

**Representative James A. Dunnigan** proposes the following substitute bill:

**INSURANCE AMENDMENTS**

2020 GENERAL SESSION

STATE OF UTAH

**Chief Sponsor: James A. Dunnigan**

Senate Sponsor: Curtis S. Bramble

---

---

**LONG TITLE**

**General Description:**

This bill amends and enacts provisions under the Insurance Code and related to certain health benefit plans and the Health Reform Task Force.

**Highlighted Provisions:**

This bill:

- ▶ defines terms;
- ▶ amends provisions related to certain contractors and subcontractors and health benefit plans;
- ▶ amends the scope and applicability of the Insurance Code;
- ▶ removes the requirement that the Insurance Department employ a chief examiner;
- ▶ permits a signature of the insurance commissioner to be in a format that affixes an exact copy of the signature;
- ▶ prohibits more than two members of the Title and Escrow Commission to be employees of an entity operating under an affiliated business arrangement;
- ▶ amends requirements for doing business in relation to service contract providers and warrantors;
- ▶ amends provisions regarding required disclosures for a service contract or a vehicle 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           ▶ amends uninsured motorist coverage regarding arbitration awards;
  - 46           ▶ enacts provisions regarding the Restatement of the Law of Liability Insurance;
  - 47           ▶ outlines requirements for a notice of assignment related to a debt;
  - 48           ▶ amends requirements related to the shared common purposes of association groups;
  - 49           ▶ amends provisions regarding dependent coverage for accident and health insurance;
  - 50           ▶ enacts the Limited Long-Term Care Insurance Act, which:
    - 51           • defines terms;
    - 52           • establishes disclosure and performance standards for limited long-term care
    - 53 insurance;
    - 54           • establishes parameters of a limited long-term care insurance policy offering a
    - 55 nonforfeiture benefit; and
    - 56           • requires the insurance commissioner to make rules;

- 57 ▶ amends provisions regarding the licensing of administrators;
- 58 ▶ amends jurisdictional provisions under the Insurance Receivership Act;
- 59 ▶ amends provisions related to health care claims practices;
- 60 ▶ enacts provisions related to the designation of a third party to receive notification of
- 61 lapse or cancellation of a policyholder's policy for nonpayment of premium;
- 62 ▶ permits a captive insurance company to provide reinsurance by another insurer with
- 63 prior approval of the commissioner;
- 64 ▶ amends the issues regarding which the Health Reform Task Force is required to
- 65 review and make recommendations; and
- 66 ▶ makes technical and conforming changes.

67 **Money Appropriated in this Bill:**

68 None

69 **Other Special Clauses:**

70 None

71 **Utah Code Sections Affected:**

72 AMENDS:

73 [17B-2a-818.5](#), as last amended by Laws of Utah 2018, Chapter 319

74 [19-1-206](#), as last amended by Laws of Utah 2018, Chapter 319

75 [26-40-115](#), as last amended by Laws of Utah 2019, Chapter 393

76 [31A-1-103](#), as last amended by Laws of Utah 2017, Chapter 27

77 [31A-1-301](#), as last amended by Laws of Utah 2019, Chapter 193

78 [31A-2-104](#), as last amended by Laws of Utah 2014, Chapters 290 and 300

79 [31A-2-110](#), as last amended by Laws of Utah 1986, Chapter 204

80 [31A-2-212](#), as last amended by Laws of Utah 2016, Chapter 138

81 [31A-2-218](#), as last amended by Laws of Utah 2015, Chapter 283

82 [31A-2-309](#), as last amended by Laws of Utah 2016, Chapter 138

83 [31A-2-403](#), as last amended by Laws of Utah 2019, Chapter 193

84 [31A-6a-101](#), as last amended by Laws of Utah 2018, Chapter 319

85 [31A-6a-103](#), as last amended by Laws of Utah 2015, Chapter 244

86 [31A-6a-104](#), as last amended by Laws of Utah 2018, Chapter 319

87 [31A-8-211](#), as last amended by Laws of Utah 2002, Chapter 308

- 88            [31A-17-404](#), as last amended by Laws of Utah 2017, Chapter 168
- 89            [31A-17-404.3](#), as last amended by Laws of Utah 2016, Chapter 138
- 90            [31A-17-601](#), as last amended by Laws of Utah 2001, Chapter 116
- 91            [31A-19a-404](#), as renumbered and amended by Laws of Utah 1999, Chapter 130
- 92            [31A-19a-405](#), as renumbered and amended by Laws of Utah 1999, Chapter 130
- 93            [31A-19a-406](#), as renumbered and amended by Laws of Utah 1999, Chapter 130
- 94            [31A-21-201](#), as last amended by Laws of Utah 2019, Chapter 193
- 95            [31A-21-301](#), as last amended by Laws of Utah 2010, Chapter 10
- 96            [31A-21-313](#), as last amended by Laws of Utah 2015, Chapter 244
- 97            [31A-22-305](#), as last amended by Laws of Utah 2019, Chapter 131
- 98            [31A-22-412](#), as last amended by Laws of Utah 1986, Chapter 204
- 99            [31A-22-413](#), as last amended by Laws of Utah 2013, Chapter 264
- 100           [31A-22-505](#), as last amended by Laws of Utah 2017, Chapter 168
- 101           [31A-22-610.5](#), as last amended by Laws of Utah 2018, Chapter 443
- 102           [31A-22-615.5](#), as enacted by Laws of Utah 2017, Chapter 53
- 103           [31A-23a-111](#), as last amended by Laws of Utah 2019, Chapter 193
- 104           [31A-23a-205](#), as renumbered and amended by Laws of Utah 2003, Chapter 298
- 105           [31A-23a-415](#), as last amended by Laws of Utah 2019, Chapter 193
- 106           [31A-23b-401](#), as last amended by Laws of Utah 2019, Chapter 193
- 107           [31A-25-208](#), as last amended by Laws of Utah 2019, Chapter 193
- 108           [31A-26-206](#), as last amended by Laws of Utah 2014, Chapters 290 and 300
- 109           [31A-26-213](#), as last amended by Laws of Utah 2019, Chapter 193
- 110           [31A-26-301.6](#), as last amended by Laws of Utah 2009, Chapter 11
- 111           [31A-27a-105](#), as enacted by Laws of Utah 2007, Chapter 309
- 112           [31A-27a-501](#), as enacted by Laws of Utah 2007, Chapter 309
- 113           [31A-30-117](#), as last amended by Laws of Utah 2015, Chapter 283
- 114           [31A-30-118](#), as last amended by Laws of Utah 2019, Chapter 193
- 115           [31A-35-402](#), as last amended by Laws of Utah 2016, Chapter 234
- 116           [31A-37-303](#), as last amended by Laws of Utah 2017, Chapter 168
- 117           [31A-37-701](#), as enacted by Laws of Utah 2019, Chapter 193
- 118           [34A-2-202](#), as last amended by Laws of Utah 2009, Chapter 212

- 119 [36-29-106](#), as enacted by Laws of Utah 2019, Chapter 193
- 120 [63A-5-205.5](#), as enacted by Laws of Utah 2018, Chapter 319
- 121 [63C-9-403](#), as last amended by Laws of Utah 2018, Chapter 319
- 122 [72-6-107.5](#), as last amended by Laws of Utah 2018, Chapter 319
- 123 [79-2-404](#), as last amended by Laws of Utah 2018, Chapter 319

124 ENACTS:

- 125 [31A-22-205](#), Utah Code Annotated 1953
- 126 [31A-22-430](#), Utah Code Annotated 1953
- 127 [31A-22-2001](#), Utah Code Annotated 1953
- 128 [31A-22-2002](#), Utah Code Annotated 1953
- 129 [31A-22-2003](#), Utah Code Annotated 1953
- 130 [31A-22-2004](#), Utah Code Annotated 1953
- 131 [31A-22-2005](#), Utah Code Annotated 1953
- 132 [31A-22-2006](#), Utah Code Annotated 1953

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

135 Section 1. Section **17B-2a-818.5** is amended to read:

136 **17B-2a-818.5. Contracting powers of public transit districts -- Health insurance**  
137 **coverage.**

138 (1) As used in this section:

139 (a) "Aggregate" means the sum of all contracts, change orders, and modifications  
140 related to a single project.

141 (b) "Change order" means the same as that term is defined in Section [63G-6a-103](#).

142 (c) "Employee" means, as defined in Section [34A-2-104](#), an "employee," "worker," or  
143 "operative" who:

144 (i) works at least 30 hours per calendar week; and

145 (ii) meets employer eligibility waiting requirements for health care insurance, which  
146 may not exceed the first day of the calendar month following 60 days after the day on which  
147 the individual is hired.

148 (d) "Health benefit plan" means:

149 (i) the same as that term is defined in Section [31A-1-301](#)[:]; or

- 150           (ii) an employee welfare benefit plan:  
151           (A) established under the Employee Retirement Income Security Act of 1974, 29  
152 U.S.C. Sec. 1001 et seq.;  
153           (B) for an employer with 100 or more employees; and  
154           (C) in which the employer establishes a self-funded or partially self-funded group  
155 health plan to provide medical care for the employer's employees and dependents of the  
156 employees.
- 157           (e) "Qualified health [~~insurance~~] coverage" means the same as that term is defined in  
158 Section [26-40-115](#).
- 159           (f) "Subcontractor" means the same as that term is defined in Section [63A-5-208](#).
- 160           (g) "Third party administrator" or "administrator" means the same as that term is  
161 defined in Section [31A-1-301](#).
- 162           (2) Except as provided in Subsection (3), the requirements of this section apply to:  
163           (a) a contractor of a design or construction contract entered into by the public transit  
164 district on or after July 1, 2009, if the prime contract is in an aggregate amount equal to or  
165 greater than \$2,000,000; and  
166           (b) a subcontractor of a contractor of a design or construction contract entered into by  
167 the public transit district on or after July 1, 2009, if the subcontract is in an aggregate amount  
168 equal to or greater than \$1,000,000.
- 169           (3) The requirements of this section do not apply to a contractor or subcontractor  
170 described in Subsection (2) if:  
171           (a) the application of this section jeopardizes the receipt of federal funds;  
172           (b) the contract is a sole source contract; or  
173           (c) the contract is an emergency procurement.
- 174           (4) A person that intentionally uses change orders, contract modifications, or multiple  
175 contracts to circumvent the requirements of this section is guilty of an infraction.
- 176           (5) (a) A contractor subject to the requirements of this section shall demonstrate to the  
177 public transit district that the contractor has and will maintain an offer of qualified health  
178 [~~insurance~~] coverage for the contractor's employees and the employee's dependents during the  
179 duration of the contract by submitting to the public transit district a written statement that:  
180           (i) the contractor offers qualified health [~~insurance~~] coverage that complies with

181 Section 26-40-115;

182 (ii) is from:

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

184 (B) an underwriter who is responsible for developing the employer group's premium  
185 rates; ~~and~~ or

186 (C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii),  
187 an actuary or underwriter selected by a third party administrator; and

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

189 (b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii)  
190 shall provide the actuary or underwriter selected by an administrator, as described in  
191 Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's  
192 contribution to the health benefit plan and the actuarial value of the health benefit plan meet the  
193 requirements of qualified health coverage.

194 (ii) A contractor may not make a change to the contractor's contribution to the health  
195 benefit plan, unless the contractor provides notice to:

196 (A) the actuary or underwriter selected by an administrator as described in Subsection  
197 (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in  
198 Subsection (5)(a) in compliance with this section; and

199 (B) the public transit district.

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

201 (i) place a requirement in each of the contractor's subcontracts that a subcontractor that  
202 is subject to the requirements of this section shall obtain and maintain an offer of qualified  
203 health ~~insurance~~ coverage for the subcontractor's employees and the employees' dependents  
204 during the duration of the subcontract; and

205 (ii) obtain from a subcontractor that is subject to the requirements of this section a  
206 written statement that:

207 (A) the subcontractor offers qualified health ~~insurance~~ coverage that complies with  
208 Section 26-40-115;

209 (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, [or]  
210 an underwriter who is responsible for developing the employer group's premium rates, or if the  
211 subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or

212 underwriter selected by an administrator; and

213 (C) was created within one year before the day on which the contractor obtains the  
214 statement.

215 ~~(c)~~ (d) (i) (A) A contractor that fails to maintain an offer of qualified health  
216 [insurance] coverage as described in Subsection (5)(a) during the duration of the contract is  
217 subject to penalties in accordance with an ordinance adopted by the public transit district under  
218 Subsection (6).

219 (B) A contractor is not subject to penalties for the failure of a subcontractor to obtain  
220 and maintain an offer of qualified health [insurance] coverage described in Subsection  
221 (5)~~(b)~~(c)(i).

222 (ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health  
223 [insurance] coverage described in Subsection (5)~~(b)~~(c)(i) during the duration of the  
224 subcontract is subject to penalties in accordance with an ordinance adopted by the public transit  
225 district under Subsection (6).

226 (B) A subcontractor is not subject to penalties for the failure of a contractor to maintain  
227 an offer of qualified health [insurance] coverage described in Subsection (5)(a).

