverage; or

3593 (ix) limited benefit health coverage.
3594 (5) "Preexisting condition" means a condition for which medical advice or treatment is
3595 recommended:
3596 (a) by, or received from, a provider of health care services; and
3597 (b) within six months before the day on which the coverage of an insured person
3598 becomes effective.
3599 (6) "Waiting period" means the time an insured waits before some or all of the
3600 insured's coverage becomes effective.
3601 Section 34. Section **31A-22-2003** is enacted to read:
3602 **31A-22-2003. Scope.**
3603 (1) The requirements of this part apply to limited long-term care insurance policies and
3604 certificates marketed, delivered, or issued for delivery in this state on or after July 1, 2020.
3605 (2) Laws and regulations designed or intended to apply to Medicare supplement
3606 insurance policies may not be applied to limited long-term care insurance.
3607 Section 35. Section **31A-22-2004** is enacted to read:
3608 **31A-22-2004. Disclosure and performance standards for limited long-term care**
3609 **insurance.**
3610 (1) A limited long-term care insurance policy may not:
3611 (a) be cancelled, nonrenewed, or otherwise terminated because of the age, gender, or
3612 the deterioration of the mental or physical health of the insured individual or certificate holder;
3613 (b) contain a provision establishing a new waiting period if existing coverage is
3614 converted to or replaced by a new or other form within the same insurer, or the insurer's
3615 affiliates, except with respect to an increase in benefits voluntarily selected by the insured
3616 individual or group policyholder; or
3617 (c) provide coverage for skilled nursing care only or provide significantly more
3618 coverage for skilled care in a facility than coverage for lower levels of care.
3619 (2) (a) A limited long-term care insurance policy or certificate may not:

3620 (i) use a definition of "preexisting condition" that is more restrictive than the definition
3621 under this part; or
3622 (ii) exclude coverage for a loss or confinement that is the result of a preexisting
3623 condition, unless the loss or confinement begins within six months after the day on which the
3624 coverage of the insured person becomes effective.
3625 (b) A preexisting condition does not prohibit an insurer from:
3626 (i) using an application form designed to elicit the complete health history of an
3627 applicant; or
3628 (ii) on the basis of the answers on the application described in Subsection (2)(b)(i),
3629 underwriting in accordance with the insurer's established underwriting standards.
3630 (c) (i) Unless otherwise provided in the policy or certificate, an insurer may exclude
3631 coverage of a preexisting condition:
3632 (A) for a time period of six months, beginning the day on which the coverage of the
3633 insured person becomes effective; and
3634 (B) regardless of whether the preexisting condition is disclosed on the application.
3635 (ii) A limited long-term care insurance policy or certificate may not exclude or use
3636 waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically
3637 named or described preexisting diseases or physical conditions for more than a time period of
3638 six months, beginning the day on which the coverage of the insured person becomes effective.
3639 (3) (a) An insurer may not deliver or issue for delivery a limited long-term care
3640 insurance policy that conditions eligibility for any benefits:
3641 (i) on a prior hospitalization requirement;
3642 (ii) provided in an institutional care setting, on the receipt of a higher level of
3643 institutional care; or
3644 (iii) other than waiver of premium, post-confinement, post-acute care, or recuperative
3645 benefits, on a prior institutionalization requirement.
3646 (b) A limited long-term care insurance policy or rider may not condition eligibility for

3647 noninstitutional benefits on the prior or continuing receipt of skilled care services.
3648 (4) (a) If, after examination of a policy, certificate, or rider, a limited long-term care
3649 insurance applicant is not satisfied for any reason, the applicant has the right to:
3650 (i) within 30 days after the day on which the applicant receives the policy, certificate,
3651 endorsement, or rider, return the policy, certificate, endorsement, or rider to the company or a
3652 producer of the company; and
3653 (ii) have the premium refunded.
3654 (b) (i) Each limited long-term care insurance policy, certificate, endorsement, and rider
3655 shall:
3656 (A) have a notice prominently printed on the first page or attached thereto detailing
3657 specific instructions to accomplish a return; and
3658 (B) include the following free-look statement or language substantially similar: "You
3659 have 30 days from the day on which you receive this policy certificate, endorsement, or rider to
3660 review it and return it to the company if you decide not to keep it. You do not have to tell the
3661 company why you are returning it. If you decide not to keep it, simply return it to the company
3662 at its administrative office. Or you may return it to the producer that you bought it from. You
3663 must return it within 30 days of the day you first received it. The company will refund the full
3664 amount of any premium paid within 30 days after it receives the returned policy, certificate, or
3665 rider. The premium refund will be sent directly to the person who paid it. The policy certificate
3666 or rider will be void as if it had never been issued."
3667 (ii) The requirements described in Subsection (4)(b)(i) do not apply to a certificate
3668 issued to an employee under an employer group limited long-term care insurance policy.
3669 (5) (a) (i) An insurer shall deliver an outline of coverage to a prospective applicant for
3670 limited long-term care insurance at the time of initial solicitation through means that
3671 prominently direct the attention of the recipient to the document and the document's purpose.
3672 (ii) In the case of an agent solicitation, the agent shall deliver the outline of coverage
3673 before the presentation of an application or enrollment form.

3674 (iii) In the case of a direct response solicitation, the outline of coverage shall be
3675 presented in conjunction with any application or enrollment form.
3676 (iv) (A) In the case of a policy issued to a group, the outline of coverage is not required
3677 to be delivered if the information described in Subsections (5)(b)(i) through (iii) is contained in
3678 other materials relating to enrollment, including the certificate.
3679 (B) Upon request, an insurer shall make the other materials described in this
3680 Subsection (5)(a)(iv) available to the commissioner.
3681 (b) An outline of coverage shall include:
3682 (i) a description of the principal benefits and coverage provided in the policy;
3683 (ii) a description of the eligibility triggers for benefits and how the eligibility triggers
3684 are met;
3685 (iii) a statement of the principal exclusions, reductions, and limitations contained in the
3686 policy;
3687 (iv) a statement of the terms under which the policy or certificate, or both, may be
3688 continued in force or discontinued, including any reservation in the policy of a right to change
3689 premium.
3690 (v) a specific description of each continuation or conversion provision of group
3691 coverage;
3692 (vi) a statement that the outline of coverage is a summary only, not a contract of
3693 insurance, and that the policy or group master policy contains governing contractual provisions;
3694 (vii) a description of the terms under which a person may return the policy or
3695 certificate and have the premium refunded;
3696 (viii) a brief description of the relationship of cost of care and benefits; and
3697 (ix) a statement that discloses to the policyholder or certificate holder that the policy is
3698 not long-term care insurance.
3699 (6) A certificate pursuant to a group limited long-term care insurance policy that is
3700 delivered or issued for delivery in this state shall include:

3701 (a) a description of the principal benefits and coverage provided in the policy;
3702 (b) a statement of the principal exclusions, reductions, and limitations contained in the
3703 policy; and
3704 (c) a statement that the group master policy determines governing contractual
3705 provisions.
3706 (7) If an application for a limited long-term care insurance contract or certificate is
3707 approved, the issuer shall deliver the contract or certificate of insurance to the applicant no
3708 later that 30 days after the day on which the application is approved.
3709 Section 36. Section **31A-22-2005** is enacted to read:
3710 **31A-22-2005. Nonforfeiture benefits.**
3711 (1) (a) A limited long-term care insurance policy may offer the option of purchasing a
3712 policy or certificate including a nonforfeiture benefit.
3713 (b) The offer of a nonforfeiture benefit may be in the form of a rider that is attached to
3714 the policy.
3715 (c) In the event the policy holder or certificate holder does not purchase a nonforfeiture
3716 benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a
3717 specified period of time following a substantial increase in premium rates.
3718 (2) If an insurer issues a group limited long-term care insurance policy, the insurer
3719 shall:
3720 (a) make any offer of a nonforfeiture benefit to the group policyholder; and
3721 (b) make any offer to each proposed certificate holder.
3722 Section 37. Section **31A-22-2006** is enacted to read:
3723 **31A-22-2006. Rulemaking.**
3724 In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the
3725 commissioner:
3726 (1) shall makes rules:
3727 (a) in the event of a substantial rate increase, promoting premium adequacy and

3728 protecting the policy holder;
3729 (b) establishing minimum standards for limited long-term care insurance marketing
3730 practices, producer compensation, producer testing, independent review of benefit
3731 determinations, penalties, and reporting practices;
3732 (c) prescribing a standard format, including style, arrangement, and overall appearance
3733 of an outline of coverage;
3734 (d) prescribing the content of an outline of coverage, in accordance with the
3735 requirements described in Subsection 31A-22-2004(5)(b);
3736 (e) specifying the type of nonforfeiture benefits offered as part of a limited long-term
3737 care insurance policy or certificate;
3738 (f) establishing the standards of nonforfeiture benefits; and
3739 (g) establishing the rules regarding contingent benefits upon lapse, including:
3740 (i) a determination of the specified period of time during which a contingent benefit
3741 upon lapse will be available; and
3742 (ii) the substantial premium rate increase that triggers a contingent benefit upon lapse
3743 as described in Subsection 31A-22-2005(1); and
3744 (2) may make rules establishing loss-ratio standards for limited long-term care
3745 insurance policies.
3746 Section 38. Section **31A-23a-111** is amended to read:
3747 **31A-23a-111. Revoking, suspending, surrendering, lapsing, limiting, or otherwise**
3748 **terminating a license -- Forfeiture -- Rulemaking for renewal or reinstatement.**
3749 (1) A license type issued under this chapter remains in force until:
3750 (a) revoked or suspended under Subsection (5);
3751 (b) surrendered to the commissioner and accepted by the commissioner in lieu of
3752 administrative action;
3753 (c) the licensee dies or is adjudicated incompetent as defined under:
3754 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

3755 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and
3756 Minors;
3757 (d) lapsed under Section 31A-23a-113; or
3758 (e) voluntarily surrendered.
3759 (2) The following may be reinstated within one year after the day on which the license
3760 is no longer in force:
3761 (a) a lapsed license; or
3762 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may
3763 not be reinstated after the license period in which the license is voluntarily surrendered.
3764 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a
3765 license, submission and acceptance of a voluntary surrender of a license does not prevent the
3766 department from pursuing additional disciplinary or other action authorized under:
3767 (a) this title; or
3768 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah
3769 Administrative Rulemaking Act.
3770 (4) A line of authority issued under this chapter remains in force until:
3771 (a) the qualifications pertaining to a line of authority are no longer met by the licensee;
3772 or
3773 (b) the supporting license type:
3774 (i) is revoked or suspended under Subsection (5);
3775 (ii) is surrendered to the commissioner and accepted by the commissioner in lieu of
3776 administrative action;
3777 (iii) lapses under Section 31A-23a-113; or
3778 (iv) is voluntarily surrendered; or
3779 (c) the licensee dies or is adjudicated incompetent as defined under:
3780 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
3781 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and

3782 Minors.
3783 (5) (a) If the commissioner makes a finding under Subsection (5)(b), as part of an
3784 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the
3785 commissioner may:
3786 (i) revoke:
3787 (A) a license; or
3788 (B) a line of authority;
3789 (ii) suspend for a specified period of 12 months or less:
3790 (A) a license; or
3791 (B) a line of authority;
3792 (iii) limit in whole or in part:
3793 (A) a license; or
3794 (B) a line of authority;
3795 (iv) deny a license application;
3796 (v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or
3797 (vi) take a combination of actions under Subsections (5)(a)(i) through (iv) and
3798 Subsection (5)(a)(v).
3799 (b) The commissioner may take an action described in Subsection (5)(a) if the
3800 commissioner finds that the licensee or license applicant:
3801 (i) is unqualified for a license or line of authority under Section 31A-23a-104,
3802 31A-23a-105, or 31A-23a-107;
3803 (ii) violates:
3804 (A) an insurance statute;
3805 (B) a rule that is valid under Subsection 31A-2-201(3); or
3806 (C) an order that is valid under Subsection 31A-2-201(4);
3807 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other
3808 delinquency proceedings in any state;

3809 (iv) fails to pay a final judgment rendered against the person in this state within 60
3810 days after the day on which the judgment became final;
3811 (v) fails to meet the same good faith obligations in claims settlement that is required of
3812 admitted insurers;
3813 (vi) is affiliated with and under the same general management or interlocking
3814 directorate or ownership as another insurance producer that transacts business in this state
3815 without a license;
3816 (vii) refuses:
3817 (A) to be examined; or
3818 (B) to produce its accounts, records, and files for examination;
3819 (viii) has an officer who refuses to:
3820 (A) give information with respect to the insurance producer's affairs; or
3821 (B) perform any other legal obligation as to an examination;
3822 (ix) provides information in the license application that is:
3823 (A) incorrect;
3824 (B) misleading;
3825 (C) incomplete; or
3826 (D) materially untrue;
3827 (x) violates an insurance law, valid rule, or valid order of another regulatory agency in
3828 any jurisdiction;
3829 (xi) obtains or attempts to obtain a license through misrepresentation or fraud;
3830 (xii) improperly withholds, misappropriates, or converts money or properties received
3831 in the course of doing insurance business;
3832 (xiii) intentionally misrepresents the terms of an actual or proposed:
3833 (A) insurance contract;
3834 (B) application for insurance; or
3835 (C) life settlement;

3836 (xiv) has been convicted of:
3837 (A) a felony; or
3838 (B) a misdemeanor involving fraud, misrepresentation, theft, or dishonesty;
3839 (xv) admits or is found to have committed an insurance unfair trade practice or fraud;
3840 (xvi) in the conduct of business in this state or elsewhere:
3841 (A) uses fraudulent, coercive, or dishonest practices; or
3842 (B) demonstrates incompetence, untrustworthiness, or financial irresponsibility;
3843 (xvii) has had an insurance license or other professional or occupational license, or an
3844 equivalent to an insurance license or registration, or other professional or occupational license
3845 or registration:
3846 (A) denied;
3847 (B) suspended;
3848 (C) revoked; or
3849 (D) surrendered to resolve an administrative action;
3850 (xviii) forges another's name to:
3851 (A) an application for insurance; or
3852 (B) a document related to an insurance transaction;
3853 (xix) improperly uses notes or another reference material to complete an examination
3854 for an insurance license;
3855 (xx) knowingly accepts insurance business from an individual who is not licensed;
3856 (xxi) fails to comply with an administrative or court order imposing a child support
3857 obligation;
3858 (xxii) fails to:
3859 (A) pay state income tax; or
3860 (B) comply with an administrative or court order directing payment of state income
3861 tax;
3862 (xxiii) has been convicted of violating the federal Violent Crime Control and Law

3863 Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and has not obtained written consent to engage
3864 in the business of insurance or participate in such business as required by 18 U.S.C. Sec. 1033;
3865 (xxiv) engages in a method or practice in the conduct of business that endangers the
3866 legitimate interests of customers and the public; or
3867 (xxv) has been convicted of any criminal felony involving dishonesty or breach of trust
3868 and has not obtained written consent to engage in the business of insurance or participate in
3869 such business as required by 18 U.S.C. Sec. 1033.
3870 (c) For purposes of this section, if a license is held by an agency, both the agency itself
3871 and any individual designated under the license are considered to be the holders of the license.
3872 (d) If an individual designated under the agency license commits an act or fails to
3873 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,
3874 the commissioner may suspend, revoke, or limit the license of:
3875 (i) the individual;
3876 (ii) the agency, if the agency:
3877 (A) is reckless or negligent in its supervision of the individual; or
3878 (B) knowingly participates in the act or failure to act that is the ground for suspending,
3879 revoking, or limiting the license; or
3880 (iii) (A) the individual; and
3881 (B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).
3882 (6) A licensee under this chapter is subject to the penalties for acting as a licensee
3883 without a license if:
3884 (a) the licensee's license is:
3885 (i) revoked;
3886 (ii) suspended;
3887 (iii) limited;
3888 (iv) surrendered in lieu of administrative action;
3889 (v) lapsed; or

3890 (vi) voluntarily surrendered; and
3891 (b) the licensee:
3892 (i) continues to act as a licensee; or
3893 (ii) violates the terms of the license limitation.
3894 (7) A licensee under this chapter shall immediately report to the commissioner:
3895 (a) a revocation, suspension, or limitation of the person's license in another state, the
3896 District of Columbia, or a territory of the United States;
3897 (b) the imposition of a disciplinary sanction imposed on that person by another state,
3898 the District of Columbia, or a territory of the United States; or
3899 (c) a judgment or injunction entered against that person on the basis of conduct
3900 involving:
3901 (i) fraud;
3902 (ii) deceit;
3903 (iii) misrepresentation; or
3904 (iv) a violation of an insurance law or rule.
3905 (8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a
3906 license in lieu of administrative action may specify a time, not to exceed five years, within
3907 which the former licensee may not apply for a new license.
3908 (b) If no time is specified in an order or agreement described in Subsection (8)(a), the
3909 former licensee may not apply for a new license for five years from the day on which the order
3910 or agreement is made without the express approval by the commissioner.
3911 (9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of
3912 a license issued under this part if so ordered by a court.
3913 (10) The commissioner shall by rule prescribe the license renewal and reinstatement
3914 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
3915 Section 39. Section **31A-23a-205** is amended to read:
3916 **31A-23a-205. Special requirements for bail bond producers and bail bond**

3917 **enforcement agents.**

3918 (1) As used in this section, "bail bond producer" and "bail enforcement agent" have the

3919 same definitions as in Section 31A-35-102.