228 (6) The public transit district shall adopt ordinances:

229 (a) in coordination with:

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

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

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

233 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403; and

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

235 (b) that establish:

236 (i) the requirements and procedures a contractor and a subcontractor shall follow to  
237 demonstrate compliance with this section, including:

238 (A) that a contractor or subcontractor's compliance with this section is subject to an  
239 audit by the public transit district or the Office of the Legislative Auditor General;

240 (B) that a contractor that is subject to the requirements of this section shall obtain a  
241 written statement described in Subsection (5)(a); and

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



243 written statement described in Subsection (5)(~~(b)~~)(c)(ii);

244 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally  
245 violates the provisions of this section, which may include:

246 (A) a three-month suspension of the contractor or subcontractor from entering into  
247 future contracts with the public transit district upon the first violation;

248 (B) a six-month suspension of the contractor or subcontractor from entering into future  
249 contracts with the public transit district upon the second violation;

250 (C) an action for debarment of the contractor or subcontractor in accordance with  
251 Section 63G-6a-904 upon the third or subsequent violation; and

252 (D) monetary penalties which may not exceed 50% of the amount necessary to  
253 purchase qualified health [~~insurance~~] coverage for employees and dependents of employees of  
254 the contractor or subcontractor who were not offered qualified health [~~insurance~~] coverage  
255 during the duration of the contract; and

256 (iii) a website on which the district shall post the commercially equivalent benchmark,  
257 for the qualified health [~~insurance~~] coverage identified in Subsection (1)(e), that is provided by  
258 the Department of Health, in accordance with Subsection 26-40-115(2).

259 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(b)(ii), a contractor  
260 or subcontractor who intentionally violates the provisions of this section is liable to the  
261 employee for health care costs that would have been covered by qualified health [~~insurance~~]  
262 coverage.

263 (ii) An employer has an affirmative defense to a cause of action under Subsection  
264 (7)(a)(i) if:

265 (A) the employer relied in good faith on a written statement described in Subsection  
266 (5)(a) or (5)(~~(b)~~)(c)(ii); or

267 (B) a department or division determines that compliance with this section is not  
268 required under the provisions of Subsection (3).

269 (b) An employee has a private right of action only against the employee's employer to  
270 enforce the provisions of this Subsection (7).

271 (8) Any penalties imposed and collected under this section shall be deposited into the  
272 Medicaid Restricted Account created in Section 26-18-402.

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

274 coverage as required by this section:

275 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,  
276 or contractor under:

277 (i) Section [63G-6a-1602](#); or

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

279 (b) may not be used by the procurement entity or a prospective bidder, offeror, or  
280 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design  
281 or construction.

282 (10) An administrator, including an administrator's actuary or underwriter, who  
283 provides a written statement under Subsection (5)(a) or (c) regarding the qualified health  
284 coverage of a contractor or subcontractor who provides a health benefit plan described in  
285 Subsection (1)(d)(ii):

286 (a) subject to Subsection (10)(b), is not liable for an error in the written statement,  
287 unless the administrator commits gross negligence in preparing the written statement;

288 (b) is not liable for any error in the written statement if the administrator relied in good  
289 faith on information from the contractor or subcontractor; and

290 (c) may require as a condition of providing the written statement that a contractor or  
291 subcontractor hold the administrator harmless for an action arising under this section.

292 Section 2. Section **19-1-206** is amended to read:

293 **19-1-206. Contracting powers of department -- Health insurance coverage.**

294 (1) As used in this section:

295 (a) "Aggregate" means the sum of all contracts, change orders, and modifications  
296 related to a single project.

297 (b) "Change order" means the same as that term is defined in Section [63G-6a-103](#).

298 (c) "Employee" means, as defined in Section [34A-2-104](#), an "employee," "worker," or  
299 "operative" who:

300 (i) works at least 30 hours per calendar week; and

301 (ii) meets employer eligibility waiting requirements for health care insurance, which  
302 may not exceed the first day of the calendar month following 60 days after the day on which  
303 the individual is hired.

304 (d) "Health benefit plan" means:

- 305           (i) the same as that term is defined in Section [31A-1-301](#)[?]; or
- 306           (ii) an employee welfare benefit plan:
- 307           (A) established under the Employee Retirement Income Security Act of 1974, 29
- 308 U.S.C. Sec. 1001 et seq.;
- 309           (B) for an employer with 100 or more employees; and
- 310           (C) in which the employer establishes a self-funded or partially self-funded group
- 311 health plan to provide medical care for the employer's employees and dependents of the
- 312 employees.
- 313           (e) "Qualified health [~~insurance~~] coverage" means the same as that term is defined in
- 314 Section [26-40-115](#).
- 315           (f) "Subcontractor" means the same as that term is defined in Section [63A-5-208](#).
- 316           (g) "Third party administrator" or "administrator" means the same as that term is
- 317 defined in Section [31A-1-301](#).
- 318           (2) Except as provided in Subsection (3), the requirements of this section apply to:
- 319           (a) a contractor of a design or construction contract entered into by, or delegated to, the
- 320 department, or a division or board of the department, on or after July 1, 2009, if the prime
- 321 contract is in an aggregate amount equal to or greater than \$2,000,000; and
- 322           (b) a subcontractor of a contractor of a design or construction contract entered into by,
- 323 or delegated to, the department, or a division or board of the department, on or after July 1,
- 324 2009, if the subcontract is in an aggregate amount equal to or greater than \$1,000,000.
- 325           (3) This section does not apply to contracts entered into by the department or a division
- 326 or board of the department if:
- 327           (a) the application of this section jeopardizes the receipt of federal funds;
- 328           (b) the contract or agreement is between:
- 329           (i) the department or a division or board of the department; and
- 330           (ii) (A) another agency of the state;
- 331               (B) the federal government;
- 332               (C) another state;
- 333               (D) an interstate agency;
- 334               (E) a political subdivision of this state; or
- 335               (F) a political subdivision of another state;

336 (c) the executive director determines that applying the requirements of this section to a  
337 particular contract interferes with the effective response to an immediate health and safety  
338 threat from the environment; or

339 (d) the contract is:

340 (i) a sole source contract; or

341 (ii) an emergency procurement.

342 (4) A person that intentionally uses change orders, contract modifications, or multiple  
343 contracts to circumvent the requirements of this section is guilty of an infraction.

344 (5) (a) A contractor subject to the requirements of this section shall demonstrate to the  
345 executive director that the contractor has and will maintain an offer of qualified health  
346 [insurance] coverage for the contractor's employees and the employees' dependents during the  
347 duration of the contract by submitting to the executive director a written statement that:

348 (i) the contractor offers qualified health [insurance] coverage that complies with  
349 Section [26-40-115](#);

350 (ii) is from:

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

352 (B) an underwriter who is responsible for developing the employer group's premium  
353 rates; [and] or

354 (C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii),  
355 an actuary or underwriter selected by a third party administrator; and

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

357 (b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii)  
358 shall provide the actuary or underwriter selected by an administrator, as described in  
359 Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's  
360 contribution to the health benefit plan and the actuarial value of the health benefit plan meet the  
361 requirements of qualified health coverage.

362 (ii) A contractor may not make a change to the contractor's contribution to the health  
363 benefit plan, unless the contractor provides notice to:

364 (A) the actuary or underwriter selected by an administrator, as described in Subsection  
365 (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in  
366 Subsection (5)(a) in compliance with this section; and

367 (B) the department.

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

369 (i) place a requirement in each of the contractor's subcontracts that a subcontractor that  
370 is subject to the requirements of this section shall obtain and maintain an offer of qualified  
371 health [~~insurance~~] coverage for the subcontractor's employees and the employees' dependents  
372 during the duration of the subcontract; and

373 (ii) obtain from a subcontractor that is subject to the requirements of this section a  
374 written statement that:

375 (A) the subcontractor offers qualified health [~~insurance~~] coverage that complies with  
376 Section [26-40-115](#);

377 (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, ~~[or]~~  
378 an underwriter who is responsible for developing the employer group's premium rates, or if the  
379 subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or  
380 underwriter selected by an administrator; and

381 (C) was created within one year before the day on which the contractor obtains the  
382 statement.

383 ~~[(e)]~~ (d) (i) (A) A contractor that fails to maintain an offer of qualified health  
384 [~~insurance~~] coverage described in Subsection (5)(a) during the duration of the contract is  
385 subject to penalties in accordance with administrative rules adopted by the department under  
386 Subsection (6).

387 (B) A contractor is not subject to penalties for the failure of a subcontractor to obtain  
388 and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection  
389 (5)~~[(b)]~~(c)(i).

390 (ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health  
391 [~~insurance~~] coverage described in Subsection (5)~~[(b)]~~(c) during the duration of the subcontract  
392 is subject to penalties in accordance with administrative rules adopted by the department under  
393 Subsection (6).

394 (B) A subcontractor is not subject to penalties for the failure of a contractor to maintain  
395 an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a).

396 (6) The department shall adopt administrative rules:

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

398 (b) in coordination with:

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

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

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

402 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;

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

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

405 (c) that establish:

406 (i) the requirements and procedures a contractor and a subcontractor shall follow to  
407 demonstrate compliance with this section, including:

408 (A) that a contractor or subcontractor's compliance with this section is subject to an  
409 audit by the department or the Office of the Legislative Auditor General;

410 (B) that a contractor that is subject to the requirements of this section shall obtain a  
411 written statement described in Subsection (5)(a); and

412 (C) that a subcontractor that is subject to the requirements of this section shall obtain a  
413 written statement described in Subsection (5)(~~b~~)(c)(ii);

414 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally  
415 violates the provisions of this section, which may include:

416 (A) a three-month suspension of the contractor or subcontractor from entering into  
417 future contracts with the state upon the first violation;

418 (B) a six-month suspension of the contractor or subcontractor from entering into future  
419 contracts with the state upon the second violation;

420 (C) an action for debarment of the contractor or subcontractor in accordance with  
421 Section 63G-6a-904 upon the third or subsequent violation; and

422 (D) notwithstanding Section 19-1-303, monetary penalties which may not exceed 50%  
423 of the amount necessary to purchase qualified health [~~insurance~~] coverage for an employee and  
424 the dependents of an employee of the contractor or subcontractor who was not offered qualified  
425 health [~~insurance~~] coverage during the duration of the contract; and

426 (iii) a website on which the department shall post the commercially equivalent  
427 benchmark, for the qualified health [~~insurance~~] coverage identified in Subsection (1)(e), that is  
428 provided by the Department of Health, in accordance with Subsection 26-40-115(2).

429 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor  
430 or subcontractor who intentionally violates the provisions of this section is liable to the  
431 employee for health care costs that would have been covered by qualified health [insurance]  
432 coverage.

433 (ii) An employer has an affirmative defense to a cause of action under Subsection  
434 (7)(a)(i) if:

435 (A) the employer relied in good faith on a written statement described in Subsection  
436 (5)(a) or (5)(~~b~~)(c)(ii); or

437 (B) the department determines that compliance with this section is not required under  
438 the provisions of Subsection (3).

439 (b) An employee has a private right of action only against the employee's employer to  
440 enforce the provisions of this Subsection (7).

441 (8) Any penalties imposed and collected under this section shall be deposited into the  
442 Medicaid Restricted Account created in Section [26-18-402](#).

443 (9) The failure of a contractor or subcontractor to provide qualified health [insurance]  
444 coverage as required by this section:

445 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,  
446 or contractor under:

447 (i) Section [63G-6a-1602](#); or

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

449 (b) may not be used by the procurement entity or a prospective bidder, offeror, or  
450 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design  
451 or construction.

452 (10) An administrator, including an administrator's actuary or underwriter, who  
453 provides a written statement under Subsection (5)(a) or (c) regarding the qualified health  
454 coverage of a contractor or subcontractor who provides a health benefit plan described in  
455 Subsection (1)(d)(ii):

456 (a) subject to Subsection (10)(b), is not liable for an error in the written statement,  
457 unless the administrator commits gross negligence in preparing the written statement;

458 (b) is not liable for any error in the written statement if the administrator relied in good  
459 faith on information from the contractor or subcontractor; and

460 (c) may require as a condition of providing the written statement that a contractor or  
461 subcontractor hold the administrator harmless for an action arising under this section.

462 Section 3. Section **26-40-115** is amended to read:

463 **26-40-115. State contractor -- Employee and dependent health benefit plan**  
464 **coverage.**

465 (1) For purposes of Sections [17B-2a-818.5](#), [19-1-206](#), [63A-5-205.5](#), [63C-9-403](#),  
466 [72-6-107.5](#), and [79-2-404](#), "qualified health [~~insurance~~] coverage" means, at the time the  
467 contract is entered into or renewed:

468 (a) a health benefit plan and employer contribution level with a combined actuarial  
469 value at least actuarially equivalent to the combined actuarial value of:

470 (i) the benchmark plan determined by the program under Subsection  
471 [26-40-106\(1\)\(a\)](#)[;]; and

472 (ii) a contribution level at which the employer pays at least 50% of the premium or  
473 contribution amounts for the employee and the dependents of the employee who reside or work  
474 in the state; or

475 (b) a federally qualified high deductible health plan that, at a minimum:

476 (i) has a deductible that is:

477 (A) the lowest deductible permitted for a federally qualified high deductible health  
478 plan; or

479 (B) a deductible that is higher than the lowest deductible permitted for a federally  
480 qualified high deductible health plan, but includes an employer contribution to a health savings  
481 account in a dollar amount at least equal to the dollar amount difference between the lowest  
482 deductible permitted for a federally qualified high deductible plan and the deductible for the  
483 employer offered federally qualified high deductible plan;

484 (ii) has an out-of-pocket maximum that does not exceed three times the amount of the  
485 annual deductible; and

486 (iii) provides that the employer pays 60% of the premium or contribution amounts for  
487 the employee and the dependents of the employee who work or reside in the state.