3920 (2) A bail bond producer may not operate in this state without an appointment from

3921 one or more authorized bail bond surety insurers or licensed bail bond [~~surety~~] companies.

3922 (3) A bail bond enforcement agent may not operate in this state without an appointment

3923 from one or more licensed bail bond producers.

3924 Section 40. Section **31A-23a-415** is amended to read:

3925 **31A-23a-415. Assessment on agency title insurance producers or title insurers --**

3926 **Account created.**

3927 (1) For purposes of this section:

3928 (a) "Premium" is as [~~defined~~] described in Subsection 59-9-101(3).

3929 (b) "Title insurer" means a person:

3930 (i) making any contract or policy of title insurance as:

3931 (A) insurer;

3932 (B) guarantor; or

3933 (C) surety;

3934 (ii) proposing to make any contract or policy of title insurance as:

3935 (A) insurer;

3936 (B) guarantor; or

3937 (C) surety; or

3938 (iii) transacting or proposing to transact any phase of title insurance, including:

3939 (A) soliciting;

3940 (B) negotiating preliminary to execution;

3941 (C) executing of a contract of title insurance;

3942 (D) insuring; and

3943 (E) transacting matters subsequent to the execution of the contract and arising out of

3944 the contract.
3945 (c) "Utah risks" means insuring, guaranteeing, or indemnifying with regard to real or
3946 personal property located in Utah, an owner of real or personal property, the holders of liens or
3947 encumbrances on that property, or others interested in the property against loss or damage
3948 suffered by reason of:
3949 (i) liens or encumbrances upon, defects in, or the unmarketability of the title to the
3950 property; or
3951 (ii) invalidity or unenforceability of any liens or encumbrances on the property.
3952 (2) (a) The commissioner may assess each title insurer, each individual title insurance
3953 producer who is not an employee of a title insurer or who is not designated by an agency title
3954 insurance producer, and each agency title insurance producer an annual assessment:
3955 (i) determined by the Title and Escrow Commission:
3956 (A) after consultation with the commissioner; and
3957 (B) in accordance with this Subsection (2); and
3958 (ii) to be used for the purposes described in Subsection (3).
3959 (b) An agency title insurance producer and individual title insurance producer who is
3960 not an employee of a title insurer or who is not designated by an agency title insurance
3961 producer shall be assessed up to:
3962 (i) $250 for the first office in each county in which the agency title insurance producer
3963 or individual title insurance producer maintains an office; and
3964 (ii) $150 for each additional office the agency title insurance producer or individual
3965 title insurance producer maintains in the county described in Subsection (2)(b)(i).
3966 (c) A title insurer shall be assessed up to:
3967 (i) $250 for the first office in each county in which the title insurer maintains an office;
3968 (ii) $150 for each additional office the title insurer maintains in the county described in
3969 Subsection (2)(c)(i); and
3970 (iii) an amount calculated by:

3971 (A) aggregating the assessments imposed on:
3972 (I) agency title insurance producers and individual title insurance producers under
3973 Subsection (2)(b); and
3974 (II) title insurers under Subsections (2)(c)(i) and (2)(c)(ii);
3975 (B) subtracting the amount determined under Subsection (2)(c)(iii)(A) from the total
3976 costs and expenses determined under Subsection (2)(d); and
3977 (C) multiplying:
3978 (I) the amount calculated under Subsection (2)(c)(iii)(B); and
3979 (II) the percentage of total premiums for title insurance on Utah risk that are premiums
3980 of the title insurer.
3981 (d) Notwithstanding Section 31A-3-103 and subject to Section 31A-2-404, the Title
3982 and Escrow Commission by rule shall establish the amount of costs and expenses described
3983 under Subsection (3) that will be covered by the assessment, except the costs or expenses to be
3984 covered by the assessment may not exceed [~~$100,000 annually~~] the cost of one full-time
3985 equivalent position.
3986 (e) (i) An individual licensed to practice law in Utah is exempt from the requirements
3987 of this Subsection (2) if that person issues 12 or less policies during a 12-month period.
3988 (ii) In determining the number of policies issued by an individual licensed to practice
3989 law in Utah for purposes of Subsection (2)(e)(i), if the individual issues a policy to more than
3990 one party to the same closing, the individual is considered to have issued only one policy.
3991 (3) (a) Money received by the state under this section shall be deposited into the Title
3992 Licensee Enforcement Restricted Account.
3993 (b) There is created in the General Fund a restricted account known as the "Title
3994 Licensee Enforcement Restricted Account."
3995 (c) The Title Licensee Enforcement Restricted Account shall consist of the money
3996 received by the state under this section.
3997 (d) The commissioner shall administer the Title Licensee Enforcement Restricted

3998 Account. Subject to appropriations by the Legislature, the commissioner shall use the money
3999 deposited into the Title Licensee Enforcement Restricted Account only to pay for a cost or
4000 expense incurred by the department in the administration, investigation, and enforcement of
4001 laws governing individual title insurance producers, agency title insurance producers, or title
4002 insurers.
4003 (e) An appropriation from the Title Licensee Enforcement Restricted Account is
4004 nonlapsing.
4005 (4) The assessment imposed by this section shall be in addition to any premium
4006 assessment imposed under Subsection 59-9-101(3).
4007 Section 41. Section **31A-23b-401** is amended to read:
4008 **31A-23b-401. Revoking, suspending, surrendering, lapsing, limiting, or otherwise**
4009 **terminating a license -- Rulemaking for renewal or reinstatement.**
4010 (1) A license as a navigator under this chapter remains in force until:
4011 (a) revoked or suspended under Subsection (4);
4012 (b) surrendered to the commissioner and accepted by the commissioner in lieu of
4013 administrative action;
4014 (c) the licensee dies or is adjudicated incompetent as defined under:
4015 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
4016 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and
4017 Minors;
4018 (d) lapsed under this section; or
4019 (e) voluntarily surrendered.
4020 (2) The following may be reinstated within one year after the day on which the license
4021 is no longer in force:
4022 (a) a lapsed license; or
4023 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may
4024 not be reinstated after the license period in which the license is voluntarily surrendered.

4025 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a
4026 license, submission and acceptance of a voluntary surrender of a license does not prevent the
4027 department from pursuing additional disciplinary or other action authorized under:
4028 (a) this title; or
4029 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah
4030 Administrative Rulemaking Act.
4031 (4) (a) If the commissioner makes a finding under Subsection (4)(b), as part of an
4032 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the
4033 commissioner may:
4034 (i) revoke a license;
4035 (ii) suspend a license for a specified period of 12 months or less;
4036 (iii) limit a license in whole or in part;
4037 (iv) deny a license application;
4038 (v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or
4039 (vi) take a combination of actions under Subsections (4)(a)(i) through (iv) and
4040 Subsection (4)(a)(v).
4041 (b) The commissioner may take an action described in Subsection (4)(a) if the
4042 commissioner finds that the licensee or license applicant:
4043 (i) is unqualified for a license under Section 31A-23b-204, 31A-23b-205, or
4044 31A-23b-206;
4045 (ii) violated:
4046 (A) an insurance statute;
4047 (B) a rule that is valid under Subsection 31A-2-201(3); or
4048 (C) an order that is valid under Subsection 31A-2-201(4);
4049 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other
4050 delinquency proceedings in any state;
4051 (iv) failed to pay a final judgment rendered against the person in this state within 60

4052 days after the day on which the judgment became final;
4053 (v) refused:
4054 (A) to be examined; or
4055 (B) to produce its accounts, records, and files for examination;
4056 (vi) had an officer who refused to:
4057 (A) give information with respect to the navigator's affairs; or
4058 (B) perform any other legal obligation as to an examination;
4059 (vii) provided information in the license application that is:
4060 (A) incorrect;
4061 (B) misleading;
4062 (C) incomplete; or
4063 (D) materially untrue;
4064 (viii) violated an insurance law, valid rule, or valid order of another regulatory agency
4065 in any jurisdiction;
4066 (ix) obtained or attempted to obtain a license through misrepresentation or fraud;
4067 (x) improperly withheld, misappropriated, or converted money or properties received
4068 in the course of doing insurance business;
4069 (xi) intentionally misrepresented the terms of an actual or proposed:
4070 (A) insurance contract;
4071 (B) application for insurance; or
4072 (C) application for public program;
4073 (xii) has been convicted of:
4074 (A) a felony; or
4075 (B) a misdemeanor involving fraud, misrepresentation, theft, or dishonesty;
4076 (xiii) admitted or is found to have committed an insurance unfair trade practice or
4077 fraud;
4078 (xiv) in the conduct of business in this state or elsewhere:

4079 (A) used fraudulent, coercive, or dishonest practices; or
4080 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;
4081 (xv) has had an insurance license, navigator license, or other professional or
4082 occupational license or registration, or an equivalent of the same denied, suspended, revoked,
4083 or surrendered to resolve an administrative action;
4084 (xvi) forged another's name to:
4085 (A) an application for insurance;
4086 (B) a document related to an insurance transaction;
4087 (C) a document related to an application for a public program; or
4088 (D) a document related to an application for premium subsidies;
4089 (xvii) improperly used notes or another reference material to complete an examination
4090 for a license;
4091 (xviii) knowingly accepted insurance business from an individual who is not licensed;
4092 (xix) failed to comply with an administrative or court order imposing a child support
4093 obligation;
4094 (xx) failed to:
4095 (A) pay state income tax; or
4096 (B) comply with an administrative or court order directing payment of state income
4097 tax;
4098 (xxi) has been convicted of violating the federal Violent Crime Control and Law
4099 Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and has not obtained written consent to engage
4100 in the business of insurance or participate in such business as required by 18 U.S.C. Sec. 1033;
4101 (xxii) engaged in a method or practice in the conduct of business that endangered the
4102 legitimate interests of customers and the public; or
4103 (xxiii) has been convicted of any criminal felony involving dishonesty or breach of
4104 trust and has not obtained written consent to engage in the business of insurance or participate
4105 in such business as required by 18 U.S.C. Sec. 1033.

4106 (c) For purposes of this section, if a license is held by an agency, both the agency itself
4107 and any individual designated under the license are considered to be the holders of the license.
4108 (d) If an individual designated under the agency license commits an act or fails to
4109 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,
4110 the commissioner may suspend, revoke, or limit the license of:
4111 (i) the individual;
4112 (ii) the agency, if the agency:
4113 (A) is reckless or negligent in its supervision of the individual; or
4114 (B) knowingly participates in the act or failure to act that is the ground for suspending,
4115 revoking, or limiting the license; or
4116 (iii) (A) the individual; and
4117 (B) the agency if the agency meets the requirements of Subsection (4)(d)(ii).
4118 (5) A licensee under this chapter is subject to the penalties for acting as a licensee
4119 without a license if:
4120 (a) the licensee's license is:
4121 (i) revoked;
4122 (ii) suspended;
4123 (iii) surrendered in lieu of administrative action;
4124 (iv) lapsed; or
4125 (v) voluntarily surrendered; and
4126 (b) the licensee:
4127 (i) continues to act as a licensee; or
4128 (ii) violates the terms of the license limitation.
4129 (6) A licensee under this chapter shall immediately report to the commissioner:
4130 (a) a revocation, suspension, or limitation of the person's license in another state, the
4131 District of Columbia, or a territory of the United States;
4132 (b) the imposition of a disciplinary sanction imposed on that person by another state,

4133 the District of Columbia, or a territory of the United States; or
4134 (c) a judgment or injunction entered against that person on the basis of conduct
4135 involving:
4136 (i) fraud;
4137 (ii) deceit;
4138 (iii) misrepresentation; or
4139 (iv) a violation of an insurance law or rule.
4140 (7) (a) An order revoking a license under Subsection (4) or an agreement to surrender a
4141 license in lieu of administrative action may specify a time, not to exceed five years, within
4142 which the former licensee may not apply for a new license.
4143 (b) If no time is specified in an order or agreement described in Subsection (7)(a), the
4144 former licensee may not apply for a new license for five years from the day on which the order
4145 or agreement is made without the express approval of the commissioner.
4146 (8) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of
4147 a license issued under this chapter if so ordered by a court.
4148 (9) The commissioner shall by rule prescribe the license renewal and reinstatement
4149 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
4150 Section 42. Section **31A-25-208** is amended to read:
4151 **31A-25-208. Revoking, suspending, surrendering, lapsing, limiting, or otherwise**
4152 **terminating a license -- Rulemaking for renewal and reinstatement.**
4153 (1) A license type issued under this chapter remains in force until:
4154 (a) revoked or suspended under Subsection (4);
4155 (b) surrendered to the commissioner and accepted by the commissioner in lieu of
4156 administrative action;
4157 (c) the licensee dies or is adjudicated incompetent as defined under:
4158 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
4159 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and

4160 Minors;
4161 (d) lapsed under Section 31A-25-210; or
4162 (e) voluntarily surrendered.
4163 (2) The following may be reinstated within one year after the day on which the license
4164 is no longer in force:
4165 (a) a lapsed license; or
4166 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may
4167 not be reinstated after the license period in which the license is voluntarily surrendered.
4168 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a
4169 license, submission and acceptance of a voluntary surrender of a license does not prevent the
4170 department from pursuing additional disciplinary or other action authorized under:
4171 (a) this title; or
4172 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah
4173 Administrative Rulemaking Act.
4174 (4) (a) If the commissioner makes a finding under Subsection (4)(b), as part of an
4175 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the
4176 commissioner may:
4177 (i) revoke a license;
4178 (ii) suspend a license for a specified period of 12 months or less;
4179 (iii) limit a license in whole or in part; or
4180 (iv) deny a license application.
4181 (b) The commissioner may take an action described in Subsection (4)(a) if the
4182 commissioner finds that the licensee or license applicant:
4183 (i) is unqualified for a license under Section 31A-25-202, 31A-25-203, or 31A-25-204;
4184 (ii) has violated:
4185 (A) an insurance statute;
4186 (B) a rule that is valid under Subsection 31A-2-201(3); or