488 (2) The department shall:

489 (a) on or before July 1, 2016:

490 (i) determine the commercial equivalent of the benchmark plan described in Subsection



491 (1)(a); and

492 (ii) post the commercially equivalent benchmark plan described in Subsection (2)(a)(i)  
493 on the department's website, noting the date posted; and

494 (b) update the posted commercially equivalent benchmark plan annually and at the  
495 time of any change in the benchmark.

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

497 **31A-1-103. Scope and applicability of title.**

498 (1) This title does not apply to:

499 (a) a retainer contract made by an attorney-at-law:

500 (i) with an individual client; and

501 (ii) under which fees are based on estimates of the nature and amount of services to be  
502 provided to the specific client;

503 (b) a contract similar to a contract described in Subsection (1)(a) made with a group of  
504 clients involved in the same or closely related legal matters;

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

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

511 (e) legal assistance by employee organizations to their members in matters relating to  
512 employment;

513 (f) death, accident, health, or disability benefits provided to a person by an organization  
514 or its affiliate if:

515 (i) the organization is tax exempt under Section 501(c)(3) of the Internal Revenue  
516 Code and has had its principal place of business in Utah for at least five years;

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

518 (iii) (A) substantially all the person's time in the organization is spent providing  
519 voluntary services:

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

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

- 522 (III) for which no compensation, other than expenses, is paid; or
- 523 (B) the time since the service under Subsection (1)(f)(iii)(A) was completed is no more
- 524 than 18 months; or
- 525 (g) a prepaid contract of limited duration that provides for scheduled maintenance only.
- 526 (2) (a) This title restricts otherwise legitimate business activity.
- 527 (b) What this title does not prohibit is permitted unless contrary to other provisions of
- 528 Utah law.
- 529 (3) Except as otherwise expressly provided, this title does not apply to:
- 530 (a) those activities of an insurer where state jurisdiction is preempted by Section 514 of
- 531 the federal Employee Retirement Income Security Act of 1974, as amended;
- 532 (b) ocean marine insurance;
- 533 (c) death, accident, health, or disability benefits provided by an organization if the
- 534 organization:
- 535 (i) has as ~~[its]~~ the organization's principal purpose to achieve charitable, educational,
- 536 social, or religious objectives rather than to provide death, accident, health, or disability
- 537 benefits;
- 538 (ii) does not incur a legal obligation to pay a specified amount; and
- 539 (iii) does not create reasonable expectations of receiving a specified amount on the part
- 540 of an insured person;
- 541 (d) other business specified in rules adopted by the commissioner on a finding that:
- 542 (i) the transaction of the business in this state does not require regulation for the
- 543 protection of the interests of the residents of this state; or
- 544 (ii) it would be impracticable to require compliance with this title;
- 545 (e) except as provided in Subsection (4), a transaction independently procured through
- 546 negotiations under Section [31A-15-104](#);
- 547 (f) self-insurance;
- 548 (g) reinsurance;
- 549 (h) subject to Subsection (5), employee and labor union group or blanket insurance
- 550 covering risks in this state if:
- 551 (i) the policyholder exists primarily for purposes other than to procure insurance;
- 552 (ii) the policyholder:

- 553 (A) is not a resident of this state;
- 554 (B) is not a domestic corporation; or
- 555 (C) does not have [~~its~~] the policyholder's principal office in this state;
- 556 (iii) no more than 25% of the certificate holders or insureds are residents of this state;
- 557 (iv) on request of the commissioner, the insurer files with the department a copy of the
- 558 policy and a copy of each form or certificate; and
- 559 (v) (A) the insurer agrees to pay premium taxes on the Utah portion of [~~its~~] the
- 560 insurer's business, as if [~~it~~] the insurer were authorized to do business in this state; and
- 561 (B) the insurer provides the commissioner with the security the commissioner
- 562 considers necessary for the payment of premium taxes under Title 59, Chapter 9, Taxation of
- 563 Admitted Insurers;
- 564 (i) to the extent provided in Subsection (6):
- 565 (i) a manufacturer's or seller's warranty; and
- 566 (ii) a manufacturer's or seller's service contract;
- 567 (j) except to the extent provided in Subsection (7), a public agency insurance mutual;
- 568 or
- 569 (k) except as provided in Chapter 6b, Guaranteed Asset Protection Waiver Act, a
- 570 guaranteed asset protection waiver.
- 571 (4) A transaction described in Subsection (3)(e) is subject to taxation under Section
- 572 [31A-3-301](#).
- 573 (5) (a) After a hearing, the commissioner may order an insurer of certain group or
- 574 blanket contracts to transfer the Utah portion of the business otherwise exempted under
- 575 Subsection (3)(h) to an authorized insurer if the contracts have been written by an unauthorized
- 576 insurer.
- 577 (b) If the commissioner finds that the conditions required for the exemption of a group
- 578 or blanket insurer are not satisfied or that adequate protection to residents of this state is not
- 579 provided, the commissioner may require:
- 580 (i) the insurer to be authorized to do business in this state; or
- 581 (ii) that any of the insurer's transactions be subject to this title.
- 582 (c) Subsection (3)(h) does not apply to blanket accident and health insurance.
- 583 (6) (a) As used in Subsection (3)(i) and this Subsection (6):

- 584 (i) "manufacturer's or seller's service contract" means a service contract:  
585 (A) made available by:  
586 (I) a manufacturer of a product;  
587 (II) a seller of a product; or  
588 (III) an affiliate of a manufacturer or seller of a product;  
589 (B) made available:  
590 (I) on one or more specific products; or  
591 (II) on products that are components of a system; and  
592 (C) under which the person described in Subsection (6)(a)(i)(A) is liable for services to  
593 be provided under the service contract including, if the manufacturer's or seller's service  
594 contract designates, providing parts and labor;
- 595 (ii) "manufacturer's or seller's warranty" means the guaranty of:  
596 (A) (I) the manufacturer of a product;  
597 (II) a seller of a product; or  
598 (III) an affiliate of a manufacturer or seller of a product;  
599 (B) (I) on one or more specific products; or  
600 (II) on products that are components of a system; and  
601 (C) under which the person described in Subsection (6)(a)(ii)(A) is liable for services  
602 to be provided under the warranty, including, if the manufacturer's or seller's warranty  
603 designates, providing parts and labor; and
- 604 (iii) "service contract" means the same as that term is defined in Section [31A-6a-101](#).  
605 (b) A manufacturer's or seller's warranty may be designated as:  
606 (i) a warranty;  
607 (ii) a guaranty; or  
608 (iii) a term similar to a term described in Subsection (6)(b)(i) or (ii).  
609 (c) This title does not apply to:  
610 (i) a manufacturer's or seller's warranty;  
611 (ii) a manufacturer's or seller's service contract paid for with consideration that is in  
612 addition to the consideration paid for the product itself; and  
613 (iii) a service contract that is not a manufacturer's or seller's warranty or manufacturer's  
614 or seller's service contract if:

- 615 (A) the service contract is paid for with consideration that is in addition to the  
616 consideration paid for the product itself;
- 617 (B) the service contract is for the repair or maintenance of goods;
- 618 (C) the ~~[cost]~~ purchase price of the product is ~~[equal to an amount determined in~~  
619 ~~accordance with Subsection (6)(e); and]~~ \$3,700 or less;
- 620 (D) the product is not a motor vehicle[-]; and
- 621 (E) the product is not the subject of a home warranty service contract.
- 622 (d) This title does not apply to a manufacturer's or seller's warranty or service contract  
623 paid for with consideration that is in addition to the consideration paid for the product itself  
624 regardless of whether the manufacturer's or seller's warranty or service contract is sold:
- 625 (i) at the time of the purchase of the product; or
- 626 (ii) at a time other than the time of the purchase of the product.
- 627 ~~[(e) (i) For fiscal year 2001-02, the amount described in Subsection (6)(c)(iii)(C) shall~~  
628 ~~be equal to \$3,700 or less.]~~
- 629 ~~[(ii) For each fiscal year after fiscal year 2001-02, the commissioner shall annually~~  
630 ~~determine whether the amount described in Subsection (6)(c)(iii)(C) should be adjusted in~~  
631 ~~accordance with changes in the Consumer Price Index published by the United States Bureau~~  
632 ~~of Labor Statistics selected by the commissioner by rule, between:]~~
- 633 ~~[(A) the Consumer Price Index for the February immediately preceding the adjustment;~~  
634 ~~and]~~
- 635 ~~[(B) the Consumer Price Index for February 2001.]~~
- 636 ~~[(iii) If under Subsection (6)(e)(ii) the commissioner determines that an adjustment~~  
637 ~~should be made, the commissioner shall make the adjustment by rule.]~~
- 638 (7) (a) For purposes of this Subsection (7), "public agency insurance mutual" means an  
639 entity formed by two or more political subdivisions or public agencies of the state:
- 640 (i) under Title 11, Chapter 13, Interlocal Cooperation Act; and
- 641 (ii) for the purpose of providing for the political subdivisions or public agencies:
- 642 (A) subject to Subsection (7)(b), insurance coverage; or
- 643 (B) risk management.
- 644 (b) Notwithstanding Subsection (7)(a)(ii)(A), a public agency insurance mutual may  
645 not provide health insurance unless the public agency insurance mutual provides the health

646 insurance using:

647 (i) a third party administrator licensed under Chapter 25, Third Party Administrators;

648 (ii) an admitted insurer; or

649 (iii) a program authorized by Title 49, Chapter 20, Public Employees' Benefit and

650 Insurance Program Act.

651 (c) Except for this Subsection (7), a public agency insurance mutual is exempt from  
652 this title.

653 (d) A public agency insurance mutual is considered to be a governmental entity and  
654 political subdivision of the state with all of the rights, privileges, and immunities of a  
655 governmental entity or political subdivision of the state including all the rights and benefits of  
656 Title 63G, Chapter 7, Governmental Immunity Act of Utah.

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

658 **31A-1-301. Definitions.**

659 As used in this title, unless otherwise specified:

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

662 (i) a medical condition including:

663 (A) a medical care expense; or

664 (B) the risk of disability;

665 (ii) accident; or

666 (iii) sickness.

667 (b) "Accident and health insurance":

668 (i) includes a contract with disability contingencies including:

669 (A) an income replacement contract;

670 (B) a health care contract;

671 (C) an expense reimbursement contract;

672 (D) a credit accident and health contract;

673 (E) a continuing care contract; and

674 (F) a long-term care contract; and

675 (ii) may provide:

676 (A) hospital coverage;

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

708 whether to:

709 (A) insure the risk under:

710 (I) the coverage as originally offered; or

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

712 (B) decline to insure the risk; or

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

714 annuity contract.

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

716 (a) the original articles;

717 (b) a special law;

718 (c) a charter;

719 (d) an amendment;

720 (e) restated articles;

721 (f) articles of merger or consolidation;

722 (g) a trust instrument;

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

724 and

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

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

729 (13) "Binder" means the same as that term is defined in Section [31A-21-102](#).

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

732 (a) without individual underwriting or application; and

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

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

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

737 (a) that is open to the public;

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



- 739 (c) at which the public may appear in person to obtain services.
- 740 (17) "Business entity" means:
- 741 (a) a corporation;
- 742 (b) an association;
- 743 (c) a partnership;
- 744 (d) a limited liability company;
- 745 (e) a limited liability partnership; or
- 746 (f) another legal entity.
- 747 (18) "Business of insurance" means the same as that term is defined in Subsection (94).
- 748 (19) "Business plan" means the information required to be supplied to the
- 749 commissioner under Subsections [31A-5-204](#)(2)(i) and (j), including the information required
- 750 when these subsections apply by reference under:
- 751 (a) Section [31A-8-205](#); or
- 752 (b) Subsection [31A-9-205](#)(2).
- 753 (20) (a) "Bylaws" means the rules adopted for the regulation or management of a
- 754 corporation's affairs, however designated.
- 755 (b) "Bylaws" includes comparable rules for a trust or other entity that is not a
- 756 corporation.
- 757 (21) "Captive insurance company" means:
- 758 (a) an insurer:
- 759 (i) owned by another organization; and
- 760 (ii) whose exclusive purpose is to insure risks of the parent organization and an
- 761 affiliated company; or
- 762 (b) in the case of a group or association, an insurer:
- 763 (i) owned by the insureds; and
- 764 (ii) whose exclusive purpose is to insure risks of:
- 765 (A) a member organization;
- 766 (B) a group member; or
- 767 (C) an affiliate of:
- 768 (I) a member organization; or
- 769 (II) a group member.