4187 (C) an order that is valid under Subsection 31A-2-201(4);
4188 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other
4189 delinquency proceedings in any state;
4190 (iv) fails to pay a final judgment rendered against the person in this state within 60
4191 days after the day on which the judgment became final;
4192 (v) fails to meet the same good faith obligations in claims settlement that is required of
4193 admitted insurers;
4194 (vi) is affiliated with and under the same general management or interlocking
4195 directorate or ownership as another third party administrator that transacts business in this state
4196 without a license;
4197 (vii) refuses:
4198 (A) to be examined; or
4199 (B) to produce its accounts, records, and files for examination;
4200 (viii) has an officer who refuses to:
4201 (A) give information with respect to the third party administrator's affairs; or
4202 (B) perform any other legal obligation as to an examination;
4203 (ix) provides information in the license application that is:
4204 (A) incorrect;
4205 (B) misleading;
4206 (C) incomplete; or
4207 (D) materially untrue;
4208 (x) has violated an insurance law, valid rule, or valid order of another regulatory
4209 agency in any jurisdiction;
4210 (xi) has obtained or attempted to obtain a license through misrepresentation or fraud;
4211 (xii) has improperly withheld, misappropriated, or converted money or properties
4212 received in the course of doing insurance business;
4213 (xiii) has intentionally misrepresented the terms of an actual or proposed:

4214 (A) insurance contract; or
4215 (B) application for insurance;
4216 (xiv) has been convicted of:
4217 (A) a felony; or
4218 (B) a misdemeanor involving fraud, misrepresentation, theft, or dishonesty;
4219 (xv) has admitted or been found to have committed an insurance unfair trade practice
4220 or fraud;
4221 (xvi) in the conduct of business in this state or elsewhere has:
4222 (A) used fraudulent, coercive, or dishonest practices; or
4223 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;
4224 (xvii) has had an insurance license or other professional or occupational license or
4225 registration, or an equivalent of the same, denied, suspended, revoked, or surrendered to
4226 resolve an administrative action;
4227 (xviii) has forged another's name to:
4228 (A) an application for insurance; or
4229 (B) a document related to an insurance transaction;
4230 (xix) has improperly used notes or any other reference material to complete an
4231 examination for an insurance license;
4232 (xx) has knowingly accepted insurance business from an individual who is not
4233 licensed;
4234 (xxi) has failed to comply with an administrative or court order imposing a child
4235 support obligation;
4236 (xxii) has failed to:
4237 (A) pay state income tax; or
4238 (B) comply with an administrative or court order directing payment of state income
4239 tax;
4240 (xxiii) [~~has violated or permitted others to violate~~] is convicted of violating the federal

4241 Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and [therefore]
4242 has not obtained written consent to engage in the business of insurance or participate in such
4243 business as required under 18 U.S.C. Sec. 1033 [is prohibited from engaging in the business of
4244 insurance; or];

4245 (xxiv) has engaged in methods and practices in the conduct of business that endanger
4246 the legitimate interests of customers and the public[.]; or

4247 (xxv) has been convicted of a criminal felony involving dishonesty or breach of trust
4248 and has not obtained written consent to engage in the business of insurance or participate in
4249 such business as required under 18 U.S.C. Sec. 1033.

4250 (c) For purposes of this section, if a license is held by an agency, both the agency itself
4251 and any individual designated under the license are considered to be the holders of the agency
4252 license.

4253 (d) If an individual designated under the agency license commits an act or fails to
4254 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,
4255 the commissioner may suspend, revoke, or limit the license of:

4256 (i) the individual;

4257 (ii) the agency if the agency:

4258 (A) is reckless or negligent in its supervision of the individual; or

4259 (B) knowingly participated in the act or failure to act that is the ground for suspending,
4260 revoking, or limiting the license; or

4261 (iii) (A) the individual; and

4262 (B) the agency if the agency meets the requirements of Subsection (4)(d)(ii).

4263 (5) A licensee under this chapter is subject to the penalties for acting as a licensee
4264 without a license if:

4265 (a) the licensee's license is:

4266 (i) revoked;

4267 (ii) suspended;

4268 (iii) limited;
4269 (iv) surrendered in lieu of administrative action;
4270 (v) lapsed; or
4271 (vi) voluntarily surrendered; and
4272 (b) the licensee:
4273 (i) continues to act as a licensee; or
4274 (ii) violates the terms of the license limitation.
4275 (6) A licensee under this chapter shall immediately report to the commissioner:
4276 (a) a revocation, suspension, or limitation of the person's license in any other state, the
4277 District of Columbia, or a territory of the United States;
4278 (b) the imposition of a disciplinary sanction imposed on that person by any other state,
4279 the District of Columbia, or a territory of the United States; or
4280 (c) a judgment or injunction entered against the person on the basis of conduct
4281 involving:
4282 (i) fraud;
4283 (ii) deceit;
4284 (iii) misrepresentation; or
4285 (iv) a violation of an insurance law or rule.
4286 (7) (a) An order revoking a license under Subsection (4) or an agreement to surrender a
4287 license in lieu of administrative action may specify a time, not to exceed five years, within
4288 which the former licensee may not apply for a new license.
4289 (b) If no time is specified in the order or agreement described in Subsection (7)(a), the
4290 former licensee may not apply for a new license for five years from the day on which the order
4291 or agreement is made without the express approval of the commissioner.
4292 (8) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of
4293 a license issued under this part if so ordered by the court.
4294 (9) The commissioner shall by rule prescribe the license renewal and reinstatement

4295 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

4296 Section 43. Section **31A-26-206** is amended to read:

4297 **31A-26-206. Continuing education requirements.**

4298 (1) Pursuant to this section, the commissioner shall by rule prescribe continuing

4299 education requirements for each class of license under Section 31A-26-204.

4300 (2) (a) The commissioner shall impose continuing education requirements in

4301 accordance with a two-year licensing period in which the licensee meets the requirements of

4302 this Subsection (2).

4303 (b) (i) Except as otherwise provided in this section, the continuing education

4304 requirements shall require:

4305 (A) that a licensee complete 24 credit hours of continuing education for every two-year

4306 licensing period;

4307 (B) that 3 of the 24 credit hours described in Subsection (2)(b)(i)(A) be ethics courses;

4308 and

4309 (C) that the licensee complete at least half of the required hours through classroom

4310 hours of insurance-related instruction.

4311 (ii) A continuing education hour completed in accordance with Subsection (2)(b)(i)

4312 may be obtained through:

4313 (A) classroom attendance;

4314 (B) home study;

4315 (C) watching a video recording;

4316 (D) experience credit; or

4317 (E) other methods provided by rule.

4318 (iii) Notwithstanding Subsections (2)(b)(i)(A) and (B), a title insurance adjuster is

4319 required to complete 12 credit hours of continuing education for every two-year licensing

4320 period, with 3 of the credit hours being ethics courses.

4321 (c) A licensee may obtain continuing education hours at any time during the two-year

4322 licensing period.

4323 (d) (i) A licensee is exempt from the continuing education requirements of this section

4324 if:

4325 (A) the licensee was first licensed before December 31, 1982;

4326 (B) the license does not have a continuous lapse for a period of more than one year,

4327 except for a license for which the licensee has had an exemption approved before May 11,

4328 2011;

4329 (C) the licensee requests an exemption from the department; and

4330 (D) the department approves the exemption.

4331 (ii) If the department approves the exemption under Subsection (2)(d)(i), the licensee is

4332 not required to apply again for the exemption.

4333 (e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the

4334 commissioner shall by rule:

4335 (i) publish a list of insurance professional designations whose continuing education

4336 requirements can be used to meet the requirements for continuing education under Subsection

4337 (2)(b); and

4338 (ii) authorize a professional adjuster association to:

4339 (A) offer a qualified program for a classification of license on a geographically

4340 accessible basis; and

4341 (B) collect a reasonable fee for funding and administration of a qualified program,

4342 subject to the review and approval of the commissioner.

4343 (f) (i) A fee permitted under Subsection (2)(e)(ii)(B) that is charged to fund and

4344 administer a qualified program shall reasonably relate to the cost of administering the qualified

4345 program.

4346 (ii) Nothing in this section shall prohibit a provider of a continuing education program

4347 or course from charging a fee for attendance at a course offered for continuing education credit.

4348 (iii) A fee permitted under Subsection (2)(e)(ii)(B) that is charged for attendance at an

4349 association program may be less for an association member, on the basis of the member's
4350 affiliation expense, but shall preserve the right of a nonmember to attend without affiliation.
4351 (3) The continuing education requirements of this section apply only to a licensee who
4352 is an individual.
4353 (4) The continuing education requirements of this section do not apply to a member of
4354 the Utah State Bar.
4355 (5) The commissioner shall designate a course that satisfies the requirements of this
4356 section, including a course presented by an insurer.
4357 (6) A nonresident adjuster is considered to have satisfied this state's continuing
4358 education requirements if:
4359 (a) the nonresident adjuster satisfies the nonresident [~~producer's~~] home state's
4360 continuing education requirements for a licensed insurance adjuster; and
4361 (b) on the same basis the nonresident adjuster's home state considers satisfaction of
4362 Utah's continuing education requirements for [~~a producer~~] an adjuster as satisfying the
4363 continuing education requirements of the home state.
4364 (7) A licensee subject to this section shall keep documentation of completing the
4365 continuing education requirements of this section for two years after the end of the two-year
4366 licensing period to which the continuing education requirement applies.
4367 Section 44. Section **31A-26-213** is amended to read:
4368 **31A-26-213. Revoking, suspending, surrendering, lapsing, limiting, or otherwise**
4369 **terminating a license -- Forfeiture -- Rulemaking for renewal or reinstatement.**
4370 (1) A license type issued under this chapter remains in force until:
4371 (a) revoked or suspended under Subsection (5);
4372 (b) surrendered to the commissioner and accepted by the commissioner in lieu of
4373 administrative action;
4374 (c) the licensee dies or is adjudicated incompetent as defined under:
4375 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

4376 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and
4377 Minors;
4378 (d) lapsed under Section 31A-26-214.5; or
4379 (e) voluntarily surrendered.
4380 (2) The following may be reinstated within one year after the day on which the license
4381 is no longer in force:
4382 (a) a lapsed license; or
4383 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may
4384 not be reinstated after the license period in which it is voluntarily surrendered.
4385 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a
4386 license, submission and acceptance of a voluntary surrender of a license does not prevent the
4387 department from pursuing additional disciplinary or other action authorized under:
4388 (a) this title; or
4389 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah
4390 Administrative Rulemaking Act.
4391 (4) A license classification issued under this chapter remains in force until:
4392 (a) the qualifications pertaining to a license classification are no longer met by the
4393 licensee; or
4394 (b) the supporting license type:
4395 (i) is revoked or suspended under Subsection (5); or
4396 (ii) is surrendered to the commissioner and accepted by the commissioner in lieu of
4397 administrative action.
4398 (5) (a) If the commissioner makes a finding under Subsection (5)(b) as part of an
4399 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the
4400 commissioner may:
4401 (i) revoke:
4402 (A) a license; or

4403 (B) a license classification;
4404 (ii) suspend for a specified period of 12 months or less:
4405 (A) a license; or
4406 (B) a license classification;
4407 (iii) limit in whole or in part:
4408 (A) a license; or
4409 (B) a license classification;
4410 (iv) deny a license application;
4411 (v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or
4412 (vi) take a combination of actions under Subsections (5)(a)(i) through (iv) and
4413 Subsection (5)(a)(v).
4414 (b) The commissioner may take an action described in Subsection (5)(a) if the
4415 commissioner finds that the licensee or license applicant:
4416 (i) is unqualified for a license or license classification under Section 31A-26-202,
4417 31A-26-203, 31A-26-204, or 31A-26-205;
4418 (ii) has violated:
4419 (A) an insurance statute;
4420 (B) a rule that is valid under Subsection 31A-2-201(3); or
4421 (C) an order that is valid under Subsection 31A-2-201(4);
4422 (iii) is insolvent, or the subject of receivership, conservatorship, rehabilitation, or other
4423 delinquency proceedings in any state;
4424 (iv) fails to pay a final judgment rendered against the person in this state within 60
4425 days after the judgment became final;
4426 (v) fails to meet the same good faith obligations in claims settlement that is required of
4427 admitted insurers;
4428 (vi) is affiliated with and under the same general management or interlocking
4429 directorate or ownership as another insurance adjuster that transacts business in this state

4430 without a license;
4431 (vii) refuses:
4432 (A) to be examined; or
4433 (B) to produce its accounts, records, and files for examination;
4434 (viii) has an officer who refuses to:
4435 (A) give information with respect to the insurance adjuster's affairs; or
4436 (B) perform any other legal obligation as to an examination;
4437 (ix) provides information in the license application that is:
4438 (A) incorrect;
4439 (B) misleading;
4440 (C) incomplete; or
4441 (D) materially untrue;
4442 (x) has violated an insurance law, valid rule, or valid order of another regulatory
4443 agency in any jurisdiction;
4444 (xi) has obtained or attempted to obtain a license through misrepresentation or fraud;
4445 (xii) has improperly withheld, misappropriated, or converted money or properties
4446 received in the course of doing insurance business;
4447 (xiii) has intentionally misrepresented the terms of an actual or proposed:
4448 (A) insurance contract; or
4449 (B) application for insurance;
4450 (xiv) has been convicted of:
4451 (A) a felony; or
4452 (B) a misdemeanor involving fraud, misrepresentation, theft, or dishonesty;
4453 (xv) has admitted or been found to have committed an insurance unfair trade practice
4454 or fraud;
4455 (xvi) in the conduct of business in this state or elsewhere has:
4456 (A) used fraudulent, coercive, or dishonest practices; or

4457 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;
4458 (xvii) has had an insurance license or other professional or occupational license or
4459 registration, or equivalent, denied, suspended, revoked, or surrendered to resolve an
4460 administrative action;
4461 (xviii) has forged another's name to:
4462 (A) an application for insurance; or
4463 (B) a document related to an insurance transaction;
4464 (xix) has improperly used notes or any other reference material to complete an
4465 examination for an insurance license;
4466 (xx) has knowingly accepted insurance business from an individual who is not
4467 licensed;
4468 (xxi) has failed to comply with an administrative or court order imposing a child
4469 support obligation;
4470 (xxii) has failed to:
4471 (A) pay state income tax; or
4472 (B) comply with an administrative or court order directing payment of state income
4473 tax;
4474 (xxiii) has been convicted of a violation of the federal Violent Crime Control and Law
4475 Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and has not obtained written consent in
4476 accordance with 18 U.S.C. Sec. 1033 to engage in the business of insurance or participate in
4477 such business;
4478 (xxiv) has engaged in methods and practices in the conduct of business that endanger
4479 the legitimate interests of customers and the public; or
4480 (xxv) has been convicted of any criminal felony involving dishonesty or breach of trust
4481 and has not obtained written consent in accordance with 18 U.S.C. Sec. 1033 to engage in the
4482 business of insurance or participate in such business.
4483 (c) For purposes of this section, if a license is held by an agency, both the agency itself