- 770 (22) "Casualty insurance" means liability insurance.
- 771 (23) "Certificate" means evidence of insurance given to:
- 772 (a) an insured under a group insurance policy; or
- 773 (b) a third party.
- 774 (24) "Certificate of authority" is included within the term "license."
- 775 (25) "Claim," unless the context otherwise requires, means a request or demand on an
- 776 insurer for payment of a benefit according to the terms of an insurance policy.
- 777 (26) "Claims-made coverage" means an insurance contract or provision limiting
- 778 coverage under a policy insuring against legal liability to claims that are first made against the
- 779 insured while the policy is in force.
- 780 (27) (a) "Commissioner" or "commissioner of insurance" means Utah's insurance
- 781 commissioner.
- 782 (b) When appropriate, the terms listed in Subsection (27)(a) apply to the equivalent
- 783 supervisory official of another jurisdiction.
- 784 (28) (a) "Continuing care insurance" means insurance that:
- 785 (i) provides board and lodging;
- 786 (ii) provides one or more of the following:
- 787 (A) a personal service;
- 788 (B) a nursing service;
- 789 (C) a medical service; or
- 790 (D) any other health-related service; and
- 791 (iii) provides the coverage described in this Subsection (28)(a) under an agreement
- 792 effective:
- 793 (A) for the life of the insured; or
- 794 (B) for a period in excess of one year.
- 795 (b) Insurance is continuing care insurance regardless of whether or not the board and
- 796 lodging are provided at the same location as a service described in Subsection (28)(a)(ii).
- 797 (29) (a) "Control," "controlling," "controlled," or "under common control" means the
- 798 direct or indirect possession of the power to direct or cause the direction of the management
- 799 and policies of a person. This control may be:
- 800 (i) by contract;

- 801 (ii) by common management;
- 802 (iii) through the ownership of voting securities; or
- 803 (iv) by a means other than those described in Subsections (29)(a)(i) through (iii).

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

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

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

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

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

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

818 (33) "Corporate governance annual disclosure" means a report an insurer or insurance  
819 group files in accordance with the requirements of Chapter 16b, Corporate Governance Annual  
820 Disclosure Act.

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

822 (i) a corporation doing business:

823 (A) as:

824 (I) an insurance producer;

825 (II) a surplus lines producer;

826 (III) a limited line producer;

827 (IV) a consultant;

828 (V) a managing general agent;

829 (VI) a reinsurance intermediary;

830 (VII) a third party administrator; or

831 (VIII) an adjuster; and

832 (B) under:

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

835 (II) Chapter 25, Third Party Administrators; or

836 (III) Chapter 26, Insurance Adjusters; or

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

839 (b) "Mutual" or "mutual corporation" means a mutual insurance corporation.

840 (c) "Stock corporation" means a stock insurance corporation.

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

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

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

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

848 (iii) the Ryan White Program Comprehensive AIDS Resources Emergency Act, Pub. L.  
849 No. 101-381, and Ryan White HIV/AIDS Treatment Modernization Act of 2006, Pub. L. No.  
850 109-415.

851 (36) "Credit accident and health insurance" means insurance on a debtor to provide  
852 indemnity for payments coming due on a specific loan or other credit transaction while the  
853 debtor has a disability.

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

856 (b) "Credit insurance" includes:

857 (i) credit accident and health insurance;

858 (ii) credit life insurance;

859 (iii) credit property insurance;

860 (iv) credit unemployment insurance;

861 (v) guaranteed automobile protection insurance;

862 (vi) involuntary unemployment insurance;

863 (vii) mortgage accident and health insurance;

864 (viii) mortgage guaranty insurance; and

865 (ix) mortgage life insurance.

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

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

869 (a) matured;

870 (b) unmatured;

871 (c) liquidated;

872 (d) unliquidated;

873 (e) secured;

874 (f) unsecured;

875 (g) absolute;

876 (h) fixed; or

877 (i) contingent.

878 (40) "Credit property insurance" means insurance:

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

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

881 (41) "Credit unemployment insurance" means insurance:

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

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

884 (i) specific loan; or

885 (ii) credit transaction.

886 (42) (a) "Crop insurance" means insurance providing protection against damage to  
887 crops from unfavorable weather conditions, fire or lightning, flood, hail, insect infestation,  
888 disease, or other yield-reducing conditions or perils that is:

889 (i) provided by the private insurance market; or

890 (ii) subsidized by the Federal Crop Insurance Corporation.

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

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

894 (i) for the customer service representative's:

895 (A) producer;

896 (B) surplus lines producer; or

897 (C) consultant employer; and

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

899 (A) customer;

900 (B) client; or

901 (C) organization.

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

904 (44) "Deadline" means a final date or time:

905 (a) imposed by:

906 (i) statute;

907 (ii) rule; or

908 (iii) order; and

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

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

914 (46) "Degree of relationship" means the number of steps between two persons  
915 determined by counting the generations separating one person from a common ancestor and  
916 then counting the generations to the other person.

917 (47) "Department" means the Insurance Department.

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

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

921 (a) perform the duties of:

922 (i) that individual's occupation; or

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

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

926 (i) eating;

927 (ii) toileting;

928 (iii) transferring;

929 (iv) bathing; or

930 (v) dressing.

931 (50) "Disability income insurance" means the same as that term is defined in

932 Subsection (85).

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

934 (52) "Domiciliary state" means the state in which an insurer:

935 (a) is incorporated;

936 (b) is organized; or

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

938 (53) (a) "Eligible employee" means:

939 (i) an employee who:

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

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

942 (ii) a person described in Subsection (53)(b).

943 (b) "Eligible employee" includes:

944 (i) an owner who:

945 (A) works on a full-time basis; [~~and~~]

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

947 (C) employs at least one common employee; and

948 (ii) if the individual is included under a health benefit plan of a small employer:

949 (A) a sole proprietor;

950 (B) a partner in a partnership; or

951 (C) an independent contractor.

952 (c) "Eligible employee" does not include, unless eligible under Subsection (53)(b):

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

954 (ii) an employer's spouse who does not meet the requirements of Subsection (53)(a)(i);

955 or

956 (iii) a dependent of an employer who does not meet the requirements of Subsection  
957 (53)(a)(i).

958 (54) "Employee" means:

959 (a) an individual employed by an employer; and

960 (b) an owner who meets the requirements of Subsection (53)(b)(i).

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

962 (a) an employee; or

963 (b) a dependent of an employee.

964 (56) (a) "Employee welfare fund" means a fund:

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

966 (A) one or more employers;

967 (B) one or more labor organizations; or

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

969 (ii) that provides employee benefits paid or contracted to be paid, other than income  
970 from investments of the fund:

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

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

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

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

977 (58) (a) "Enrollee" means:

978 (i) a policyholder;

979 (ii) a certificate holder;

980 (iii) a subscriber; or

981 (iv) a covered individual:

982 (A) who has entered into a contract with an organization for health care; or

983 (B) on whose behalf an arrangement for health care has been made.

984 (b) "Enrollee" includes an insured.

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

986 (a) the first day of coverage; or



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

988 (60) "Enterprise risk" means an activity, circumstance, event, or series of events  
989 involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a  
990 material adverse effect upon the financial condition or liquidity of the insurer or its insurance  
991 holding company system as a whole, including anything that would cause:

992 (a) the insurer's risk-based capital to fall into an action or control level as set forth in  
993 Sections 31A-17-601 through 31A-17-613; or

994 (b) the insurer to be in hazardous financial condition set forth in Section 31A-27a-101.

995 (61) (a) "Escrow" means:

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

1000 (A) the explanation, holding, or creation of a document; or

1001 (B) the receipt, deposit, and disbursement of money;

1002 (ii) a settlement or closing involving:

1003 (A) a mobile home;

1004 (B) a grazing right;

1005 (C) a water right; or

1006 (D) other personal property authorized by the commissioner.

1007 (b) "Escrow" does not include:

1008 (i) the following notarial acts performed by a notary within the state:

1009 (A) an acknowledgment;

1010 (B) a copy certification;

1011 (C) jurat; and

1012 (D) an oath or affirmation;

1013 (ii) the receipt or delivery of a document; or

1014 (iii) the receipt of money for delivery to the escrow agent.

1015 (62) "Escrow agent" means an agency title insurance producer meeting the  
1016 requirements of Sections 31A-4-107, 31A-14-211, and 31A-23a-204, who is acting through an  
1017 individual title insurance producer licensed with an escrow subline of authority.

1018 (63) (a) "Excludes" is not exhaustive and does not mean that another thing is not also  
1019 excluded.

1020 (b) The items listed in a list using the term "excludes" are representative examples for  
1021 use in interpretation of this title.

1022 (64) "Exclusion" means for the purposes of accident and health insurance that an  
1023 insurer does not provide insurance coverage, for whatever reason, for one of the following:

1024 (a) a specific physical condition;

1025 (b) a specific medical procedure;

1026 (c) a specific disease or disorder; or

1027 (d) a specific prescription drug or class of prescription drugs.

1028 (65) "Expense reimbursement insurance" means insurance:

1029 (a) written to provide a payment for an expense relating to hospital confinement  
1030 resulting from illness or injury; and

1031 (b) written:

1032 (i) as a daily limit for a specific number of days in a hospital; and

1033 (ii) to have a one or two day waiting period following a hospitalization.

1034 (66) "Fidelity insurance" means insurance guaranteeing the fidelity of a person holding  
1035 a position of public or private trust.

1036 (67) (a) "Filed" means that a filing is:

1037 (i) submitted to the department as required by and in accordance with applicable  
1038 statute, rule, or filing order;

1039 (ii) received by the department within the time period provided in applicable statute,  
1040 rule, or filing order; and

1041 (iii) accompanied by the appropriate fee in accordance with:

1042 (A) Section [31A-3-103](#); or

1043 (B) rule.

1044 (b) "Filed" does not include a filing that is rejected by the department because it is not  
1045 submitted in accordance with Subsection (67)(a).

1046 (68) "Filing," when used as a noun, means an item required to be filed with the  
1047 department including:

1048 (a) a policy;

- 1049 (b) a rate;
  - 1050 (c) a form;
  - 1051 (d) a document;
  - 1052 (e) a plan;
  - 1053 (f) a manual;
  - 1054 (g) an application;
  - 1055 (h) a report;
  - 1056 (i) a certificate;
  - 1057 (j) an endorsement;
  - 1058 (k) an actuarial certification;
  - 1059 (l) a licensee annual statement;
  - 1060 (m) a licensee renewal application;
  - 1061 (n) an advertisement;
  - 1062 (o) a binder; or
  - 1063 (p) an outline of coverage.
- 1064 (69) "First party insurance" means an insurance policy or contract in which the insurer  
1065 agrees to pay a claim submitted to it by the insured for the insured's losses.
- 1066 (70) "Foreign insurer" means an insurer domiciled outside of this state, including an  
1067 alien insurer.
- 1068 (71) (a) "Form" means one of the following prepared for general use:
- 1069 (i) a policy;
  - 1070 (ii) a certificate;
  - 1071 (iii) an application;
  - 1072 (iv) an outline of coverage; or
  - 1073 (v) an endorsement.
- 1074 (b) "Form" does not include a document specially prepared for use in an individual  
1075 case.
- 1076 (72) "Franchise insurance" means an individual insurance policy provided through a  
1077 mass marketing arrangement involving a defined class of persons related in some way other  
1078 than through the purchase of insurance.
- 1079 (73) "General lines of authority" include:

- 1080 (a) the general lines of insurance in Subsection (74);
- 1081 (b) title insurance under one of the following sublines of authority:
- 1082 (i) title examination, including authority to act as a title marketing representative;
- 1083 (ii) escrow, including authority to act as a title marketing representative; and
- 1084 (iii) title marketing representative only;
- 1085 (c) surplus lines;
- 1086 (d) workers' compensation; and
- 1087 (e) another line of insurance that the commissioner considers necessary to recognize in
- 1088 the public interest.
- 1089 (74) "General lines of insurance" include:
- 1090 (a) accident and health;
- 1091 (b) casualty;
- 1092 (c) life;
- 1093 (d) personal lines;
- 1094 (e) property; and
- 1095 (f) variable contracts, including variable life and annuity.
- 1096 (75) "Group health plan" means an employee welfare benefit plan to the extent that the
- 1097 plan provides medical care:
- 1098 (a) (i) to an employee; or
- 1099 (ii) to a dependent of an employee; and
- 1100 (b) (i) directly;
- 1101 (ii) through insurance reimbursement; or
- 1102 (iii) through another method.
- 1103 (76) (a) "Group insurance policy" means a policy covering a group of persons that is
- 1104 issued:
- 1105 (i) to a policyholder on behalf of the group; and
- 1106 (ii) for the benefit of a member of the group who is selected under a procedure defined
- 1107 in:
- 1108 (A) the policy; or
- 1109 (B) an agreement that is collateral to the policy.
- 1110 (b) A group insurance policy may include a member of the policyholder's family or a

1111 dependent.

1112 (77) "Group-wide supervisor" means the commissioner or other regulatory official  
1113 designated as the group-wide supervisor for an internationally active insurance group under  
1114 Section [31A-16-108.6](#).

1115 (78) "Guaranteed automobile protection insurance" means insurance offered in  
1116 connection with an extension of credit that pays the difference in amount between the  
1117 insurance settlement and the balance of the loan if the insured automobile is a total loss.

1118 (79) (a) "Health benefit plan" means, except as provided in Subsection (79)(b), a  
1119 policy, contract, certificate, or agreement offered or issued by a health carrier to provide,  
1120 deliver, arrange for, pay for, or reimburse any of the costs of health care.

1121 (b) "Health benefit plan" does not include:

1122 (i) coverage only for accident or disability income insurance, or any combination  
1123 thereof;

1124 (ii) coverage issued as a supplement to liability insurance;

1125 (iii) liability insurance, including general liability insurance and automobile liability  
1126 insurance;

1127 (iv) workers' compensation or similar insurance;

1128 (v) automobile medical payment insurance;

1129 (vi) credit-only insurance;

1130 (vii) coverage for on-site medical clinics;

1131 (viii) other similar insurance coverage, specified in federal regulations issued pursuant  
1132 to Pub. L. No. 104-191, under which benefits for health care services are secondary or  
1133 incidental to other insurance benefits;

1134 (ix) the following benefits if they are provided under a separate policy, certificate, or  
1135 contract of insurance or are otherwise not an integral part of the plan:

1136 (A) limited scope dental or vision benefits;

1137 (B) benefits for long-term care, nursing home care, home health care,  
1138 community-based care, or any combination thereof; or

1139 (C) other similar limited benefits, specified in federal regulations issued pursuant to  
1140 Pub. L. No. 104-191;

1141 (x) the following benefits if the benefits are provided under a separate policy,

1142 certificate, or contract of insurance, there is no coordination between the provision of benefits  
1143 and any exclusion of benefits under any health plan, and the benefits are paid with respect to an  
1144 event without regard to whether benefits are provided under any health plan:

1145 (A) coverage only for specified disease or illness; or

1146 (B) hospital indemnity or other fixed indemnity insurance; [~~and~~]

1147 (xi) the following if offered as a separate policy, certificate, or contract of insurance:

1148 (A) Medicare supplemental health insurance as defined under the Social Security Act,  
1149 42 U.S.C. Sec. 1395ss(g)(1);

1150 (B) coverage supplemental to the coverage provided under United States Code, Title  
1151 10, Chapter 55, Civilian Health and Medical Program of the Uniformed Services  
1152 (CHAMPUS); or

1153 (C) similar supplemental coverage provided to coverage under a group health insurance  
1154 plan[.];

1155 (xii) short-term, limited-duration insurance; and

1156 (xiii) student health insurance, except as required under 45 C.F.R. Sec. 147.145.

1157 (80) "Health care" means any of the following intended for use in the diagnosis,  
1158 treatment, mitigation, or prevention of a human ailment or impairment:

1159 (a) a professional service;

1160 (b) a personal service;

1161 (c) a facility;

1162 (d) equipment;

1163 (e) a device;

1164 (f) supplies; or

1165 (g) medicine.

1166 (81) (a) "Health care insurance" or "health insurance" means insurance providing:

1167 (i) a health care benefit; or

1168 (ii) payment of an incurred health care expense.

1169 (b) "Health care insurance" or "health insurance" does not include accident and health  
1170 insurance providing a benefit for:

1171 (i) replacement of income;

1172 (ii) short-term accident;

- 1173 (iii) fixed indemnity;
- 1174 (iv) credit accident and health;
- 1175 (v) supplements to liability;
- 1176 (vi) workers' compensation;
- 1177 (vii) automobile medical payment;
- 1178 (viii) no-fault automobile;
- 1179 (ix) equivalent self-insurance; or
- 1180 (x) a type of accident and health insurance coverage that is a part of or attached to
- 1181 another type of policy.

1182 (82) "Health care provider" means the same as that term is defined in Section  
1183 [78B-3-403](#).

1184 (83) "Health insurance exchange" means an exchange as defined in 45 C.F.R. Sec.  
1185 155.20.

1186 (84) "Health Insurance Portability and Accountability Act" means the Health Insurance  
1187 Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, as amended.

1188 (85) "Income replacement insurance" or "disability income insurance" means insurance  
1189 written to provide payments to replace income lost from accident or sickness.

1190 (86) "Indemnity" means the payment of an amount to offset all or part of an insured  
1191 loss.

1192 (87) "Independent adjuster" means an insurance adjuster required to be licensed under  
1193 Section [31A-26-201](#) who engages in insurance adjusting as a representative of an insurer.

1194 (88) "Independently procured insurance" means insurance procured under Section  
1195 [31A-15-104](#).

1196 (89) "Individual" means a natural person.

1197 (90) "Inland marine insurance" includes insurance covering:

- 1198 (a) property in transit on or over land;
- 1199 (b) property in transit over water by means other than boat or ship;
- 1200 (c) bailee liability;
- 1201 (d) fixed transportation property such as bridges, electric transmission systems, radio
- 1202 and television transmission towers and tunnels; and
- 1203 (e) personal and commercial property floaters.

- 1204 (91) "Insolvency" or "insolvent" means that:
- 1205 (a) an insurer is unable to pay the insurer's obligations as the obligations are due;
- 1206 (b) an insurer's total adjusted capital is less than the insurer's mandatory control level
- 1207 RBC under Subsection [31A-17-601](#)(8)(c); or
- 1208 (c) an insurer's admitted assets are less than the insurer's liabilities.
- 1209 (92) (a) "Insurance" means:
- 1210 (i) an arrangement, contract, or plan for the transfer of a risk or risks from one or more
- 1211 persons to one or more other persons; or
- 1212 (ii) an arrangement, contract, or plan for the distribution of a risk or risks among a
- 1213 group of persons that includes the person seeking to distribute that person's risk.
- 1214 (b) "Insurance" includes:
- 1215 (i) a risk distributing arrangement providing for compensation or replacement for
- 1216 damages or loss through the provision of a service or a benefit in kind;
- 1217 (ii) a contract of guaranty or suretyship entered into by the guarantor or surety as a
- 1218 business and not as merely incidental to a business transaction; and
- 1219 (iii) a plan in which the risk does not rest upon the person who makes an arrangement,
- 1220 but with a class of persons who have agreed to share the risk.
- 1221 (93) "Insurance adjuster" means a person who directs or conducts the investigation,
- 1222 negotiation, or settlement of a claim under an insurance policy other than life insurance or an
- 1223 annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.
- 1224 (94) "Insurance business" or "business of insurance" includes:
- 1225 (a) providing health care insurance by an organization that is or is required to be
- 1226 licensed under this title;
- 1227 (b) providing a benefit to an employee in the event of a contingency not within the
- 1228 control of the employee, in which the employee is entitled to the benefit as a right, which
- 1229 benefit may be provided either:
- 1230 (i) by a single employer or by multiple employer groups; or
- 1231 (ii) through one or more trusts, associations, or other entities;
- 1232 (c) providing an annuity:
- 1233 (i) including an annuity issued in return for a gift; and
- 1234 (ii) except an annuity provided by a person specified in Subsections [31A-22-1305](#)(2)



1235 and (3);

1236 (d) providing the characteristic services of a motor club as outlined in Subsection

1237 (125);

1238 (e) providing another person with insurance;

1239 (f) making as insurer, guarantor, or surety, or proposing to make as insurer, guarantor,

1240 or surety, a contract or policy of title insurance;

1241 (g) transacting or proposing to transact any phase of title insurance, including:

1242 (i) solicitation;

1243 (ii) negotiation preliminary to execution;

1244 (iii) execution of a contract of title insurance;

1245 (iv) insuring; and

1246 (v) transacting matters subsequent to the execution of the contract and arising out of

1247 the contract, including reinsurance;

1248 (h) transacting or proposing a life settlement; and

1249 (i) doing, or proposing to do, any business in substance equivalent to Subsections

1250 (94)(a) through (h) in a manner designed to evade this title.

1251 (95) "Insurance consultant" or "consultant" means a person who:

1252 (a) advises another person about insurance needs and coverages;

1253 (b) is compensated by the person advised on a basis not directly related to the insurance

1254 placed; and

1255 (c) except as provided in Section [31A-23a-501](#), is not compensated directly or

1256 indirectly by an insurer or producer for advice given.

1257 (96) "Insurance group" means the persons that comprise an insurance holding company

1258 system.

1259 (97) "Insurance holding company system" means a group of two or more affiliated

1260 persons, at least one of whom is an insurer.

1261 (98) (a) "Insurance producer" or "producer" means a person licensed or required to be

1262 licensed under the laws of this state to sell, solicit, or negotiate insurance.

1263 (b) (i) "Producer for the insurer" means a producer who is compensated directly or

1264 indirectly by an insurer for selling, soliciting, or negotiating an insurance product of that

1265 insurer.

- 1266 (ii) "Producer for the insurer" may be referred to as an "agent."
- 1267 (c) (i) "Producer for the insured" means a producer who:
- 1268 (A) is compensated directly and only by an insurance customer or an insured; and
- 1269 (B) receives no compensation directly or indirectly from an insurer for selling,
- 1270 soliciting, or negotiating an insurance product of that insurer to an insurance customer or
- 1271 insured.
- 1272 (ii) "Producer for the insured" may be referred to as a "broker."
- 1273 (99) (a) "Insured" means a person to whom or for whose benefit an insurer makes a
- 1274 promise in an insurance policy and includes:
- 1275 (i) a policyholder;
- 1276 (ii) a subscriber;
- 1277 (iii) a member; and
- 1278 (iv) a beneficiary.
- 1279 (b) The definition in Subsection (99)(a):
- 1280 (i) applies only to this title;
- 1281 (ii) does not define the meaning of "insured" as used in an insurance policy or
- 1282 certificate; and
- 1283 (iii) includes an enrollee.
- 1284 (100) (a) "Insurer" means a person doing an insurance business as a principal
- 1285 including:
- 1286 (i) a fraternal benefit society;
- 1287 (ii) an issuer of a gift annuity other than an annuity specified in Subsections
- 1288 [31A-22-1305\(2\)](#) and (3);
- 1289 (iii) a motor club;
- 1290 (iv) an employee welfare plan;
- 1291 (v) a person purporting or intending to do an insurance business as a principal on that
- 1292 person's own account; and
- 1293 (vi) a health maintenance organization.
- 1294 (b) "Insurer" does not include a governmental entity.
- 1295 (101) "Interinsurance exchange" means the same as that term is defined in Subsection
- 1296 (160).

1297 (102) "Internationally active insurance group" means an insurance holding company  
1298 system:

- 1299 (a) that includes an insurer registered under Section 31A-16-105;
- 1300 (b) that has premiums written in at least three countries;
- 1301 (c) whose percentage of gross premiums written outside the United States is at least  
1302 10% of its total gross written premiums; and
- 1303 (d) that, based on a three-year rolling average, has:
  - 1304 (i) total assets of at least \$50,000,000,000; or
  - 1305 (ii) total gross written premiums of at least \$10,000,000,000.

1306 (103) "Involuntary unemployment insurance" means insurance:

- 1307 (a) offered in connection with an extension of credit; and
- 1308 (b) that provides indemnity if the debtor is involuntarily unemployed for payments  
1309 coming due on a:
  - 1310 (i) specific loan; or
  - 1311 (ii) credit transaction.

1312 (104) ~~[(a)]~~ "Large employer," in connection with a health benefit plan, means an  
1313 employer who, with respect to a calendar year and to a plan year:

1314 ~~[(i)]~~ (a) employed an average of at least 51 employees on business days during the  
1315 preceding calendar year; and

1316 ~~[(ii)]~~ (b) employs at least one employee on the first day of the plan year.

1317 ~~[(b) The number of employees shall be determined using the method set forth in 26~~  
1318 ~~U.S.C. Sec. 4980H(c)(2).]~~

1319 (105) "Late enrollee," with respect to an employer health benefit plan, means an  
1320 individual whose enrollment is a late enrollment.

1321 (106) "Late enrollment," with respect to an employer health benefit plan, means  
1322 enrollment of an individual other than:

- 1323 (a) on the earliest date on which coverage can become effective for the individual  
1324 under the terms of the plan; or
- 1325 (b) through special enrollment.

1326 (107) (a) Except for a retainer contract or legal assistance described in Section  
1327 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for a

1328 specified legal expense.

1329 (b) "Legal expense insurance" includes an arrangement that creates a reasonable  
1330 expectation of an enforceable right.

1331 (c) "Legal expense insurance" does not include the provision of, or reimbursement for,  
1332 legal services incidental to other insurance coverage.

1333 (108) (a) "Liability insurance" means insurance against liability:

1334 (i) for death, injury, or disability of a human being, or for damage to property,  
1335 exclusive of the coverages under:

1336 (A) medical malpractice insurance;

1337 (B) professional liability insurance; and

1338 (C) workers' compensation insurance;

1339 (ii) for a medical, hospital, surgical, and funeral benefit to a person other than the  
1340 insured who is injured, irrespective of legal liability of the insured, when issued with or  
1341 supplemental to insurance against legal liability for the death, injury, or disability of a human  
1342 being, exclusive of the coverages under:

1343 (A) medical malpractice insurance;

1344 (B) professional liability insurance; and

1345 (C) workers' compensation insurance;

1346 (iii) for loss or damage to property resulting from an accident to or explosion of a  
1347 boiler, pipe, pressure container, machinery, or apparatus;

1348 (iv) for loss or damage to property caused by:

1349 (A) the breakage or leakage of a sprinkler, water pipe, or water container; or

1350 (B) water entering through a leak or opening in a building; or

1351 (v) for other loss or damage properly the subject of insurance not within another kind  
1352 of insurance as defined in this chapter, if the insurance is not contrary to law or public policy.