4484 and any individual designated under the license are considered to be the holders of the license.
4485 (d) If an individual designated under the agency license commits an act or fails to
4486 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,
4487 the commissioner may suspend, revoke, or limit the license of:
4488 (i) the individual;
4489 (ii) the agency, if the agency:
4490 (A) is reckless or negligent in its supervision of the individual; or
4491 (B) knowingly participated in the act or failure to act that is the ground for suspending,
4492 revoking, or limiting the license; or
4493 (iii) (A) the individual; and
4494 (B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).
4495 (6) A licensee under this chapter is subject to the penalties for conducting an insurance
4496 business without a license if:
4497 (a) the licensee's license is:
4498 (i) revoked;
4499 (ii) suspended;
4500 (iii) limited;
4501 (iv) surrendered in lieu of administrative action;
4502 (v) lapsed; or
4503 (vi) voluntarily surrendered; and
4504 (b) the licensee:
4505 (i) continues to act as a licensee; or
4506 (ii) violates the terms of the license limitation.
4507 (7) A licensee under this chapter shall immediately report to the commissioner:
4508 (a) a revocation, suspension, or limitation of the person's license in any other state, the
4509 District of Columbia, or a territory of the United States;
4510 (b) the imposition of a disciplinary sanction imposed on that person by any other state,

4511 the District of Columbia, or a territory of the United States; or
4512 (c) a judgment or injunction entered against that person on the basis of conduct
4513 involving:
4514 (i) fraud;
4515 (ii) deceit;
4516 (iii) misrepresentation; or
4517 (iv) a violation of an insurance law or rule.
4518 (8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a
4519 license in lieu of administrative action may specify a time not to exceed five years within
4520 which the former licensee may not apply for a new license.
4521 (b) If no time is specified in the order or agreement described in Subsection (8)(a), the
4522 former licensee may not apply for a new license for five years without the express approval of
4523 the commissioner.
4524 (9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of
4525 a license issued under this part if so ordered by a court.
4526 (10) The commissioner shall by rule prescribe the license renewal and reinstatement
4527 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
4528 Section 45. Section **31A-26-301.6** is amended to read:
4529 **31A-26-301.6. Health care claims practices.**
4530 (1) As used in this section:
4531 [~~(a) "Articulable reason" may include a determination regarding:~~]
4532 [~~(i) eligibility for coverage;~~]
4533 [~~(ii) preexisting conditions;~~]
4534 [~~(iii) applicability of other public or private insurance;~~]
4535 [~~(iv) medical necessity; and~~]
4536 [~~(v) any other reason that would justify an extension of the time to investigate a claim.~~]
4537 [~~(b)~~] <u>(a)</u> "Health care provider" means a person licensed to provide health care under:

4538 (i) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or
4539 (ii) Title 58, Occupations and Professions.
4540 [~~(c)~~] (b) "Insurer" means an admitted or authorized insurer, as defined in Section
4541 31A-1-301, and includes:
4542 (i) a health maintenance organization; and
4543 (ii) a third party administrator that is subject to this title, provided that nothing in this
4544 section may be construed as requiring a third party administrator to use its own funds to pay
4545 claims that have not been funded by the entity for which the third party administrator is paying
4546 claims.
4547 [~~(d)~~] (c) "Provider" means a health care provider to whom an insurer is obligated to pay
4548 directly in connection with a claim by virtue of:
4549 (i) an agreement between the insurer and the provider;
4550 (ii) a health insurance policy or contract of the insurer; or
4551 (iii) state or federal law.
4552 (2) An insurer shall timely pay every valid insurance claim submitted by a provider in
4553 accordance with this section.
4554 (3) (a) Except as provided in Subsection (4), within 30 days of the day on which the
4555 insurer receives a written claim, an insurer shall:
4556 (i) pay the claim; or
4557 (ii) deny the claim and provide a written explanation for the denial.
4558 (b) (i) Subject to Subsection (3)(b)(ii), the time period described in Subsection (3)(a)
4559 may be extended by 15 days if the insurer:
4560 (A) determines that the extension is necessary due to matters beyond the control of the
4561 insurer; and
4562 (B) before the end of the 30-day period described in Subsection (3)(a), notifies the
4563 provider and insured in writing of:
4564 (I) the circumstances requiring the extension of time; and

4565 (II) the date by which the insurer expects to pay the claim or deny the claim with a
4566 written explanation for the denial.
4567 (ii) If an extension is necessary due to a failure of the provider or insured to submit the
4568 information necessary to decide the claim:
4569 (A) the notice of extension required by this Subsection (3)(b) shall specifically describe
4570 the required information; and
4571 (B) the insurer shall give the provider or insured at least 45 days from the day on which
4572 the provider or insured receives the notice before the insurer denies the claim for failure to
4573 provide the information requested in Subsection (3)(b)(ii)(A).
4574 (4) (a) In the case of a claim for income replacement benefits, within 45 days of the day
4575 on which the insurer receives a written claim, an insurer shall:
4576 (i) pay the claim; or
4577 (ii) deny the claim and provide a written explanation of the denial.
4578 (b) Subject to Subsections (4)(d) and (e), the time period described in Subsection (4)(a)
4579 may be extended for 30 days if the insurer:
4580 (i) determines that the extension is necessary due to matters beyond the control of the
4581 insurer; and
4582 (ii) before the expiration of the 45-day period described in Subsection (4)(a), notifies
4583 the insured of:
4584 (A) the circumstances requiring the extension of time; and
4585 (B) the date by which the insurer expects to pay the claim or deny the claim with a
4586 written explanation for the denial.
4587 (c) Subject to Subsections (4)(d) and (e), the time period for complying with
4588 Subsection (4)(a) may be extended for up to an additional 30 days from the day on which the
4589 30-day extension period provided in Subsection (4)(b) ends if before the day on which the
4590 30-day extension period ends, the insurer:
4591 (i) determines that due to matters beyond the control of the insurer a decision cannot be

4592 rendered within the 30-day extension period; and
4593 (ii) notifies the insured of:
4594 (A) the circumstances requiring the extension; and
4595 (B) the date as of which the insurer expects to pay the claim or deny the claim with a
4596 written explanation for the denial.
4597 (d) A notice of extension under this Subsection (4) shall specifically explain:
4598 (i) the standards on which entitlement to a benefit is based; and
4599 (ii) the unresolved issues that prevent a decision on the claim.
4600 (e) If an extension allowed by Subsection (4)(b) or (c) is necessary due to a failure of
4601 the insured to submit the information necessary to decide the claim:
4602 (i) the notice of extension required by Subsection (4)(b) or (c) shall specifically
4603 describe the necessary information; and
4604 (ii) the insurer shall give the insured at least 45 days from the day on which the insured
4605 receives the notice before the insurer denies the claim for failure to provide the information
4606 requested in Subsection (4)(b) or (c).
4607 (5) If a period of time is extended as permitted under Subsection (3)(b), (4)(b), or
4608 (4)(c), due to an insured or provider failing to submit information necessary to decide a claim,
4609 the period for making the benefit determination shall be tolled from the date on which the
4610 notification of the extension is sent to the insured or provider until the date on which the
4611 insured or provider responds to the request for additional information.
4612 (6) An insurer shall pay all sums to the provider or insured that the insurer is obligated
4613 to pay on the claim, and provide a written explanation of the insurer's decision regarding any
4614 part of the claim that is denied within 20 days of receiving the information requested under
4615 Subsection (3)(b), (4)(b), or (4)(c).
4616 (7) (a) Whenever an insurer makes a payment to a provider on any part of a claim
4617 under this section, the insurer shall also send to the insured an explanation of benefits paid.
4618 (b) Whenever an insurer denies any part of a claim under this section, the insurer shall

4619 also send to the insured:
4620 (i) a written explanation of the part of the claim that was denied; and
4621 (ii) notice of the adverse benefit determination review process established under
4622 Section 31A-22-629.
4623 (c) This Subsection (7) does not apply to a person receiving benefits under the state
4624 Medicaid program as defined in Section 26-18-2, unless required by the Department of Health
4625 or federal law.
4626 (8) (a) [Beginning with health care claims submitted on or after January 1, 2002, a] A
4627 late fee shall be imposed on:
4628 (i) an insurer that fails to timely pay a claim in accordance with this section; and
4629 (ii) a provider that fails to timely provide information on a claim in accordance with
4630 this section.
4631 (b) [For the first 90 days that a claim payment or a provider response to a request for
4632 information is late, the] The late fee described in Subsection (8)(a) shall be determined by
4633 multiplying together:
4634 (i) the total amount of the claim the insurer is obliged to pay;
4635 (ii) the total number of days the response or the payment is late; and
4636 (iii) [.1%] 0.033% daily interest rate.
4637 [(c) For a claim payment or a provider response to a request for information that is 91
4638 or more days late, the late fee shall be determined by adding together:]
4639 [(i) the late fee for a 90-day period under Subsection (8)(b); and]
4640 [(ii) the following multiplied together:]
4641 [(A) the total amount of the claim;]
4642 [(B) the total number of days the response or payment was late beyond the initial
4643 90-day period; and]
4644 [(C) the rate of interest set in accordance with Section 15-1-1.]
4645 [(d)] (c) Any late fee paid or collected under this [section] Subsection (8) shall be

4646 separately identified on the documentation used by the insurer to pay the claim.

4647 [(c)] (d) For purposes of this Subsection (8), "late fee" does not include an amount that

4648 is less than $1.

4649 (9) Each insurer shall establish a review process to resolve claims-related disputes

4650 between the insurer and providers.

4651 (10) An insurer or person representing an insurer may not engage in any unfair claim

4652 settlement practice with respect to a provider. Unfair claim settlement practices include:

4653 (a) knowingly misrepresenting a material fact or the contents of an insurance policy in

4654 connection with a claim;

4655 (b) failing to acknowledge and substantively respond within 15 days to any written

4656 communication from a provider relating to a pending claim;

4657 (c) denying or threatening to deny the payment of a claim for any reason that is not

4658 clearly described in the insured's policy;

4659 (d) failing to maintain a payment process sufficient to comply with this section;

4660 (e) failing to maintain claims documentation sufficient to demonstrate compliance with

4661 this section;

4662 (f) failing, upon request, to give to the provider written information regarding the

4663 specific rate and terms under which the provider will be paid for health care services;

4664 (g) failing to timely pay a valid claim in accordance with this section as a means of

4665 influencing, intimidating, retaliating, or gaining an advantage over the provider with respect to

4666 an unrelated claim, an undisputed part of a pending claim, or some other aspect of the

4667 contractual relationship;

4668 (h) failing to pay the sum when required and as required under Subsection (8) when a

4669 violation has occurred;

4670 (i) threatening to retaliate or actual retaliation against a provider for the provider

4671 applying this section;

4672 (j) any material violation of this section; and

4673 (k) any other unfair claim settlement practice established in rule or law.

4674 (11) (a) The provisions of this section shall apply to each contract between an insurer
4675 and a provider for the duration of the contract.

4676 (b) Notwithstanding Subsection (11)(a), this section may not be the basis for a bad
4677 faith insurance claim.

4678 (c) Nothing in Subsection (11)(a) may be construed as limiting the ability of an insurer
4679 and a provider from including provisions in their contract that are more stringent than the
4680 provisions of this section.

4681 (12) (a) Pursuant to Chapter 2, Part 2, Duties and Powers of Commissioner, [~~and~~
4682 ~~beginning January 1, 2002,~~] the commissioner may conduct examinations to determine an
4683 insurer's level of compliance with this section and impose sanctions for each violation.

4684 (b) The commissioner may adopt rules only as necessary to implement this section.

4685 (c) The commissioner may establish rules to facilitate the exchange of electronic
4686 confirmations when claims-related information has been received.

4687 (d) Notwithstanding Subsection (12)(b), the commissioner may not adopt rules
4688 regarding the review process required by Subsection (9).

4689 (13) Nothing in this section may be construed as limiting the collection rights of a
4690 provider under Section 31A-26-301.5.

4691 (14) Nothing in this section may be construed as limiting the ability of an insurer to:

4692 (a) recover any amount improperly paid to a provider or an insured:

4693 (i) in accordance with Section 31A-31-103 or any other provision of state or federal
4694 law;

4695 (ii) within 24 months of the amount improperly paid for a coordination of benefits
4696 error;

4697 (iii) within 12 months of the amount improperly paid for any other reason not
4698 identified in Subsection (14)(a)(i) or (ii); or

4699 (iv) within 36 months of the amount improperly paid when the improper payment was

4700 due to a recovery by Medicaid, Medicare, the Children's Health Insurance Program, or any
4701 other state or federal health care program;
4702 (b) take any action against a provider that is permitted under the terms of the provider
4703 contract and not prohibited by this section;
4704 (c) report the provider to a state or federal agency with regulatory authority over the
4705 provider for unprofessional, unlawful, or fraudulent conduct; or
4706 (d) enter into a mutual agreement with a provider to resolve alleged violations of this
4707 section through mediation or binding arbitration.
4708 (15) A health care provider may only seek recovery from the insurer for an amount
4709 improperly paid by the insurer within the same time frames as Subsections (14)(a) and (b).
4710 (16) (a) An insurer may offer the remittance of payment through a credit card or other
4711 similar arrangement.
4712 (b) (i) A health care provider may elect not to receive remittance through a credit card
4713 or other similar arrangement.
4714 (ii) An insurer:
4715 (A) shall permit a health care provider's election described in Subsection (16)(b)(i) to
4716 apply to the health care provider's entire practice; and
4717 (B) may not require a health care provider's election described in Subsection (16)(b)(i)
4718 to be made on a patient-by-patient basis.
4719 (c) An insurer may not require a health care provider or insured to accept remittance
4720 through a credit card or other similar arrangement.
4721 Section 46. Section **31A-27a-105** is amended to read:
4722 **31A-27a-105. Jurisdiction -- Venue.**
4723 (1) (a) A delinquency proceeding under this chapter may not be commenced by a
4724 person other than the commissioner of this state.
4725 (b) No court has jurisdiction to entertain, hear, or determine a delinquency proceeding
4726 commenced by any person other than the commissioner of this state.

4727 (2) Other than in accordance with this chapter, a court of this state has no jurisdiction
4728 to entertain, hear, or determine any complaint:
4729 (a) requesting the liquidation, rehabilitation, seizure, sequestration, or receivership of
4730 an insurer; or
4731 (b) requesting a stay, an injunction, a restraining order, or other relief preliminary to,
4732 incidental to, or relating to a delinquency proceeding.
4733 (3) (a) The receivership court, as of the commencement of a delinquency proceeding
4734 under this chapter, has exclusive jurisdiction of all property of the insurer, wherever located,
4735 including property located outside the territorial limits of the state.
4736 (b) The receivership court has original but not exclusive jurisdiction of all civil
4737 proceedings arising:
4738 (i) under this chapter; or
4739 (ii) in or related to a delinquency proceeding under this chapter.
4740 (4) In addition to other grounds for jurisdiction provided by the law of this state, a
4741 court of this state having jurisdiction of the subject matter has jurisdiction over a person served
4742 pursuant to the Utah Rules of Civil Procedure or other applicable provisions of law in an action
4743 brought by the receiver if the person served:
4744 (a) in an action resulting from or incident to a relationship with the insurer described in
4745 this Subsection (4)(a), is or has been an agent, broker, or other person who has at any time:
4746 (i) written a policy of insurance for an insurer against which a delinquency proceeding
4747 is instituted; or
4748 (ii) acted in any manner whatsoever on behalf of an insurer against which a
4749 delinquency proceeding is instituted;
4750 (b) in an action on or incident to a reinsurance contract described in this Subsection
4751 (4)(b):
4752 (i) is or has been an insurer or reinsurer who has at any time entered into the contract of
4753 reinsurance with an insurer against which a delinquency proceeding is instituted; or

4754 (ii) is an intermediary, agent, or broker of or for the reinsurer, or with respect to the
4755 contract;
4756 (c) in an action resulting from or incident to a relationship with the insurer described in
4757 this Subsection (4)(c), is or has been an officer, director, manager, trustee, organizer, promoter,
4758 or other person in a position of comparable authority or influence over an insurer against which
4759 a delinquency proceeding is instituted;
4760 (d) in an action concerning assets described in this Subsection (4)(d), is or was at the
4761 time of the institution of the delinquency proceeding against the insurer, holding assets in
4762 which the receiver claims an interest on behalf of the insurer; or
4763 (e) in any action on or incident to the obligation described in this Subsection (4)(e), is
4764 obligated to the insurer in any way whatsoever.
4765 (5) (a) Subject to Subsection (5)(b), service shall be made upon the person named in
4766 the petition in accordance with the Utah Rules of Civil Procedure.
4767 (b) In lieu of service under Subsection (5)(a), upon application to the receivership
4768 court, service may be made in such a manner as the receivership court directs whenever it is
4769 satisfactorily shown by the commissioner's affidavit:
4770 (i) in the case of a corporation, that the officers of the corporation cannot be served
4771 because they have departed from the state or have otherwise concealed themselves with intent
4772 to avoid service;
4773 (ii) in the case of an insurer whose business is conducted, at least in part, by an
4774 attorney-in-fact, managing general agent, or other similar entity including a reciprocal, Lloyd's
4775 association, or interinsurance exchange, that the individual attorney-in-fact, managing general
4776 agent, or other entity, or its officers of the corporate attorney-in-fact cannot be served because
4777 of the individual's departure or concealment; or
4778 (iii) in the case of a natural person, that the person cannot be served because of the
4779 person's departure or concealment.
4780 (6) If the receivership court on motion of any party finds that an action should as a

4781 matter of substantial justice be tried in a forum outside this state, the receivership court may
4782 enter an appropriate order to stay further proceedings on the action in this state.
4783 (7) (a) Nothing in this chapter deprives a reinsurer of any contractual right to pursue
4784 arbitration except:
4785 (i) as to a claim against the estate; and
4786 (ii) in regard to a contract rejected by the receiver under Section 31A-27a-113.
4787 (b) A party in arbitration may bring a claim or counterclaim against the estate, but the
4788 claim or counterclaim is subject to this chapter.
4789 (8) An action authorized by this chapter shall be brought in the Third District Court for
4790 Salt Lake County.
4791 (9) (a) At any time after an order is entered pursuant to Section 31A-27a-201,
4792 31A-27a-301, or 31A-27a-401, the commissioner or receiver may transfer the case to the
4793 county of the principal office of the person proceeded against.
4794 (b) In the event of a transfer under this Subsection (9), the court in which the
4795 proceeding is commenced shall, upon application of the commissioner or receiver, direct its
4796 clerk to transmit the court's file to the clerk of the court to which the case is to be transferred.
4797 (c) After a transfer under this Subsection (9), the proceeding shall be conducted in the
4798 same manner as if it had been commenced in the court to which the matter is transferred.
4799 (10) (a) Except as provided in Subsection (10)(c), a person may not intervene in a
4800 liquidation proceeding in this state for the purpose of seeking or obtaining payment of a
4801 judgment, lien, or other claim of any kind.
4802 (b) Except as provided in Subsection (10)(c), the claims procedure set for this chapter
4803 constitute the exclusive means for obtaining payment of claims from the liquidation estate.
4804 (c) (i) An affected guaranty association or the affected guaranty association's
4805 representative may intervene as a party as a matter of right and otherwise appear and participate
4806 in any court proceeding concerning a liquidation proceeding against an insurer.
4807 (ii) Intervention by an affected guaranty association or by an affected guaranty

4808 association's designated representative conferred by this Subsection (10)(c) may not constitute
4809 grounds to establish general personal jurisdiction by the courts of this state.
4810 (iii) An intervening affected guaranty association or the affected guaranty association's
4811 representative are subject to the receivership court's jurisdiction for the limited purpose for
4812 which the affected guaranty association intervenes.
4813 (11) (a) Notwithstanding the other provisions of this section, this chapter does not
4814 confer jurisdiction on the receivership court to resolve coverage disputes between an affected
4815 guaranty association and those asserting claims against the affected guaranty association
4816 resulting from the initiation of a receivership proceeding under this chapter, except to the
4817 extent that the affected guaranty association otherwise expressly consents to the jurisdiction of
4818 the receivership court pursuant to a plan of rehabilitation or liquidation that resolves its
4819 obligations to covered policyholders.
4820 (b) The determination of a dispute with respect to the statutory coverage obligations of
4821 an affected guaranty association by a court or administrative agency or body with jurisdiction
4822 in the affected guaranty association's state of domicile is binding and conclusive as to the
4823 affected guaranty association's claim in the liquidation proceeding.
4824 (12) Upon the request of the receiver, the receivership court or the presiding judge of
4825 the Third District Court for Salt Lake County may order that one judge hear all cases and
4826 controversies arising out of or related to the delinquency proceeding.
4827 (13) A delinquency proceeding is exempt from any program maintained for the early
4828 closure of civil actions.
4829 (14) In a proceeding, case, or controversy arising out of or related to a delinquency
4830 proceeding, to the extent there is a conflict between the Utah Rules of Civil Procedure and this
4831 chapter, the provisions of this chapter govern the proceeding, case, or controversy.
4832 Section 47. Section **31A-27a-501** is amended to read:
4833 **31A-27a-501. Turnover of assets.**
4834 (1) (a) If the receiver determines that funds or property in the possession of another

4835 person are rightfully the property of the estate, the receiver shall deliver to the person a written
4836 demand for immediate delivery of the funds or property:
4837 (i) referencing this section by number;
4838 (ii) referencing the court and docket number of the receivership action; and
4839 (iii) notifying the person that any claim of right to the funds or property by the person
4840 shall be presented to the receivership court within 20 days of the day on which the person
4841 receives the written demand.
4842 (b) (i) A person who holds funds or other property belonging to an entity subject to an
4843 order of receivership under this chapter shall deliver the funds or other property to the receiver
4844 on demand.
4845 (ii) If the person described in Subsection (1)(b)(i) alleges a right to retain the funds or
4846 other property, the person shall:
4847 (A) file [~~a pleading~~] an objection with the receivership court setting out that right
4848 within 20 days of the day on which the person receives the demand that the funds or property
4849 be delivered to the receiver; and
4850 (B) serve a copy of the [~~pleading~~] objection on the receiver.
4851 (iii) The [~~pleading~~] objection described in Subsection (1)(b)(ii) shall inform the
4852 receivership court as to:
4853 (A) the nature of the claim to the funds or property;
4854 (B) the alleged value of the property or amount of funds held; and
4855 (C) what action has been taken by the person to preserve any funds or to preserve and
4856 protect the property pending determination of the dispute.
4857 (c) The relinquishment of possession of funds or property by a person who receives a
4858 demand pursuant to this section is not a waiver of a right to make a claim in the receivership.
4859 (2) (a) If requested by the receiver, the receivership court shall hold a hearing to
4860 determine where and under what conditions the funds or property shall be held by a person
4861 described in Subsection (1) pending determination of a dispute concerning the funds or

4862 property.

4863 (b) The receivership court may impose the conditions the receivership court considers
4864 necessary or appropriate for the preservation of the funds or property until the receivership
4865 court can determine the validity of the person's claim to the funds or property.

4866 (c) If funds or property are allowed to remain in the possession of the person after
4867 demand made by the receiver, that person is strictly liable to the estate for any waste, loss, or
4868 damage to or diminution of value of the funds or property retained.

4869 (3) If a person files [~~a pleading~~] an objection alleging a right to retain funds or property
4870 as provided in Subsection (1), the receivership court shall hold a subsequent hearing to
4871 determine the entitlement of the person to the funds or property claimed by the receiver.

4872 (4) If a person fails to deliver the funds or property or to file the [~~pleading~~] objection
4873 described by Subsection (1) within the 20-day period, the receivership court may issue a
4874 summary order:

4875 (a) upon:

4876 (i) petition of the receiver; and

4877 (ii) a copy of the petition being served by the petitioner to that person;

4878 (b) directing the immediate delivery of the funds or property to the receiver; and

4879 (c) finding that the person waived all claims of right to the funds or property.

4880 (5) The liquidator shall reduce the assets to a degree of liquidity that is consistent with
4881 the effective execution of the liquidation.

4882 Section 48. Section **31A-30-117** is amended to read:

4883 **31A-30-117. Patient Protection and Affordable Care Act -- Market transition.**

4884 (1) (a) [~~After complying with the reporting requirements of Section 63N-11-106, the~~]
4885 The commissioner may adopt administrative rules in accordance with Title 63G, Chapter 3,
4886 Utah Administrative Rulemaking Act, that change the rating and underwriting requirements of
4887 this chapter as necessary to transition the insurance market to meet federal qualified health plan
4888 standards and rating practices under PPACA.

4889 (b) Administrative rules adopted by the commissioner under this section may include:
4890 (i) the regulation of health benefit plans as described in [~~Subsections 31A-2-212(5)(a)~~
4891 ~~and (b)~~] Subsection 31A-2-212(5); and
4892 (ii) disclosure of records and information required by PPACA and state law.
4893 (c) (i) The commissioner shall establish by administrative rule one statewide open
4894 enrollment period that applies to the individual insurance market that is not on the PPACA
4895 certified individual exchange.
4896 (ii) The statewide open enrollment period:
4897 (A) may be shorter, but no longer than the open enrollment period established for the
4898 individual insurance market offered in the PPACA certified exchange; and
4899 (B) may not be extended beyond the dates of the open enrollment period established
4900 for the individual insurance market offered in the PPACA certified exchange.
4901 (2) A carrier that offers health benefit plans in the individual market that is not part of
4902 the individual PPACA certified exchange:
4903 (a) shall open enrollment:
4904 (i) during the statewide open enrollment period established in Subsection (1)(c); and
4905 (ii) at other times, for qualifying events, as determined by administrative rule adopted
4906 by the commissioner; and
4907 (b) may open enrollment at any time.
4908 (3) To the extent permitted by the Centers for Medicare and Medicaid Services policy,
4909 or federal regulation, the commissioner shall allow a health insurer to choose to continue
4910 coverage and individuals and small employers to choose to re-enroll in coverage in
4911 nongrandfathered health coverage that is not in compliance with market reforms required by
4912 PPACA.
4913 Section 49. Section **31A-30-118** is amended to read:
4914 **31A-30-118. Patient Protection and Affordable Care Act -- State insurance**
4915 **mandates -- Cost of additional benefits.**

4916 (1) (a) The commissioner shall identify a new mandated benefit that is in excess of the
4917 essential health benefits required by PPACA.
4918 (b) The state shall quantify the cost attributable to each additional mandated benefit
4919 specified in Subsection (1)(a) based on a qualified health plan issuer's calculation of the cost
4920 associated with the mandated benefit, which shall be:
4921 (i) calculated in accordance with generally accepted actuarial principles and
4922 methodologies;
4923 (ii) conducted by a member of the American Academy of Actuaries; and
4924 (iii) reported to the commissioner and to the individual exchange operating in the state.
4925 (c) The commissioner may require a proponent of a new mandated benefit under
4926 Subsection (1)(a) to provide the commissioner with a cost analysis conducted in accordance
4927 with Subsection (1)(b). The commissioner may use the cost information provided under this
4928 Subsection (1)(c) to establish estimates of the cost to the state under Subsection (2).
4929 (2) If the state is required to defray the cost of additional required benefits under the
4930 provisions of 45 C.F.R. 155.170:
4931 (a) the state shall make the required payments:
4932 (i) in accordance with Subsection (3); and
4933 (ii) directly to the qualified health plan issuer in accordance with 45 C.F.R. 155.170;
4934 (b) an issuer of a qualified health plan that receives a payment under the provisions of
4935 Subsection (1) and 45 C.F.R. 155.170 shall:
4936 (i) reduce the premium charged to the individual on whose behalf the issuer will be
4937 paid under Subsection (1), in an amount equal to the amount of the payment under Subsection
4938 (1); or
4939 (ii) notwithstanding Subsection 31A-23a-402.5(5), provide a premium rebate to an
4940 individual on whose behalf the issuer received a payment under Subsection (1), in an amount
4941 equal to the amount of the payment under Subsection (1); and
4942 (c) a premium rebate made under this section is not a prohibited inducement under

4943 Section 31A-23a-402.5.

4944 (3) A payment required under 45 C.F.R. 155.170(c) shall:

4945 (a) unless otherwise required by PPACA, be based on a statewide average of the cost
4946 of the additional benefit for all issuers who are entitled to payment under the provisions of 45
4947 C.F.R. [~~155.70~~] 155.170; and

4948 (b) be submitted to an issuer through a process established [~~and administered by the~~
4949 ~~federal marketplace exchange for the state under PPACA for individual health plans~~] by the
4950 commissioner.

4951 (4) The commissioner may adopt rules in accordance with Title 63G, Chapter 3, Utah
4952 Administrative Rulemaking Act, to:

4953 (a) [~~adopt rules as necessary to~~] administer the provisions of this section and 45 C.F.R.
4954 155.170; and

4955 (b) establish or implement a process for submitting a payment to an issuer under
4956 Subsection (3)(b).

4957 Section 50. Section **31A-35-402** is amended to read:

4958 **31A-35-402. Authority related to bail bonds.**

4959 (1) A bail bond agency may only sell bail bonds.

4960 (2) In accordance with Section 31A-23a-205, a bail bond producer may not execute or
4961 issue a bail bond in this state without holding a current appointment from a surety insurer or a
4962 current designation from a bail bond agency.