1353 (b) "Liability insurance" includes:

1354 (i) vehicle liability insurance;

1355 (ii) residential dwelling liability insurance; and

1356 (iii) making inspection of, and issuing a certificate of inspection upon, an elevator,  
1357 boiler, machinery, or apparatus of any kind when done in connection with insurance on the  
1358 elevator, boiler, machinery, or apparatus.

1359 (109) (a) "License" means authorization issued by the commissioner to engage in an  
1360 activity that is part of or related to the insurance business.

1361 (b) "License" includes a certificate of authority issued to an insurer.

1362 (110) (a) "Life insurance" means:

1363 (i) insurance on a human life; and

1364 (ii) insurance pertaining to or connected with human life.

1365 (b) The business of life insurance includes:

1366 (i) granting a death benefit;

1367 (ii) granting an annuity benefit;

1368 (iii) granting an endowment benefit;

1369 (iv) granting an additional benefit in the event of death by accident;

1370 (v) granting an additional benefit to safeguard the policy against lapse; and

1371 (vi) providing an optional method of settlement of proceeds.

1372 (111) "Limited license" means a license that:

1373 (a) is issued for a specific product of insurance; and

1374 (b) limits an individual or agency to transact only for that product or insurance.

1375 (112) "Limited line credit insurance" includes the following forms of insurance:

1376 (a) credit life;

1377 (b) credit accident and health;

1378 (c) credit property;

1379 (d) credit unemployment;

1380 (e) involuntary unemployment;

1381 (f) mortgage life;

1382 (g) mortgage guaranty;

1383 (h) mortgage accident and health;

1384 (i) guaranteed automobile protection; and

1385 (j) another form of insurance offered in connection with an extension of credit that:

1386 (i) is limited to partially or wholly extinguishing the credit obligation; and

1387 (ii) the commissioner determines by rule should be designated as a form of limited line  
1388 credit insurance.

1389 (113) "Limited line credit insurance producer" means a person who sells, solicits, or

1390 negotiates one or more forms of limited line credit insurance coverage to an individual through  
1391 a master, corporate, group, or individual policy.

1392 (114) "Limited line insurance" includes:

1393 (a) bail bond;

1394 (b) limited line credit insurance;

1395 (c) legal expense insurance;

1396 (d) motor club insurance;

1397 (e) car rental related insurance;

1398 (f) travel insurance;

1399 (g) crop insurance;

1400 (h) self-service storage insurance;

1401 (i) guaranteed asset protection waiver;

1402 (j) portable electronics insurance; and

1403 (k) another form of limited insurance that the commissioner determines by rule should

1404 be designated a form of limited line insurance.

1405 (115) "Limited lines authority" includes the lines of insurance listed in Subsection

1406 (114).

1407 (116) "Limited lines producer" means a person who sells, solicits, or negotiates limited

1408 lines insurance.

1409 (117) (a) "Long-term care insurance" means an insurance policy or rider advertised,

1410 marketed, offered, or designated to provide coverage:

1411 (i) in a setting other than an acute care unit of a hospital;

1412 (ii) for not less than 12 consecutive months for a covered person on the basis of:

1413 (A) expenses incurred;

1414 (B) indemnity;

1415 (C) prepayment; or

1416 (D) another method;

1417 (iii) for one or more necessary or medically necessary services that are:

1418 (A) diagnostic;

1419 (B) preventative;

1420 (C) therapeutic;

- 1421 (D) rehabilitative;
- 1422 (E) maintenance; or
- 1423 (F) personal care; and
- 1424 (iv) that may be issued by:
- 1425 (A) an insurer;
- 1426 (B) a fraternal benefit society;
- 1427 (C) (I) a nonprofit health hospital; and
- 1428 (II) a medical service corporation;
- 1429 (D) a prepaid health plan;
- 1430 (E) a health maintenance organization; or
- 1431 (F) an entity similar to the entities described in Subsections (117)(a)(iv)(A) through (E)
- 1432 to the extent that the entity is otherwise authorized to issue life or health care insurance.
- 1433 (b) "Long-term care insurance" includes:
- 1434 (i) any of the following that provide directly or supplement long-term care insurance:
- 1435 (A) a group or individual annuity or rider; or
- 1436 (B) a life insurance policy or rider;
- 1437 (ii) a policy or rider that provides for payment of benefits on the basis of:
- 1438 (A) cognitive impairment; or
- 1439 (B) functional capacity; or
- 1440 (iii) a qualified long-term care insurance contract.
- 1441 (c) "Long-term care insurance" does not include:
- 1442 (i) a policy that is offered primarily to provide basic Medicare supplement coverage;
- 1443 (ii) basic hospital expense coverage;
- 1444 (iii) basic medical/surgical expense coverage;
- 1445 (iv) hospital confinement indemnity coverage;
- 1446 (v) major medical expense coverage;
- 1447 (vi) income replacement or related asset-protection coverage;
- 1448 (vii) accident only coverage;
- 1449 (viii) coverage for a specified:
- 1450 (A) disease; or
- 1451 (B) accident;

- 1452 (ix) limited benefit health coverage; or  
1453 (x) a life insurance policy that accelerates the death benefit to provide the option of a  
1454 lump sum payment:  
1455 (A) if the following are not conditioned on the receipt of long-term care:  
1456 (I) benefits; or  
1457 (II) eligibility; and  
1458 (B) the coverage is for one or more the following qualifying events:  
1459 (I) terminal illness;  
1460 (II) medical conditions requiring extraordinary medical intervention; or  
1461 (III) permanent institutional confinement.  
1462 (118) "Managed care organization" means a person:  
1463 (a) licensed as a health maintenance organization under Chapter 8, Health Maintenance  
1464 Organizations and Limited Health Plans; or  
1465 (b) (i) licensed under:  
1466 (A) Chapter 5, Domestic Stock and Mutual Insurance Corporations;  
1467 (B) Chapter 7, Nonprofit Health Service Insurance Corporations; or  
1468 (C) Chapter 14, Foreign Insurers; and  
1469 (ii) that requires an enrollee to use, or offers incentives, including financial incentives,  
1470 for an enrollee to use, network providers.  
1471 (119) "Medical malpractice insurance" means insurance against legal liability incident  
1472 to the practice and provision of a medical service other than the practice and provision of a  
1473 dental service.  
1474 (120) "Member" means a person having membership rights in an insurance  
1475 corporation.  
1476 (121) "Minimum capital" or "minimum required capital" means the capital that must be  
1477 constantly maintained by a stock insurance corporation as required by statute.  
1478 (122) "Mortgage accident and health insurance" means insurance offered in connection  
1479 with an extension of credit that provides indemnity for payments coming due on a mortgage  
1480 while the debtor has a disability.  
1481 (123) "Mortgage guaranty insurance" means surety insurance under which a mortgagee  
1482 or other creditor is indemnified against losses caused by the default of a debtor.



1483 (124) "Mortgage life insurance" means insurance on the life of a debtor in connection  
1484 with an extension of credit that pays if the debtor dies.

1485 (125) "Motor club" means a person:

1486 (a) licensed under:

1487 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;

1488 (ii) Chapter 11, Motor Clubs; or

1489 (iii) Chapter 14, Foreign Insurers; and

1490 (b) that promises for an advance consideration to provide for a stated period of time

1491 one or more:

1492 (i) legal services under Subsection 31A-11-102(1)(b);

1493 (ii) bail services under Subsection 31A-11-102(1)(c); or

1494 (iii) (A) trip reimbursement;

1495 (B) towing services;

1496 (C) emergency road services;

1497 (D) stolen automobile services;

1498 (E) a combination of the services listed in Subsections (125)(b)(iii)(A) through (D); or

1499 (F) other services given in Subsections 31A-11-102(1)(b) through (f).

1500 (126) "Mutual" means a mutual insurance corporation.

1501 (127) "Network plan" means health care insurance:

1502 (a) that is issued by an insurer; and

1503 (b) under which the financing and delivery of medical care is provided, in whole or in  
1504 part, through a defined set of providers under contract with the insurer, including the financing  
1505 and delivery of an item paid for as medical care.

1506 (128) "Network provider" means a health care provider who has an agreement with a  
1507 managed care organization to provide health care services to an enrollee with an expectation of  
1508 receiving payment, other than coinsurance, copayments, or deductibles, directly from the  
1509 managed care organization.

1510 (129) "Nonparticipating" means a plan of insurance under which the insured is not  
1511 entitled to receive a dividend representing a share of the surplus of the insurer.

1512 (130) "Ocean marine insurance" means insurance against loss of or damage to:

1513 (a) ships or hulls of ships;

1514 (b) goods, freight, cargoes, merchandise, effects, disbursements, profits, money,  
1515 securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia  
1516 interests, or other cargoes in or awaiting transit over the oceans or inland waterways;

1517 (c) earnings such as freight, passage money, commissions, or profits derived from  
1518 transporting goods or people upon or across the oceans or inland waterways; or

1519 (d) a vessel owner or operator as a result of liability to employees, passengers, bailors,  
1520 owners of other vessels, owners of fixed objects, customs or other authorities, or other persons  
1521 in connection with maritime activity.

1522 (131) "Order" means an order of the commissioner.

1523 (132) "ORSA guidance manual" means the current version of the Own Risk and  
1524 Solvency Assessment Guidance Manual developed and adopted by the National Association of  
1525 Insurance Commissioners and as amended from time to time.

1526 (133) "ORSA summary report" means a confidential high-level summary of an insurer  
1527 or insurance group's own risk and solvency assessment.

1528 (134) "Outline of coverage" means a summary that explains an accident and health  
1529 insurance policy.

1530 (135) "Own risk and solvency assessment" means an insurer or insurance group's  
1531 confidential internal assessment:

1532 (a) (i) of each material and relevant risk associated with the insurer or insurance group;

1533 (ii) of the insurer or insurance group's current business plan to support each risk  
1534 described in Subsection (135)(a)(i); and

1535 (iii) of the sufficiency of capital resources to support each risk described in Subsection  
1536 (135)(a)(i); and

1537 (b) that is appropriate to the nature, scale, and complexity of an insurer or insurance  
1538 group.

1539 (136) "Participating" means a plan of insurance under which the insured is entitled to  
1540 receive a dividend representing a share of the surplus of the insurer.

1541 (137) "Participation," as used in a health benefit plan, means a requirement relating to  
1542 the minimum percentage of eligible employees that must be enrolled in relation to the total  
1543 number of eligible employees of an employer reduced by each eligible employee who  
1544 voluntarily declines coverage under the plan because the employee:

- 1545 (a) has other group health care insurance coverage; or  
1546 (b) receives:  
1547 (i) Medicare, under the Health Insurance for the Aged Act, Title XVIII of the Social  
1548 Security Amendments of 1965; or  
1549 (ii) another government health benefit.  
1550 (138) "Person" includes:  
1551 (a) an individual;  
1552 (b) a partnership;  
1553 (c) a corporation;  
1554 (d) an incorporated or unincorporated association;  
1555 (e) a joint stock company;  
1556 (f) a trust;  
1557 (g) a limited liability company;  
1558 (h) a reciprocal;  
1559 (i) a syndicate; or  
1560 (j) another similar entity or combination of entities acting in concert.  
1561 (139) "Personal lines insurance" means property and casualty insurance coverage sold  
1562 for primarily noncommercial purposes to:  
1563 (a) an individual; or  
1564 (b) a family.  
1565 (140) "Plan sponsor" means the same as that term is defined in 29 U.S.C. Sec.  
1566 1002(16)(B).  
1567 (141) "Plan year" means:  
1568 (a) the year that is designated as the plan year in:  
1569 (i) the plan document of a group health plan; or  
1570 (ii) a summary plan description of a group health plan;  
1571 (b) if the plan document or summary plan description does not designate a plan year or  
1572 there is no plan document or summary plan description:  
1573 (i) the year used to determine deductibles or limits;  
1574 (ii) the policy year, if the plan does not impose deductibles or limits on a yearly basis;  
1575 or

1576 (iii) the employer's taxable year if:  
1577 (A) the plan does not impose deductibles or limits on a yearly basis; and  
1578 (B) (I) the plan is not insured; or  
1579 (II) the insurance policy is not renewed on an annual basis; or  
1580 (c) in a case not described in Subsection (141)(a) or (b), the calendar year.  
1581 (142) (a) "Policy" means a document, including an attached endorsement or application  
1582 that:  
1583 (i) purports to be an enforceable contract; and  
1584 (ii) memorializes in writing some or all of the terms of an insurance contract.  
1585 (b) "Policy" includes a service contract issued by:  
1586 (i) a motor club under Chapter 11, Motor Clubs;  
1587 (ii) a service contract provided under Chapter 6a, Service Contracts; and  
1588 (iii) a corporation licensed under:  
1589 (A) Chapter 7, Nonprofit Health Service Insurance Corporations; or  
1590 (B) Chapter 8, Health Maintenance Organizations and Limited Health Plans.  
1591 (c) "Policy" does not include:  
1592 (i) a certificate under a group insurance contract; or  
1593 (ii) a document that does not purport to have legal effect.  
1594 (143) "Policyholder" means a person who controls a policy, binder, or oral contract by  
1595 ownership, premium payment, or otherwise.  
1596 (144) "Policy illustration" means a presentation or depiction that includes  
1597 nonguaranteed elements of a policy of life insurance over a period of years.  
1598 (145) "Policy summary" means a synopsis describing the elements of a life insurance  
1599 policy.  
1600 (146) "PPACA" means the Patient Protection and Affordable Care Act, Pub. L. No.  
1601 111-148 and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, and  
1602 related federal regulations and guidance.  
1603 (147) "Preexisting condition," with respect to health care insurance:  
1604 (a) means a condition that was present before the effective date of coverage, whether or  
1605 not medical advice, diagnosis, care, or treatment was recommended or received before that day,  
1606 and

1607 (b) does not include a condition indicated by genetic information unless an actual  
1608 diagnosis of the condition by a physician has been made.