4963 (3) A bail bond [~~surety~~] agency or surety insurer may not allow any person who is not a
4964 bail bond producer to engage in the bail bond insurance business on the bail bond agency's or
4965 surety insurer's behalf, except for individuals:

4966 (a) employed solely for the performance of clerical, stenographic, investigative, or
4967 other administrative duties that do not require a license as:

4968 (i) a bail bond agency; or

4969 (ii) a bail bond producer; and

4970 (b) whose compensation is not related to or contingent upon the number of bail bonds
4971 written.
4972 Section 51. Section **31A-37-303** is amended to read:
4973 **31A-37-303. Reinsurance.**
4974 (1) (a) A captive insurance company may cede risks to any insurance company
4975 approved by the commissioner.
4976 (b) A captive insurance company may provide reinsurance, as authorized in this title,
4977 on risks ceded [~~for the benefit of a parent, affiliate, or controlled unaffiliated business~~] by any
4978 other insurer with prior approval of the commissioner.
4979 (2) (a) A captive insurance company may take credit for reserves on risks or portions of
4980 risks ceded to reinsurers if the captive insurance company complies with Section 31A-17-404,
4981 31A-17-404.1, 31A-17-404.3, or 31A-17-404.4 or if the captive insurance company complies
4982 with other requirements as the commissioner may establish by rule made in accordance with
4983 Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
4984 (b) Unless the reinsurer is in compliance with Section 31A-17-404, 31A-17-404.1,
4985 31A-17-404.3, or 31A-17-404.4 or a rule adopted under Subsection (2)(a), a captive insurance
4986 company may not take credit for:
4987 (i) reserves on risks ceded to a reinsurer; or
4988 (ii) portions of risks ceded to a reinsurer.
4989 Section 52. Section **31A-37-701** is amended to read:
4990 **31A-37-701. Certificate of dormancy.**
4991 (1) In accordance with the provisions of this section, a captive insurance company,
4992 other than a risk retention group may apply, without fee, to the commissioner for a certificate
4993 of dormancy.
4994 (2) (a) A captive insurance company, other than a risk retention group, is eligible for a
4995 certificate of dormancy if the captive insurance company:
4996 (i) has ceased transacting the business of insurance, including the issuance of insurance

4997 policies; and
4998 (ii) has no remaining insurance liabilities or obligations associated with insurance
4999 business transactions or insurance policies.
5000 (b) For purposes of Subsection (2)(a)(ii), the commissioner may disregard liabilities or
5001 obligations for which the captive insurance company has withheld sufficient funds or that are
5002 otherwise sufficiently secured.
5003 (3) Except as provided in Subsection (5), a captive insurance company that holds a
5004 certificate of dormancy is subject to all requirements of this chapter.
5005 (4) A captive insurance company that holds a certificate of dormancy:
5006 (a) shall possess and maintain unimpaired paid-in capital and unimpaired paid-in
5007 surplus of:
5008 (i) in the case of a pure captive insurance company or a special purpose captive
5009 insurance company, not less than $25,000;
5010 (ii) in the case of an association captive insurance company, not less than $75,000; or
5011 (iii) in the case of a sponsored captive insurance company, not less than $100,000, of
5012 which at least $35,000 is provided by the sponsor; and
5013 (b) is not required to:
5014 (i) subject to Subsection (5), submit an annual audit or statement of actuarial opinion;
5015 (ii) maintain an active agreement with an independent auditor or actuary; or
5016 (iii) hold an annual meeting of the captive insurance company in the state.
5017 (5) The commissioner may require a captive insurance company that holds a certificate
5018 of dormancy to submit an annual audit if the commissioner determines that there are concerns
5019 regarding the captive insurance company's solvency or liquidity.
5020 (6) To maintain a certificate of dormancy and in lieu of a certificate of authority
5021 renewal fee, no later than July 1 of each year, a captive insurance company shall pay an annual
5022 dormancy renewal fee that is equal to 50% of the captive insurance's company's certificate of
5023 authority renewal fee.

5024 (7) A captive insurance company may consecutively renew a certificate [~~or~~] of
5025 dormancy no more than five times.
5026 Section 53. Section **34A-2-202** is amended to read:
5027 **34A-2-202. Assessment on self-insured employers including the state, counties,**
5028 **cities, towns, or school districts paying compensation direct.**
5029 (1) (a) (i) A self-insured employer, including a county, city, town, or school district,
5030 shall pay annually, on or before March 31, an assessment in accordance with this section and
5031 rules made by the commission under this section.
5032 (ii) For purposes of this section, "self-insured employer" is as defined in Section
5033 34A-2-201.5, except it includes the state if the state self-insures under Section 34A-2-203.
5034 (b) The assessment required by Subsection (1)(a) is:
5035 (i) to be collected by the State Tax Commission;
5036 (ii) paid by the State Tax Commission into the state treasury as provided in Subsection
5037 59-9-101(2); and
5038 (iii) subject to the offset provided in Section 34A-2-202.5.
5039 (c) The assessment under Subsection (1)(a) shall be based on a total calculated
5040 premium multiplied by the premium assessment rate established pursuant to Subsection
5041 59-9-101(2).
5042 (d) The total calculated premium, for purposes of calculating the assessment under
5043 Subsection (1)(a), shall be calculated by:
5044 (i) multiplying the total of the standard premium for each class code calculated in
5045 Subsection (1)(e) by the self-insured employer's experience modification factor; and
5046 (ii) multiplying the total under Subsection (1)(d)(i) by a safety factor determined under
5047 Subsection (1)(g).
5048 (e) A standard premium shall be calculated by:
5049 (i) multiplying the [~~prospective~~] advisory loss cost for the year being considered, as
5050 filed with the insurance department pursuant to Section 31A-19a-406, for each applicable class

5051 code by 1.10 to determine the manual rate for each class code; and

5052 (ii) multiplying the manual rate for each class code under Subsection (1)(e)(i) by each

5053 $100 of the self-insured employer's covered payroll for each class code.

5054 (f) (i) Each self-insured employer paying compensation direct shall annually obtain the

5055 experience modification factor required in Subsection (1)(d)(i) by using:

5056 (A) the rate service organization designated by the insurance commissioner in Section

5057 31A-19a-404; or

5058 (B) for a self-insured employer that is a public agency insurance mutual, an actuary

5059 approved by the commission.

5060 (ii) If a self-insured employer's experience modification factor under Subsection

5061 (1)(f)(i) is less than 0.50, the self-insured employer shall use an experience modification factor

5062 of 0.50 in determining the total calculated premium.

5063 (g) To provide incentive for improved safety, the safety factor required in Subsection

5064 (1)(d)(ii) shall be determined based on the self-insured employer's experience modification

5065 factor as follows:

	EXPERIENCE MODIFICATION FACTOR	SAFETY FACTOR
5066		
5067	Less than or equal to 0.90	0.56
5068	Greater than 0.90 but less than or equal to 1.00	0.78
5069	Greater than 1.00 but less than or equal to 1.10	1.00
5070	Greater than 1.10 but less than or equal to 1.20	1.22
5071	Greater than 1.20	1.44

5072 (h) (i) A premium or premium assessment modification other than a premium or

5073 premium assessment modification under this section may not be allowed.

5074 (ii) If a self-insured employer paying compensation direct fails to obtain an experience

5075 modification factor as required in Subsection (1)(f)(i) within the reasonable time period

5076 established by rule by the State Tax Commission, the State Tax Commission shall use an
5077 experience modification factor of 2.00 and a safety factor of 2.00 to calculate the total
5078 calculated premium for purposes of determining the assessment.
5079 (iii) [~~Prior to~~] Before calculating the total calculated premium under Subsection
5080 (1)(h)(ii), the State Tax Commission shall provide the self-insured employer with written
5081 notice that failure to obtain an experience modification factor within a reasonable time period,
5082 as established by rule by the State Tax Commission:
5083 (A) shall result in the State Tax Commission using an experience modification factor
5084 of 2.00 and a safety factor of 2.00 in calculating the total calculated premium for purposes of
5085 determining the assessment; and
5086 (B) may result in the division revoking the self-insured employer's right to pay
5087 compensation direct.
5088 (i) The division may immediately revoke a self-insured employer's certificate issued
5089 under Sections 34A-2-201 and 34A-2-201.5 that permits the self-insured employer to pay
5090 compensation direct if the State Tax Commission assigns an experience modification factor
5091 and a safety factor under Subsection (1)(h) because the self-insured employer failed to obtain
5092 an experience modification factor.
5093 (2) Notwithstanding the annual payment requirement in Subsection (1)(a), a
5094 self-insured employer whose total assessment obligation under Subsection (1)(a) for the
5095 preceding year was $10,000 or more shall pay the assessment in quarterly installments in the
5096 same manner provided in Section 59-9-104 and subject to the same penalty provided in Section
5097 59-9-104 for not paying or underpaying an installment.
5098 (3) (a) The State Tax Commission shall have access to all the records of the division
5099 for the purpose of auditing and collecting any amounts described in this section.
5100 (b) Time periods for the State Tax Commission to allow a refund or make an
5101 assessment shall be determined in accordance with Title 59, Chapter 1, Part 14, Assessment,
5102 Collections, and Refunds Act.

5103 (4) (a) A review of appropriate use of job class assignment and calculation
5104 methodology may be conducted as directed by the division at any reasonable time as a
5105 condition of the self-insured employer's certification of paying compensation direct.
5106 (b) The State Tax Commission shall make any records necessary for the review
5107 available to the commission.
5108 (c) The commission shall make the results of any review available to the State Tax
5109 Commission.
5110 Section 54. Section **36-29-106** is amended to read:
5111 **36-29-106. Health Reform Task Force.**
5112 (1) There is created the Health Reform Task Force consisting of the following 11
5113 members:
5114 (a) four members of the Senate appointed by the president of the Senate, no more than
5115 three of whom are from the same political party; and
5116 (b) seven members of the House of Representatives appointed by the speaker of the
5117 House of Representatives, no more than five of whom are from the same political party.
5118 (2) (a) The president of the Senate shall designate a member of the Senate appointed
5119 under Subsection (1)(a) as a cochair of the task force.
5120 (b) The speaker of the House of Representatives shall designate a member of the House
5121 of Representatives appointed under Subsection (1)(b) as a cochair of the task force.
5122 (3) Salaries and expenses of the members of the task force shall be paid in accordance
5123 with Section 36-2-2 and Legislative Joint Rules, Title 5, Chapter 3, Legislator Compensation.
5124 (4) The Office of Legislative Research and General Counsel shall provide staff support
5125 to the task force.
5126 (5) The task force shall review and make recommendations on health system reform,
5127 including the following issues:
5128 (a) the need for state statutory and regulatory changes in response to federal actions
5129 affecting health care;

5130 (b) Medicaid and reforms to the Medicaid program;
5131 (c) options for increasing state flexibility, including the use of federal waivers;
5132 (d) the state's health insurance marketplace;
5133 (e) health insurance code modifications;
5134 (f) insurance network adequacy standards and balance billing; and
5135 [(g) health care provider workforce in the state;]
5136 [(h)] (g) rising health care costs[; and].
5137 [(i) non-opiate pain management options.]
5138 (6) A final report, including any proposed legislation, shall be presented to the
5139 Business and Labor Interim Committee and Health and Human Services Interim Committee
5140 before November 30, 2019, and November 30, 2020.
5141 Section 55. Section **63A-5-205.5** is amended to read:
5142 **63A-5-205.5. Health insurance requirements -- Penalties.**
5143 (1) As used in this section:
5144 (a) "Aggregate" means the sum of all contracts, change orders, and modifications
5145 related to a single project.
5146 (b) "Change order" means the same as that term is defined in Section 63G-6a-103.
5147 (c) "Employee" means, as defined in Section 34A-2-104, an "employee," "worker," or
5148 "operative" who:
5149 (i) works at least 30 hours per calendar week; and
5150 (ii) meets employer eligibility waiting requirements for health care insurance, which
5151 may not exceed the first day of the calendar month following 60 days after the day on which
5152 the individual is hired.
5153 (d) "Health benefit plan" means:
5154 (i) the same as that term is defined in Section 31A-1-301[.]; or
5155 (ii) an employee welfare benefit plan:
5156 (A) established under the Employee Retirement Income Security Act of 1974, 29

5157 U.S.C. Sec. 1001 et seq.;
5158 (B) for an employer with 100 or more employees; and
5159 (C) in which the employer establishes a self-funded or partially self-funded group
5160 health plan to provide medical care for the employer's employees and dependents of the
5161 employees.
5162 (e) "Qualified health [insurance] coverage" means the same as that term is defined in
5163 Section 26-40-115.
5164 (f) "Subcontractor" means the same as that term is defined in Section 63A-5-208.
5165 (g) "Third party administrator" or "administrator" means the same as that term is
5166 defined in Section 31A-1-301.
5167 (2) Except as provided in Subsection (3), the requirements of this section apply to:
5168 (a) a contractor of a design or construction contract entered into by the division or the
5169 State Building Board on or after July 1, 2009, if the prime contract is in an aggregate amount
5170 equal to or greater than $2,000,000; and
5171 (b) a subcontractor of a contractor of a design or construction contract entered into by
5172 the division or State Building Board on or after July 1, 2009, if the subcontract is in an
5173 aggregate amount equal to or greater than $1,000,000.
5174 (3) The requirements of this section do not apply to a contractor or subcontractor
5175 described in Subsection (2) if:
5176 (a) the application of this section jeopardizes the receipt of federal funds;
5177 (b) the contract is a sole source contract; or
5178 (c) the contract is an emergency procurement.
5179 (4) A person that intentionally uses change orders, contract modifications, or multiple
5180 contracts to circumvent the requirements of this section is guilty of an infraction.
5181 (5) (a) A contractor that is subject to the requirements of this section shall demonstrate
5182 to the director that the contractor has and will maintain an offer of qualified health [insurance]
5183 coverage for the contractor's employees and the employees' dependents by submitting to the

5184 director a written statement that:

5185 (i) the contractor offers qualified health [~~insurance~~] coverage that complies with

5186 Section 26-40-115;

5187 (ii) is from:

5188 (A) an actuary selected by the contractor or the contractor's insurer; [~~or~~]

5189 (B) an underwriter who is responsible for developing the employer group's premium

5190 rates; [~~and~~] or

5191 (C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii),

5192 an actuary or underwriter selected by a third party administrator; and

5193 (iii) was created within one year before the day on which the statement is submitted.

5194 (b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii)

5195 shall provide the actuary or underwriter selected by an administrator, as described in

5196 Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's

5197 contribution to the health benefit plan and the actuarial value of the health benefit plan meet the

5198 requirements of qualified health coverage.

5199 (ii) A contractor may not make a change to the contractor's contribution to the health

5200 benefit plan, unless the contractor provides notice to:

5201 (A) the actuary or underwriter selected by an administrator, as described in Subsection

5202 (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in

5203 Subsection (5)(a) in compliance with this section; and

5204 (B) the division.

5205 [~~(b)~~] (c) A contractor that is subject to the requirements of this section shall:

5206 (i) place a requirement in each of the contractor's subcontracts that a subcontractor that

5207 is subject to the requirements of this section shall obtain and maintain an offer of qualified

5208 health [~~insurance~~] coverage for the subcontractor's employees and the employees' dependents

5209 during the duration of the subcontract; and

5210 (ii) obtain from a subcontractor that is subject to the requirements of this section a

5211 written statement that:
5212 (A) the subcontractor offers qualified health [~~insurance~~] coverage that complies with
5213 Section 26-40-115;
5214 (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, [~~or~~]
5215 an underwriter who is responsible for developing the employer group's premium rates, or if the
5216 subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or
5217 underwriter selected by an administrator; and
5218 (C) was created within one year before the day on which the contractor obtains the
5219 statement.
5220 [~~(c)~~] (d) (i) (A) A contractor that fails to maintain an offer of qualified health
5221 [~~insurance~~] coverage described in Subsection (5)(a) during the duration of the contract is
5222 subject to penalties in accordance with administrative rules adopted by the division under
5223 Subsection (6).
5224 (B) A contractor is not subject to penalties for the failure of a subcontractor to obtain
5225 and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection
5226 (5)[~~(b)~~](c)(i).
5227 (ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health
5228 [~~insurance~~] coverage described in Subsection (5)[~~(b)~~](c)(i) during the duration of the
5229 subcontract is subject to penalties in accordance with administrative rules adopted by the
5230 division under Subsection (6).
5231 (B) A subcontractor is not subject to penalties for the failure of a contractor to maintain
5232 an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a).
5233 (6) The division shall adopt administrative rules:
5234 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;
5235 (b) in coordination with:
5236 (i) the Department of Environmental Quality in accordance with Section 19-1-206;
5237 (ii) the Department of Natural Resources in accordance with Section 79-2-404;

5238 (iii) a public transit district in accordance with Section 17B-2a-818.5;
5239 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;
5240 (v) the Department of Transportation in accordance with Section 72-6-107.5; and
5241 (vi) the Legislature's Administrative Rules Review Committee; and
5242 (c) that establish:
5243 (i) the requirements and procedures a contractor and a subcontractor shall follow to
5244 demonstrate compliance with this section, including:
5245 (A) that a contractor or subcontractor's compliance with this section is subject to an
5246 audit by the division or the Office of the Legislative Auditor General;
5247 (B) that a contractor that is subject to the requirements of this section shall obtain a
5248 written statement described in Subsection (5)(a); and
5249 (C) that a subcontractor that is subject to the requirements of this section shall obtain a
5250 written statement described in Subsection (5)[~~(b)~~](c)(ii);
5251 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally
5252 violates the provisions of this section, which may include:
5253 (A) a three-month suspension of the contractor or subcontractor from entering into
5254 future contracts with the state upon the first violation;
5255 (B) a six-month suspension of the contractor or subcontractor from entering into future
5256 contracts with the state upon the second violation;
5257 (C) an action for debarment of the contractor or subcontractor in accordance with
5258 Section 63G-6a-904 upon the third or subsequent violation; and
5259 (D) monetary penalties which may not exceed 50% of the amount necessary to
5260 purchase qualified health [~~insurance~~] coverage for employees and dependents of employees of
5261 the contractor or subcontractor who were not offered qualified health [~~insurance~~] coverage
5262 during the duration of the contract; and
5263 (iii) a website on which the department shall post the commercially equivalent
5264 benchmark for the qualified health [~~insurance~~] coverage that is provided by the Department of

5265 Health in accordance with Subsection 26-40-115(2).

5266 (7) (a) During the duration of a contract, the division may perform an audit to verify a

5267 contractor or subcontractor's compliance with this section.