1609 (148) (a) "Premium" means the monetary consideration for an insurance policy.

1610 (b) "Premium" includes, however designated:

1611 (i) an assessment;

1612 (ii) a membership fee;

1613 (iii) a required contribution; or

1614 (iv) monetary consideration.

1615 (c) (i) "Premium" does not include consideration paid to a third party administrator for  
1616 the third party administrator's services.

1617 (ii) "Premium" includes an amount paid by a third party administrator to an insurer for  
1618 insurance on the risks administered by the third party administrator.

1619 (149) "Principal officers" for a corporation means the officers designated under  
1620 Subsection 31A-5-203(3).

1621 (150) "Proceeding" includes an action or special statutory proceeding.

1622 (151) "Professional liability insurance" means insurance against legal liability incident  
1623 to the practice of a profession and provision of a professional service.

1624 (152) (a) Except as provided in Subsection (152)(b), "property insurance" means  
1625 insurance against loss or damage to real or personal property of every kind and any interest in  
1626 that property:

1627 (i) from all hazards or causes; and

1628 (ii) against loss consequential upon the loss or damage including vehicle  
1629 comprehensive and vehicle physical damage coverages.

1630 (b) "Property insurance" does not include:

1631 (i) inland marine insurance; and

1632 (ii) ocean marine insurance.

1633 (153) "Qualified long-term care insurance contract" or "federally tax qualified  
1634 long-term care insurance contract" means:

1635 (a) an individual or group insurance contract that meets the requirements of Section  
1636 7702B(b), Internal Revenue Code; or

1637 (b) the portion of a life insurance contract that provides long-term care insurance:

1638 (i) (A) by rider; or  
1639 (B) as a part of the contract; and  
1640 (ii) that satisfies the requirements of Sections 7702B(b) and (e), Internal Revenue  
1641 Code.  
1642 (154) "Qualified United States financial institution" means an institution that:  
1643 (a) is:  
1644 (i) organized under the laws of the United States or any state; or  
1645 (ii) in the case of a United States office of a foreign banking organization, licensed  
1646 under the laws of the United States or any state;  
1647 (b) is regulated, supervised, and examined by a United States federal or state authority  
1648 having regulatory authority over a bank or trust company; and  
1649 (c) meets the standards of financial condition and standing that are considered  
1650 necessary and appropriate to regulate the quality of a financial institution whose letters of credit  
1651 will be acceptable to the commissioner as determined by:  
1652 (i) the commissioner by rule; or  
1653 (ii) the Securities Valuation Office of the National Association of Insurance  
1654 Commissioners.  
1655 (155) (a) "Rate" means:  
1656 (i) the cost of a given unit of insurance; or  
1657 (ii) for property or casualty insurance, that cost of insurance per exposure unit either  
1658 expressed as:  
1659 (A) a single number; or  
1660 (B) a pure premium rate, adjusted before the application of individual risk variations  
1661 based on loss or expense considerations to account for the treatment of:  
1662 (I) expenses;  
1663 (II) profit; and  
1664 (III) individual insurer variation in loss experience.  
1665 (b) "Rate" does not include a minimum premium.  
1666 (156) (a) Except as provided in Subsection (156)(b), "rate service organization" means  
1667 a person who assists an insurer in rate making or filing by:  
1668 (i) collecting, compiling, and furnishing loss or expense statistics;

1669 (ii) recommending, making, or filing rates or supplementary rate information; or  
1670 (iii) advising about rate questions, except as an attorney giving legal advice.

1671 (b) "Rate service organization" does not mean:

- 1672 (i) an employee of an insurer;
- 1673 (ii) a single insurer or group of insurers under common control;
- 1674 (iii) a joint underwriting group; or
- 1675 (iv) an individual serving as an actuarial or legal consultant.

1676 (157) "Rating manual" means any of the following used to determine initial and  
1677 renewal policy premiums:

- 1678 (a) a manual of rates;
- 1679 (b) a classification;
- 1680 (c) a rate-related underwriting rule; and
- 1681 (d) a rating formula that describes steps, policies, and procedures for determining  
1682 initial and renewal policy premiums.

1683 (158) (a) "Rebate" means a licensee paying, allowing, giving, or offering to pay, allow,  
1684 or give, directly or indirectly:

- 1685 (i) a refund of premium or portion of premium;
- 1686 (ii) a refund of commission or portion of commission;
- 1687 (iii) a refund of all or a portion of a consultant fee; or
- 1688 (iv) providing services or other benefits not specified in an insurance or annuity  
1689 contract.

1690 (b) "Rebate" does not include:

- 1691 (i) a refund due to termination or changes in coverage;
- 1692 (ii) a refund due to overcharges made in error by the licensee; or
- 1693 (iii) savings or wellness benefits as provided in the contract by the licensee.

1694 (159) "Received by the department" means:

- 1695 (a) the date delivered to and stamped received by the department, if delivered in  
1696 person;
- 1697 (b) the post mark date, if delivered by mail;
- 1698 (c) the delivery service's post mark or pickup date, if delivered by a delivery service;
- 1699 (d) the received date recorded on an item delivered, if delivered by:

- 1700 (i) facsimile;
- 1701 (ii) email; or
- 1702 (iii) another electronic method; or
- 1703 (e) a date specified in:
- 1704 (i) a statute;
- 1705 (ii) a rule; or
- 1706 (iii) an order.
- 1707 (160) "Reciprocal" or "interinsurance exchange" means an unincorporated association
- 1708 of persons:
- 1709 (a) operating through an attorney-in-fact common to all of the persons; and
- 1710 (b) exchanging insurance contracts with one another that provide insurance coverage
- 1711 on each other.
- 1712 (161) "Reinsurance" means an insurance transaction where an insurer, for
- 1713 consideration, transfers any portion of the risk it has assumed to another insurer. In referring to
- 1714 reinsurance transactions, this title sometimes refers to:
- 1715 (a) the insurer transferring the risk as the "ceding insurer"; and
- 1716 (b) the insurer assuming the risk as the:
- 1717 (i) "assuming insurer"; or
- 1718 (ii) "assuming reinsurer."
- 1719 (162) "Reinsurer" means a person licensed in this state as an insurer with the authority
- 1720 to assume reinsurance.
- 1721 (163) "Residential dwelling liability insurance" means insurance against liability
- 1722 resulting from or incident to the ownership, maintenance, or use of a residential dwelling that is
- 1723 a detached single family residence or multifamily residence up to four units.
- 1724 (164) (a) "Retrocession" means reinsurance with another insurer of a liability assumed
- 1725 under a reinsurance contract.
- 1726 (b) A reinsurer "retrocedes" when the reinsurer reinsures with another insurer part of a
- 1727 liability assumed under a reinsurance contract.
- 1728 (165) "Rider" means an endorsement to:
- 1729 (a) an insurance policy; or
- 1730 (b) an insurance certificate.



1731 (166) "Secondary medical condition" means a complication related to an exclusion  
1732 from coverage in accident and health insurance.

1733 (167) (a) "Security" means a:

1734 (i) note;

1735 (ii) stock;

1736 (iii) bond;

1737 (iv) debenture;

1738 (v) evidence of indebtedness;

1739 (vi) certificate of interest or participation in a profit-sharing agreement;

1740 (vii) collateral-trust certificate;

1741 (viii) preorganization certificate or subscription;

1742 (ix) transferable share;

1743 (x) investment contract;

1744 (xi) voting trust certificate;

1745 (xii) certificate of deposit for a security;

1746 (xiii) certificate of interest of participation in an oil, gas, or mining title or lease or in  
1747 payments out of production under such a title or lease;

1748 (xiv) commodity contract or commodity option;

1749 (xv) certificate of interest or participation in, temporary or interim certificate for,

1750 receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed

1751 in Subsections (167)(a)(i) through (xiv); or

1752 (xvi) another interest or instrument commonly known as a security.

1753 (b) "Security" does not include:

1754 (i) any of the following under which an insurance company promises to pay money in a  
1755 specific lump sum or periodically for life or some other specified period:

1756 (A) insurance;

1757 (B) an endowment policy; or

1758 (C) an annuity contract; or

1759 (ii) a burial certificate or burial contract.

1760 (168) "Securityholder" means a specified person who owns a security of a person,

1761 including:

1762 (a) common stock;  
1763 (b) preferred stock;  
1764 (c) debt obligations; and  
1765 (d) any other security convertible into or evidencing the right of any of the items listed  
1766 in this Subsection (168).

1767 (169) (a) "Self-insurance" means an arrangement under which a person provides for  
1768 spreading its own risks by a systematic plan.

1769 (b) Except as provided in this Subsection (169), "self-insurance" does not include an  
1770 arrangement under which a number of persons spread their risks among themselves.

1771 (c) "Self-insurance" includes:

1772 (i) an arrangement by which a governmental entity undertakes to indemnify an  
1773 employee for liability arising out of the employee's employment; and

1774 (ii) an arrangement by which a person with a managed program of self-insurance and  
1775 risk management undertakes to indemnify its affiliates, subsidiaries, directors, officers, or  
1776 employees for liability or risk that is related to the relationship or employment.

1777 (d) "Self-insurance" does not include an arrangement with an independent contractor.

1778 (170) "Sell" means to exchange a contract of insurance:

1779 (a) by any means;

1780 (b) for money or its equivalent; and

1781 (c) on behalf of an insurance company.

1782 (171) "Short-term care insurance" means an insurance policy or rider advertised,  
1783 marketed, offered, or designed to provide coverage that is similar to long-term care insurance,  
1784 but that provides coverage for less than 12 consecutive months for each covered person.

1785 (172) "Short-term [~~limited duration health~~], limited-duration insurance" means a health  
1786 benefit product that:

1787 (a) after taking into account any renewals or extensions, has a total duration of no more  
1788 than 36 months; and

1789 (b) has an expiration date specified in the contract that is less than 12 months after the  
1790 original effective date of coverage under the health benefit product.

1791 (173) "Significant break in coverage" means a period of 63 consecutive days during  
1792 each of which an individual does not have creditable coverage.

1793 (174) (a) "Small employer" means, in connection with a health benefit plan and with  
1794 respect to a calendar year and to a plan year, an employer who:

1795 (i) (A) employed at least one but not more than 50 eligible employees on business days  
1796 during the preceding calendar year; or

1797 (B) if the employer did not exist for the entirety of the preceding calendar year,  
1798 reasonably expects to employ an average of at least one but not more than 50 eligible  
1799 employees on business days during the current calendar year;

1800 (ii) employs at least one employee on the first day of the plan year; and

1801 (iii) for an employer who has common ownership with one or more other employers, is  
1802 treated as a single employer under 26 U.S.C. Sec. 414(b), (c), (m), or (o).

1803 (b) "Small employer" does not include a sole proprietor that does not employ at least  
1804 one employee.

1805 (175) "Special enrollment period," in connection with a health benefit plan, has the  
1806 same meaning as provided in federal regulations adopted pursuant to the Health Insurance  
1807 Portability and Accountability Act.

1808 (176) (a) "Subsidiary" of a person means an affiliate controlled by that person either  
1809 directly or indirectly through one or more affiliates or intermediaries.

1810 (b) "Wholly owned subsidiary" of a person is a subsidiary of which all of the voting  
1811 shares are owned by that person either alone or with its affiliates, except for the minimum  
1812 number of shares the law of the subsidiary's domicile requires to be owned by directors or  
1813 others.

1814 (177) Subject to Subsection (91)(b), "surety insurance" includes:

1815 (a) a guarantee against loss or damage resulting from the failure of a principal to pay or  
1816 perform the principal's obligations to a creditor or other obligee;

1817 (b) bail bond insurance; and

1818 (c) fidelity insurance.

1819 (178) (a) "Surplus" means the excess of assets over the sum of paid-in capital and  
1820 liabilities.

1821 (b) (i) "Permanent surplus" means the surplus of an insurer or organization that is  
1822 designated by the insurer or organization as permanent.

1823 (ii) Sections [31A-5-211](#), [31A-7-201](#), [31A-8-209](#), [31A-9-209](#), and [31A-14-205](#) require

1824 that insurers or organizations doing business in this state maintain specified minimum levels of  
1825 permanent surplus.