5268 (b) Upon the division's request, a contractor or subcontractor shall provide the division:

5269 (i) a signed actuarial certification that the coverage the contractor or subcontractor

5270 offers is qualified health [~~insurance~~] coverage; or

5271 (ii) all relevant documents and information necessary for the division to determine

5272 compliance with this section.

5273 (c) If a contractor or subcontractor provides the documents and information described

5274 in Subsection (7)(b)(ii), the Insurance Department shall assist the division in determining if the

5275 coverage the contractor or subcontractor offers is qualified health [~~insurance~~] coverage.

5276 (8) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor

5277 or subcontractor that intentionally violates the provisions of this section is liable to the

5278 employee for health care costs that would have been covered by qualified health [~~insurance~~]

5279 coverage.

5280 (ii) An employer has an affirmative defense to a cause of action under Subsection

5281 (8)(a) if:

5282 (A) the employer relied in good faith on a written statement described in Subsection

5283 (5)(a) or (5)[~~(b)~~](c)(ii); or

5284 (B) the department determines that compliance with this section is not required under

5285 the provisions of Subsection (3).

5286 (b) An employee has a private right of action only against the employee's employer to

5287 enforce the provisions of this Subsection (8).

5288 (9) Any penalties imposed and collected under this section shall be deposited into the

5289 Medicaid Restricted Account created by Section 26-18-402.

5290 (10) The failure of a contractor or subcontractor to provide qualified health [~~insurance~~]

5291 coverage as required by this section:

5292 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,
5293 or contractor under:
5294 (i) Section 63G-6a-1602; or
5295 (ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and
5296 (b) may not be used by the procurement entity or a prospective bidder, offeror, or
5297 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
5298 or construction.
5299 (11) An administrator, including an administrator's actuary or underwriter, who
5300 provides a written statement under Subsection (5)(a) or (c) regarding the qualified health
5301 coverage of a contractor or subcontractor who provides a health benefit plan described in
5302 Subsection (1)(d)(ii):
5303 (a) subject to Subsection (11)(b), is not liable for an error in the written statement,
5304 unless the administrator commits gross negligence in preparing the written statement;
5305 (b) is not liable for any error in the written statement if the administrator relied in good
5306 faith on information from the contractor or subcontractor; and
5307 (c) may require as a condition of providing the written statement that a contractor or
5308 subcontractor hold the administrator harmless for an action arising under this section.
5309 Section 56. Section **63C-9-403** is amended to read:
5310 **63C-9-403. Contracting power of executive director -- Health insurance coverage.**
5311 (1) As used in this section:
5312 (a) "Aggregate" means the sum of all contracts, change orders, and modifications
5313 related to a single project.
5314 (b) "Change order" means the same as that term is defined in Section 63G-6a-103.
5315 (c) "Employee" means, as defined in Section 34A-2-104, an "employee," "worker," or
5316 "operative" who:
5317 (i) works at least 30 hours per calendar week; and
5318 (ii) meets employer eligibility waiting requirements for health care insurance, which

5319 may not exceed the first of the calendar month following 60 days after the day on which the
5320 individual is hired.
5321 (d) "Health benefit plan" means:
5322 (i) the same as that term is defined in Section 31A-1-301[.]; or
5323 (ii) an employee welfare benefit plan:
5324 (A) established under the Employee Retirement Income Security Act of 1974, 29
5325 U.S.C. Sec. 1001 et seq.;
5326 (B) for an employer with 100 or more employees; and
5327 (C) in which the employer establishes a self-funded or partially self-funded group
5328 health plan to provide medical care for the employer's employees and dependents of the
5329 employees.
5330 (e) "Qualified health [insurance] coverage" means the same as that term is defined in
5331 Section 26-40-115.
5332 (f) "Subcontractor" means the same as that term is defined in Section 63A-5-208.
5333 (g) "Third party administrator" or "administrator" means the same as that term is
5334 defined in Section 31A-1-301.
5335 (2) Except as provided in Subsection (3), the requirements of this section apply to:
5336 (a) a contractor of a design or construction contract entered into by the board, or on
5337 behalf of the board, on or after July 1, 2009, if the prime contract is in an aggregate amount
5338 equal to or greater than $2,000,000; and
5339 (b) a subcontractor of a contractor of a design or construction contract entered into by
5340 the board, or on behalf of the board, on or after July 1, 2009, if the subcontract is in an
5341 aggregate amount equal to or greater than $1,000,000.
5342 (3) The requirements of this section do not apply to a contractor or subcontractor
5343 described in Subsection (2) if:
5344 (a) the application of this section jeopardizes the receipt of federal funds;
5345 (b) the contract is a sole source contract; or

5346 (c) the contract is an emergency procurement.
5347 (4) A person that intentionally uses change orders, contract modifications, or multiple
5348 contracts to circumvent the requirements of this section is guilty of an infraction.
5349 (5) (a) A contractor subject to the requirements of this section shall demonstrate to the
5350 executive director that the contractor has and will maintain an offer of qualified health
5351 [~~insurance~~] coverage for the contractor's employees and the employees' dependents during the
5352 duration of the contract by submitting to the executive director a written statement that:
5353 (i) the contractor offers qualified health [~~insurance~~] coverage that complies with
5354 Section 26-40-115;
5355 (ii) is from:
5356 (A) an actuary selected by the contractor or the contractor's insurer; [~~or~~]
5357 (B) an underwriter who is responsible for developing the employer group's premium
5358 rates; [~~and~~] or
5359 (C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii),
5360 an actuary or underwriter selected by a third party administrator; and
5361 (iii) was created within one year before the day on which the statement is submitted.
5362 (b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii)
5363 shall provide the actuary or underwriter selected by the administrator, as described in
5364 Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's
5365 contribution to the health benefit plan and the health benefit plan's actuarial value meets the
5366 requirements of qualified health coverage.
5367 (ii) A contractor may not make a change to the contractor's contribution to the health
5368 benefit plan, unless the contractor provides notice to:
5369 (A) the actuary or underwriter selected by the administrator, as described in Subsection
5370 (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in
5371 Subsection (5)(a) in compliance with this section; and
5372 (B) the executive director.

5373 [(b)] (c) A contractor that is subject to the requirements of this section shall:
5374 (i) place a requirement in each of the contractor's subcontracts that a subcontractor that
5375 is subject to the requirements of this section shall obtain and maintain an offer of qualified
5376 health [insurance] coverage for the subcontractor's employees and the employees' dependents
5377 during the duration of the subcontract; and
5378 (ii) obtain from a subcontractor that is subject to the requirements of this section a
5379 written statement that:
5380 (A) the subcontractor offers qualified health [insurance] coverage that complies with
5381 Section 26-40-115;
5382 (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, [or]
5383 an underwriter who is responsible for developing the employer group's premium rates, or if the
5384 subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or
5385 underwriter selected by an administrator; and
5386 (C) was created within one year before the day on which the contractor obtains the
5387 statement.
5388 [(c)] (d) (i) (A) A contractor that fails to maintain an offer of qualified health
5389 [insurance] coverage as described in Subsection (5)(a) during the duration of the contract is
5390 subject to penalties in accordance with administrative rules adopted by the division under
5391 Subsection (6).
5392 (B) A contractor is not subject to penalties for the failure of a subcontractor to obtain
5393 and maintain an offer of qualified health [insurance] coverage described in Subsection
5394 (5)[(b)](c)(i).
5395 (ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health
5396 [insurance] coverage described in Subsection (5)[(b)](c)(i) during the duration of the
5397 subcontract is subject to penalties in accordance with administrative rules adopted by the
5398 department under Subsection (6).
5399 (B) A subcontractor is not subject to penalties for the failure of a contractor to maintain

5400 an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a).

5401 (6) The department shall adopt administrative rules:

5402 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

5403 (b) in coordination with:

5404 (i) the Department of Environmental Quality in accordance with Section 19-1-206;

5405 (ii) the Department of Natural Resources in accordance with Section 79-2-404;

5406 (iii) the State Building Board in accordance with Section 63A-5-205.5;

5407 (iv) a public transit district in accordance with Section 17B-2a-818.5;

5408 (v) the Department of Transportation in accordance with Section 72-6-107.5; and

5409 (vi) the Legislature's Administrative Rules Review Committee; and

5410 (c) that establish:

5411 (i) the requirements and procedures a contractor and a subcontractor shall follow to

5412 demonstrate compliance with this section, including:

5413 (A) that a contractor or subcontractor's compliance with this section is subject to an

5414 audit by the department or the Office of the Legislative Auditor General;

5415 (B) that a contractor that is subject to the requirements of this section shall obtain a

5416 written statement described in Subsection (5)(a); and

5417 (C) that a subcontractor that is subject to the requirements of this section shall obtain a

5418 written statement described in Subsection (5)[~~(b)~~](c)(ii);

5419 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally

5420 violates the provisions of this section, which may include:

5421 (A) a three-month suspension of the contractor or subcontractor from entering into

5422 future contracts with the state upon the first violation;

5423 (B) a six-month suspension of the contractor or subcontractor from entering into future

5424 contracts with the state upon the second violation;

5425 (C) an action for debarment of the contractor or subcontractor in accordance with

5426 Section 63G-6a-904 upon the third or subsequent violation; and

5427 (D) monetary penalties which may not exceed 50% of the amount necessary to
5428 purchase qualified health [insurance] coverage for employees and dependents of employees of
5429 the contractor or subcontractor who were not offered qualified health [insurance] coverage
5430 during the duration of the contract; and
5431 (iii) a website on which the department shall post the commercially equivalent
5432 benchmark, for the qualified health [insurance] coverage identified in Subsection (1)(e), that is
5433 provided by the Department of Health, in accordance with Subsection 26-40-115(2).
5434 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor
5435 or subcontractor who intentionally violates the provisions of this section is liable to the
5436 employee for health care costs that would have been covered by qualified health [insurance]
5437 coverage.
5438 (ii) An employer has an affirmative defense to a cause of action under Subsection
5439 (7)(a)(i) if:
5440 (A) the employer relied in good faith on a written statement described in Subsection
5441 (5)(a) or (5)[(b)](c)(ii); or
5442 (B) the department determines that compliance with this section is not required under
5443 the provisions of Subsection (3).
5444 (b) An employee has a private right of action only against the employee's employer to
5445 enforce the provisions of this Subsection (7).
5446 (8) Any penalties imposed and collected under this section shall be deposited into the
5447 Medicaid Restricted Account created in Section 26-18-402.
5448 (9) The failure of a contractor or subcontractor to provide qualified health [insurance]
5449 coverage as required by this section:
5450 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,
5451 or contractor under:
5452 (i) Section 63G-6a-1602; or
5453 (ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

5454 (b) may not be used by the procurement entity or a prospective bidder, offeror, or
5455 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
5456 or construction.
5457 (10) An administrator, including the administrator's actuary or underwriter, who
5458 provides a written statement under Subsection (5)(a) or (c) regarding the qualified health
5459 coverage of a contractor or subcontractor who provides a health benefit plan described in
5460 Subsection (1)(d)(ii):
5461 (a) subject to Subsection (10)(b), is not liable for an error in the written statement,
5462 unless the administrator commits gross negligence in preparing the written statement;
5463 (b) is not liable for any error in the written statement if the administrator relied in good
5464 faith on information from the contractor or subcontractor; and
5465 (c) may require as a condition of providing the written statement that a contractor or
5466 subcontractor hold the administrator harmless for an action arising under this section.
5467 Section 57. Section **72-6-107.5** is amended to read:
5468 **72-6-107.5. Construction of improvements of highway -- Contracts -- Health**
5469 **insurance coverage.**
5470 (1) As used in this section:
5471 (a) "Aggregate" means the sum of all contracts, change orders, and modifications
5472 related to a single project.
5473 (b) "Change order" means the same as that term is defined in Section 63G-6a-103.
5474 (c) "Employee" means, as defined in Section 34A-2-104, an "employee," "worker," or
5475 "operative" who:
5476 (i) works at least 30 hours per calendar week; and
5477 (ii) meets employer eligibility waiting requirements for health care insurance, which
5478 may not exceed the first day of the calendar month following 60 days after the day on which
5479 the individual is hired.
5480 (d) "Health benefit plan" means:

5481 (i) the same as that term is defined in Section 31A-1-301[.]; or
5482 (ii) an employee welfare benefit plan:
5483 (A) established under the Employee Retirement Income Security Act of 1974, 29
5484 U.S.C. Sec. 1001 et seq.;
5485 (B) for an employer with 100 or more employees; and
5486 (C) in which the employer establishes a self-funded or partially self-funded group
5487 health plan to provide medical care for the employer's employees and dependents of the
5488 employees.
5489 (e) "Qualified health [insurance] coverage" means the same as that term is defined in
5490 Section 26-40-115.
5491 (f) "Subcontractor" means the same as that term is defined in Section 63A-5-208.
5492 (g) "Third party administrator" or "administrator" means the same as that term is
5493 defined in Section 31A-1-301.
5494 (2) Except as provided in Subsection (3), the requirements of this section apply to:
5495 (a) a contractor of a design or construction contract entered into by the department on
5496 or after July 1, 2009, if the prime contract is in an aggregate amount equal to or greater than
5497 $2,000,000; and
5498 (b) a subcontractor of a contractor of a design or construction contract entered into by
5499 the department on or after July 1, 2009, if the subcontract is in an aggregate amount equal to or
5500 greater than $1,000,000.
5501 (3) The requirements of this section do not apply to a contractor or subcontractor
5502 described in Subsection (2) if:
5503 (a) the application of this section jeopardizes the receipt of federal funds;
5504 (b) the contract is a sole source contract; or
5505 (c) the contract is an emergency procurement.
5506 (4) A person that intentionally uses change orders, contract modifications, or multiple
5507 contracts to circumvent the requirements of this section is guilty of an infraction.

5508 (5) (a) A contractor subject to the requirements of this section shall demonstrate to the
5509 department that the contractor has and will maintain an offer of qualified health [~~insurance~~]
5510 coverage for the contractor's employees and the employees' dependents during the duration of
5511 the contract by submitting to the department a written statement that:
5512 (i) the contractor offers qualified health [~~insurance~~] coverage that complies with
5513 Section 26-40-115;
5514 (ii) is from:
5515 (A) an actuary selected by the contractor or the contractor's insurer; [~~or~~]
5516 (B) an underwriter who is responsible for developing the employer group's premium
5517 rates; [~~and~~] or
5518 (C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii),
5519 an actuary or underwriter selected by a third party administrator; and
5520 (iii) was created within one year before the day on which the statement is submitted.
5521 (b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii)
5522 shall provide the actuary or underwriter selected by an administrator, as described in
5523 Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's
5524 contribution to the health benefit plan and the actuarial value of the health benefit plan meet the
5525 requirements of qualified health coverage.
5526 (ii) A contractor may not make a change to the contractor's contribution to the health
5527 benefit plan, unless the contractor provides notice to:
5528 (A) the actuary or underwriter selected by an administrator, as described in Subsection
5529 (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in
5530 Subsection (5)(a) in compliance with this section; and
5531 (B) the department.
5532 [~~(b)~~] (c) A contractor that is subject to the requirements of this section shall:
5533 (i) place a requirement in each of the contractor's subcontracts that a subcontractor that
5534 is subject to the requirements of this section shall obtain and maintain an offer of qualified

5535 health [~~insurance~~] coverage for the subcontractor's employees and the employees' dependents
5536 during the duration of the subcontract; and
5537 (ii) obtain from a subcontractor that is subject to the requirements of this section a
5538 written statement that:
5539 (A) the subcontractor offers qualified health [~~insurance~~] coverage that complies with
5540 Section 26-40-115;
5541 (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, [~~or~~]
5542 an underwriter who is responsible for developing the employer group's premium rates, or if the
5543 subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or
5544 underwriter selected by an administrator; and
5545 (C) was created within one year before the day on which the contractor obtains the
5546 statement.
5547 [~~(c)~~] (d) (i) (A) A contractor that fails to maintain an offer of qualified health
5548 [~~insurance~~] coverage described in Subsection (5)(a) during the duration of the contract is
5549 subject to penalties in accordance with administrative rules adopted by the department under
5550 Subsection (6).
5551 (B) A contractor is not subject to penalties for the failure of a subcontractor to obtain
5552 and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection
5553 (5)[~~(b)~~](c)(i).
5554 (ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health
5555 [~~insurance~~] coverage described in Subsection (5)[~~(b)~~](c) during the duration of the subcontract
5556 is subject to penalties in accordance with administrative rules adopted by the department under
5557 Subsection (6).
5558 (B) A subcontractor is not subject to penalties for the failure of a contractor to maintain
5559 an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a).
5560 (6) The department shall adopt administrative rules:
5561 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

5562 (b) in coordination with:
5563 (i) the Department of Environmental Quality in accordance with Section 19-1-206;
5564 (ii) the Department of Natural Resources in accordance with Section 79-2-404;
5565 (iii) the State Building Board in accordance with Section 63A-5-205.5;
5566 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;
5567 (v) a public transit district in accordance with Section 17B-2a-818.5; and
5568 (vi) the Legislature's Administrative Rules Review Committee; and
5569 (c) that establish:
5570 (i) the requirements and procedures a contractor and a subcontractor shall follow to
5571 demonstrate compliance with this section, including:
5572 (A) that a contractor or subcontractor's compliance with this section is subject to an
5573 audit by the department or the Office of the Legislative Auditor General;
5574 (B) that a contractor that is subject to the requirements of this section shall obtain a
5575 written statement described in Subsection (5)(a); and
5576 (C) that a subcontractor that is subject to the requirements of this section shall obtain a
5577 written statement described in Subsection (5)[~~(b)~~](c)(ii);
5578 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally
5579 violates the provisions of this section, which may include:
5580 (A) a three-month suspension of the contractor or subcontractor from entering into
5581 future contracts with the state upon the first violation;
5582 (B) a six-month suspension of the contractor or subcontractor from entering into future
5583 contracts with the state upon the second violation;
5584 (C) an action for debarment of the contractor or subcontractor in accordance with
5585 Section 63G-6a-904 upon the third or subsequent violation; and
5586 (D) monetary penalties which may not exceed 50% of the amount necessary to
5587 purchase qualified health [~~insurance~~] coverage for an employee and a dependent of the
5588 employee of the contractor or subcontractor who was not offered qualified health [~~insurance~~]

5589 coverage during the duration of the contract; and

5590 (iii) a website on which the department shall post the commercially equivalent

5591 benchmark, for the qualified health [insurance] coverage identified in Subsection (1)(e), that is

5592 provided by the Department of Health, in accordance with Subsection 26-40-115(2).

5593 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor

5594 or subcontractor who intentionally violates the provisions of this section is liable to the

5595 employee for health care costs that would have been covered by qualified health [insurance]

5596 coverage.

5597 (ii) An employer has an affirmative defense to a cause of action under Subsection

5598 (7)(a)(i) if:

5599 (A) the employer relied in good faith on a written statement described in Subsection

5600 (5)(a) or (5)[(b)](c)(ii); or

5601 (B) the department determines that compliance with this section is not required under

5602 the provisions of Subsection (3).

5603 (b) An employee has a private right of action only against the employee's employer to

5604 enforce the provisions of this Subsection (7).

5605 (8) Any penalties imposed and collected under this section shall be deposited into the

5606 Medicaid Restricted Account created in Section 26-18-402.

5607 (9) The failure of a contractor or subcontractor to provide qualified health [insurance]

5608 coverage as required by this section:

5609 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,

5610 or contractor under:

5611 (i) Section 63G-6a-1602; or

5612 (ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

5613 (b) may not be used by the procurement entity or a prospective bidder, offeror, or

5614 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design

5615 or construction.

5616 (10) An administrator, including an administrator's actuary or underwriter, who
5617 provides a written statement under Subsection (5)(a) or (c) regarding the qualified health
5618 coverage of a contractor or subcontractor who provides a health benefit plan described in
5619 Subsection (1)(d)(ii):
5620 (a) subject to Subsection (10)(b), is not liable for an error in the written statement,
5621 unless the administrator commits gross negligence in preparing the written statement;
5622 (b) is not liable for any error in the written statement if the administrator relied in good
5623 faith on information from the contractor or subcontractor; and
5624 (c) may require as a condition of providing the written statement that a contractor or
5625 subcontractor hold the administrator harmless for an action arising under this section.
5626 Section 58. Section **79-2-404** is amended to read:
5627 **79-2-404. Contracting powers of department -- Health insurance coverage.**
5628 (1) As used in this section:
5629 (a) "Aggregate" means the sum of all contracts, change orders, and modifications
5630 related to a single project.
5631 (b) "Change order" means the same as that term is defined in Section 63G-6a-103.
5632 (c) "Employee" means, as defined in Section 34A-2-104, an "employee," "worker," or
5633 "operative" who:
5634 (i) works at least 30 hours per calendar week; and
5635 (ii) meets employer eligibility waiting requirements for health care insurance, which
5636 may not exceed the first day of the calendar month following 60 days after the day on which
5637 the individual is hired.
5638 (d) "Health benefit plan" means:
5639 (i) the same as that term is defined in Section 31A-1-301[.]; or
5640 (ii) an employee welfare benefit plan:
5641 (A) established under the Employee Retirement Income Security Act of 1974, 29
5642 U.S.C. Sec. 1001 et seq.;

5643 (B) for an employer with 100 or more employees; and
5644 (C) in which the employer establishes a self-funded or partially self-funded group
5645 health plan to provide medical care for the employer's employees and dependents of the
5646 employees.
5647 (e) "Qualified health [insurance] coverage" means the same as that term is defined in
5648 Section 26-40-115.
5649 (f) "Subcontractor" means the same as that term is defined in Section 63A-5-208.
5650 (g) "Third party administrator" or "administrator" means the same as that term is
5651 defined in Section 31A-1-301.
5652 (2) Except as provided in Subsection (3), the requirements of this section apply to:
5653 (a) a contractor of a design or construction contract entered into by, or delegated to, the
5654 department or a division, board, or council of the department on or after July 1, 2009, if the
5655 prime contract is in an aggregate amount equal to or greater than $2,000,000; and
5656 (b) a subcontractor of a contractor of a design or construction contract entered into by,
5657 or delegated to, the department or a division, board, or council of the department on or after
5658 July 1, 2009, if the subcontract is in an aggregate amount equal to or greater than $1,000,000.
5659 (3) This section does not apply to contracts entered into by the department or a
5660 division, board, or council of the department if:
5661 (a) the application of this section jeopardizes the receipt of federal funds;
5662 (b) the contract or agreement is between:
5663 (i) the department or a division, board, or council of the department; and
5664 (ii) (A) another agency of the state;
5665 (B) the federal government;
5666 (C) another state;
5667 (D) an interstate agency;
5668 (E) a political subdivision of this state; or
5669 (F) a political subdivision of another state; or

5670 (c) the contract or agreement is:
5671 (i) for the purpose of disbursing grants or loans authorized by statute;
5672 (ii) a sole source contract; or
5673 (iii) an emergency procurement.
5674 (4) A person that intentionally uses change orders, contract modifications, or multiple
5675 contracts to circumvent the requirements of this section is guilty of an infraction.
5676 (5) (a) A contractor subject to the requirements of this section shall demonstrate to the
5677 department that the contractor has and will maintain an offer of qualified health [~~insurance~~]
5678 coverage for the contractor's employees and the employees' dependents during the duration of
5679 the contract by submitting to the department a written statement that:
5680 (i) the contractor offers qualified health [~~insurance~~] coverage that complies with
5681 Section 26-40-115;
5682 (ii) is from:
5683 (A) an actuary selected by the contractor or the contractor's insurer; [~~or~~]
5684 (B) an underwriter who is responsible for developing the employer group's premium
5685 rates; [~~and~~] or
5686 (C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii),
5687 an actuary or underwriter selected by a third party administrator; and
5688 (iii) was created within one year before the day on which the statement is submitted.
5689 (b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii)
5690 shall provide the actuary or underwriter selected by an administrator, as described in
5691 Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's
5692 contribution to the health benefit plan and the actuarial value of the health benefit plan meet the
5693 requirements of qualified health coverage.
5694 (ii) A contractor may not make a change to the contractor's contribution to the health
5695 benefit plan, unless the contractor provides notice to:
5696 (A) the actuary or underwriter selected by an administrator, as described in Subsection

5697 (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in
5698 Subsection (5)(a) in compliance with this section; and
5699 (B) the department.
5700 [(b)] (c) A contractor that is subject to the requirements of this section shall:
5701 (i) place a requirement in each of the contractor's subcontracts that a subcontractor that
5702 is subject to the requirements of this section shall obtain and maintain an offer of qualified
5703 health [insurance] coverage for the subcontractor's employees and the employees' dependents
5704 during the duration of the subcontract; and
5705 (ii) obtain from a subcontractor that is subject to the requirements of this section a
5706 written statement that:
5707 (A) the subcontractor offers qualified health [insurance] coverage that complies with
5708 Section 26-40-115;
5709 (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, [or]
5710 an underwriter who is responsible for developing the employer group's premium rates, or if the
5711 subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or
5712 underwriter selected by an administrator; and
5713 (C) was created within one year before the day on which the contractor obtains the
5714 statement.
5715 [(c)] (d) (i) (A) A contractor that fails to maintain an offer of qualified health
5716 [insurance] coverage described in Subsection (5)(a) during the duration of the contract is
5717 subject to penalties in accordance with administrative rules adopted by the department under
5718 Subsection (6).
5719 (B) A contractor is not subject to penalties for the failure of a subcontractor to obtain
5720 and maintain an offer of qualified health [insurance] coverage described in Subsection
5721 (5)[(b)](c)(i).
5722 (ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health
5723 [insurance] coverage described in Subsection (5)[(b)](c) during the duration of the subcontract

5724 is subject to penalties in accordance with administrative rules adopted by the department under
5725 Subsection (6).
5726 (B) A subcontractor is not subject to penalties for the failure of a contractor to maintain
5727 an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a).
5728 (6) The department shall adopt administrative rules:
5729 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;
5730 (b) in coordination with:
5731 (i) the Department of Environmental Quality in accordance with Section 19-1-206;
5732 (ii) a public transit district in accordance with Section 17B-2a-818.5;
5733 (iii) the State Building Board in accordance with Section 63A-5-205.5;
5734 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;
5735 (v) the Department of Transportation in accordance with Section 72-6-107.5; and
5736 (vi) the Legislature's Administrative Rules Review Committee; and
5737 (c) that establish:
5738 (i) the requirements and procedures a contractor and a subcontractor shall follow to
5739 demonstrate compliance with this section, including:
5740 (A) that a contractor or subcontractor's compliance with this section is subject to an
5741 audit by the department or the Office of the Legislative Auditor General;
5742 (B) that a contractor that is subject to the requirements of this section shall obtain a
5743 written statement described in Subsection (5)(a); and
5744 (C) that a subcontractor that is subject to the requirements of this section shall obtain a
5745 written statement described in Subsection (5)[~~(b)~~](c)(ii);
5746 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally
5747 violates the provisions of this section, which may include:
5748 (A) a three-month suspension of the contractor or subcontractor from entering into
5749 future contracts with the state upon the first violation;
5750 (B) a six-month suspension of the contractor or subcontractor from entering into future

5751 contracts with the state upon the second violation;

5752 (C) an action for debarment of the contractor or subcontractor in accordance with

5753 Section 63G-6a-904 upon the third or subsequent violation; and

5754 (D) monetary penalties which may not exceed 50% of the amount necessary to

5755 purchase qualified health [~~insurance~~] coverage for an employee and a dependent of an

5756 employee of the contractor or subcontractor who was not offered qualified health [~~insurance~~]

5757 coverage during the duration of the contract; and

5758 (iii) a website on which the department shall post the commercially equivalent

5759 benchmark, for the qualified health [~~insurance~~] coverage identified in Subsection (1)(e),

5760 provided by the Department of Health, in accordance with Subsection 26-40-115(2).

5761 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor

5762 or subcontractor who intentionally violates the provisions of this section is liable to the

5763 employee for health care costs that would have been covered by qualified health [~~insurance~~]

5764 coverage.

5765 (ii) An employer has an affirmative defense to a cause of action under Subsection

5766 (7)(a)(i) if:

5767 (A) the employer relied in good faith on a written statement described in Subsection

5768 (5)(a) or (5)[~~(b)~~](c)(ii); or

5769 (B) the department determines that compliance with this section is not required under

5770 the provisions of Subsection (3).

5771 (b) An employee has a private right of action only against the employee's employer to

5772 enforce the provisions of this Subsection (7).

5773 (8) Any penalties imposed and collected under this section shall be deposited into the

5774 Medicaid Restricted Account created in Section 26-18-402.

5775 (9) The failure of a contractor or subcontractor to provide qualified health [~~insurance~~]

5776 coverage as required by this section:

5777 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,

5778 or contractor under:
5779 (i) Section 63G-6a-1602; or
5780 (ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and
5781 (b) may not be used by the procurement entity or a prospective bidder, offeror, or
5782 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design
5783 or construction.
5784 (10) An administrator, including an administrator's actuary or underwriter, who
5785 provides a written statement under Subsection (5)(a) or (c) regarding the qualified health
5786 coverage of a contractor or subcontractor who provides a health benefit plan described in
5787 Subsection (1)(d)(ii):
5788 (a) subject to Subsection (10)(b), is not liable for an error in the written statement,
5789 unless the administrator commits gross negligence in preparing the written statement;
5790 (b) is not liable for any error in the written statement if the administrator relied in good
5791 faith on information from the contractor or subcontractor; and
5792 (c) may require as a condition of providing the written statement that a contractor or
5793 subcontractor hold the administrator harmless for an action arising under this section.
5794 Section 59. **Effective date.**
5795 This bill takes effect on May 12, 2020, except that Section 31A-17-404 takes effect on
5796 January 1, 2021.