1826 (iii) Except for assessable mutuals, the minimum permanent surplus requirement is the  
1827 same as the minimum required capital requirement that applies to stock insurers.

1828 (c) "Excess surplus" means:

1829 (i) for a life insurer, accident and health insurer, health organization, or property and  
1830 casualty insurer as defined in Section 31A-17-601, the lesser of:

1831 (A) that amount of an insurer's or health organization's total adjusted capital that  
1832 exceeds the product of:

1833 (I) 2.5; and

1834 (II) the sum of the insurer's or health organization's minimum capital or permanent  
1835 surplus required under Section 31A-5-211, 31A-9-209, or 31A-14-205; or

1836 (B) that amount of an insurer's or health organization's total adjusted capital that  
1837 exceeds the product of:

1838 (I) 3.0; and

1839 (II) the authorized control level RBC as defined in Subsection 31A-17-601(8)(a); and

1840 (ii) for a monoline mortgage guaranty insurer, financial guaranty insurer, or title insurer  
1841 that amount of an insurer's paid-in-capital and surplus that exceeds the product of:

1842 (A) 1.5; and

1843 (B) the insurer's total adjusted capital required by Subsection 31A-17-609(1).

1844 (179) "Third party administrator" or "administrator" means a person who collects  
1845 charges or premiums from, or who, for consideration, adjusts or settles claims of residents of  
1846 the state in connection with insurance coverage, annuities, or service insurance coverage,  
1847 except:

1848 (a) a union on behalf of its members;

1849 (b) a person administering a:

1850 (i) pension plan subject to the federal Employee Retirement Income Security Act of  
1851 1974;

1852 (ii) governmental plan as defined in Section 414(d), Internal Revenue Code; or

1853 (iii) nonelecting church plan as described in Section 410(d), Internal Revenue Code;

1854 (c) an employer on behalf of the employer's employees or the employees of one or

1855 more of the subsidiary or affiliated corporations of the employer;

1856 (d) an insurer licensed under the following, but only for a line of insurance for which  
1857 the insurer holds a license in this state:

1858 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;

1859 (ii) Chapter 7, Nonprofit Health Service Insurance Corporations;

1860 (iii) Chapter 8, Health Maintenance Organizations and Limited Health Plans;

1861 (iv) Chapter 9, Insurance Fraternal; or

1862 (v) Chapter 14, Foreign Insurers;

1863 (e) a person:

1864 (i) licensed or exempt from licensing under:

1865 (A) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and  
1866 Reinsurance Intermediaries; or

1867 (B) Chapter 26, Insurance Adjusters; and

1868 (ii) whose activities are limited to those authorized under the license the person holds  
1869 or for which the person is exempt; or

1870 (f) an institution, bank, or financial institution:

1871 (i) that is:

1872 (A) an institution whose deposits and accounts are to any extent insured by a federal  
1873 deposit insurance agency, including the Federal Deposit Insurance Corporation or National  
1874 Credit Union Administration; or

1875 (B) a bank or other financial institution that is subject to supervision or examination by  
1876 a federal or state banking authority; and

1877 (ii) that does not adjust claims without a third party administrator license.

1878 (180) "Title insurance" means the insuring, guaranteeing, or indemnifying of an owner  
1879 of real or personal property or the holder of liens or encumbrances on that property, or others  
1880 interested in the property against loss or damage suffered by reason of liens or encumbrances  
1881 upon, defects in, or the unmarketability of the title to the property, or invalidity or  
1882 unenforceability of any liens or encumbrances on the property.

1883 (181) "Total adjusted capital" means the sum of an insurer's or health organization's  
1884 statutory capital and surplus as determined in accordance with:

1885 (a) the statutory accounting applicable to the annual financial statements required to be

1886 filed under Section 31A-4-113; and

1887 (b) another item provided by the RBC instructions, as RBC instructions is defined in  
1888 Section 31A-17-601.

1889 (182) (a) "Trustee" means "director" when referring to the board of directors of a  
1890 corporation.

1891 (b) "Trustee," when used in reference to an employee welfare fund, means an  
1892 individual, firm, association, organization, joint stock company, or corporation, whether acting  
1893 individually or jointly and whether designated by that name or any other, that is charged with  
1894 or has the overall management of an employee welfare fund.

1895 (183) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted insurer"  
1896 means an insurer:

1897 (i) not holding a valid certificate of authority to do an insurance business in this state;

1898 or

1899 (ii) transacting business not authorized by a valid certificate.

1900 (b) "Admitted insurer" or "authorized insurer" means an insurer:

1901 (i) holding a valid certificate of authority to do an insurance business in this state; and

1902 (ii) transacting business as authorized by a valid certificate.

1903 (184) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

1904 (185) "Vehicle liability insurance" means insurance against liability resulting from or  
1905 incident to ownership, maintenance, or use of a land vehicle or aircraft, exclusive of a vehicle  
1906 comprehensive or vehicle physical damage coverage under Subsection (152).

1907 (186) "Voting security" means a security with voting rights, and includes a security  
1908 convertible into a security with a voting right associated with the security.

1909 (187) "Waiting period" for a health benefit plan means the period that must pass before  
1910 coverage for an individual, who is otherwise eligible to enroll under the terms of the health  
1911 benefit plan, can become effective.

1912 (188) "Workers' compensation insurance" means:

1913 (a) insurance for indemnification of an employer against liability for compensation  
1914 based on:

1915 (i) a compensable accidental injury; and

1916 (ii) occupational disease disability;

1917 (b) employer's liability insurance incidental to workers' compensation insurance and  
1918 written in connection with workers' compensation insurance; and

1919 (c) insurance assuring to a person entitled to workers' compensation benefits the  
1920 compensation provided by law.

1921 Section 6. Section **31A-2-104** is amended to read:

1922 **31A-2-104. Other employees -- Insurance fraud investigators.**

1923 (1) The department shall employ [~~a chief examiner and such other~~] professional,  
1924 technical, and clerical employees as necessary to carry out the duties of the department.

1925 (2) An insurance fraud investigator employed [~~pursuant to~~] in accordance with  
1926 Subsection (1) may as [~~approved by~~] the commissioner approves:

1927 (a) be designated a law enforcement officer, as defined in Section **53-13-103**; and

1928 (b) be eligible for retirement benefits under the Public Safety Employee's Retirement  
1929 System.

1930 Section 7. Section **31A-2-110** is amended to read:

1931 **31A-2-110. Official seal and signature.**

1932 (1) (a) Any statutory or common-law requirement that an official seal be affixed is  
1933 satisfied by the signature of the commissioner.

1934 (b) However, the commissioner may adopt and use a seal bearing the words  
1935 "Commissioner of Insurance for Utah," an impression of which shall be filed with the Division  
1936 of Archives.

1937 (2) Any signature of the commissioner may be in [~~facsimile~~] a format that affixes an  
1938 exact copy of the signature, unless specifically required to be handwritten.

1939 Section 8. Section **31A-2-212** is amended to read:

1940 **31A-2-212. Miscellaneous duties.**

1941 (1) Upon issuance of an order limiting, suspending, or revoking a person's authority to  
1942 do business in Utah, and when the commissioner begins a proceeding against an insurer under  
1943 Chapter 27a, Insurer Receivership Act, the commissioner:

1944 (a) shall notify by mail the producers of the person or insurer of whom the  
1945 commissioner has record; and

1946 (b) may publish notice of the order or proceeding in any manner the commissioner  
1947 considers necessary to protect the rights of the public.

1948 (2) (a) When required for evidence in a legal proceeding, the commissioner shall  
1949 furnish a certificate of authority of a licensee to transact the business of insurance in Utah on  
1950 any particular date.

1951 (b) The court or other officer shall receive ~~[the]~~ a certificate of authority described in  
1952 this Subsection (2) in lieu of the commissioner's testimony.

1953 (3) (a) On the request of an insurer authorized to do a surety business, the  
1954 commissioner shall furnish a copy of the insurer's certificate of authority to a designated public  
1955 officer in this state who requires that certificate of authority before accepting a bond.

1956 (b) The public officer described in Subsection (3)(a) shall file the certificate of  
1957 authority furnished under Subsection (3)(a).

1958 (c) After a certified copy of a certificate of authority is furnished to a public officer, it  
1959 is not necessary, while the certificate of authority remains effective, to attach a copy of it to any  
1960 instrument of suretyship filed with that public officer.

1961 (d) Whenever the commissioner revokes the certificate of authority or begins a  
1962 proceeding under Chapter 27a, Insurer Receivership Act, against an insurer authorized to do a  
1963 surety business, the commissioner shall immediately give notice of that action to each public  
1964 officer who is sent a certified copy under this Subsection (3).

1965 (4) (a) The commissioner shall immediately notify every judge and clerk of the courts  
1966 of record in the state when:

1967 (i) an authorized insurer doing a surety business:

1968 (A) files a petition for receivership; or

1969 (B) is in receivership; or

1970 (ii) the commissioner has reason to believe that the authorized insurer doing surety  
1971 business:

1972 (A) is in financial difficulty; or

1973 (B) has unreasonably failed to carry out any of ~~[its]~~ the authorized insurer's contracts.

1974 (b) Upon the receipt of the notice required by this Subsection (4), it is the duty of the  
1975 judges and clerks to notify and require a person that files with the court a bond on which the  
1976 authorized insurer doing surety business is surety to immediately file a new bond with a new  
1977 surety.

1978 ~~[(5) (a) The commissioner shall report to the Legislature in accordance with Section~~



1979 ~~63N-11-106~~ before adopting a rule authorized by Subsection (5)(b).]

1980           ~~[(b)]~~ (5) (a) The commissioner shall require an insurer that issues, sells, renews, or  
1981 offers health insurance coverage in this state to comply with PPACA and administrative rules  
1982 adopted by the commissioner related to regulation of health benefit plans, including:

- 1983           (i) lifetime and annual limits;
- 1984           (ii) prohibition of rescissions;
- 1985           (iii) coverage of preventive health services;
- 1986           (iv) coverage for a child or dependent;
- 1987           (v) pre-existing condition limitations;
- 1988           (vi) insurer transparency of consumer information including plan disclosures, uniform  
1989 coverage documents, and standard definitions;
- 1990           (vii) premium rate reviews;
- 1991           (viii) essential health benefits;
- 1992           (ix) provider choice;
- 1993           (x) waiting periods;
- 1994           (xi) appeals processes;
- 1995           (xii) rating restrictions;
- 1996           (xiii) uniform applications and notice provisions;
- 1997           (xiv) certification and regulation of qualified health plans; and
- 1998           (xv) network adequacy standards.

1999           ~~[(c)]~~ (b) The commissioner shall preserve state control over:

- 2000           (i) the health insurance market in the state;
- 2001           (ii) qualified health plans offered in the state; and
- 2002           (iii) the conduct of navigators, producers, and in-person assisters operating in the state.

2003           ~~[(d) If the state enters into an agreement with the United States Department of Health  
2004 and Human Services in which the state operates health insurance plan management, the  
2005 commissioner may:]~~

2006           ~~[(i) for fiscal year 2014, hire one temporary and two permanent full-time employees to  
2007 be funded through the department's existing budget; and]~~

2008           ~~[(ii) for fiscal year 2015, hire two permanent full-time employees funded through the  
2009 Insurance Department Restricted Account, subject to appropriations from the Legislature and~~

2010 approval by the governor.]

2011 Section 9. Section **31A-2-218** is amended to read:

2012 **31A-2-218. Strategic plan for health system reform.**

2013 The commissioner and the department shall:

2014 [~~(1) work with the Governor's Office of Economic Development, the Department of~~  
2015 ~~Health, the Department of Workforce Services, and the Legislature to develop health system~~  
2016 ~~reform in accordance with the strategic plan described in Title 63N, Chapter 11, Health System~~  
2017 ~~Reform Act;]~~

2018 [~~(2) work with health insurers in accordance with Section [31A-22-635](#) to develop~~  
2019 ~~standards for health insurance applications and compatible electronic systems;]~~

2020 [(3)] (1) facilitate a private sector method for the collection of health insurance  
2021 premium payments made for a single policy by multiple payers, including the policyholder, one  
2022 or more employers of one or more individuals covered by the policy, government programs,  
2023 and others by educating employers and insurers about collection services available through  
2024 private vendors, including financial institutions;

2025 [(4)] (2) encourage health insurers to develop products that:

2026 (a) encourage health care providers to follow best practice protocols;

2027 (b) incorporate other health care quality improvement mechanisms; and

2028 (c) incorporate rewards and incentives for healthy lifestyles and behaviors as permitted  
2029 by the Health Insurance Portability and Accountability Act;

2030 [(5)] (3) involve the Office of Consumer Health Assistance created in Section  
2031 [31A-2-216](#), as necessary, to accomplish the requirements of this section; and

2032 [(6)] (4) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking  
2033 Act, make rules, as necessary, to implement Subsections (1) and (2)[, (3), and (4)].

2034 Section 10. Section **31A-2-309** is amended to read:

2035 **31A-2-309. Service of process through state officer.**

2036 (1) The commissioner, or the lieutenant governor when the subject proceeding is  
2037 brought by the state, is the agent for receipt of service of a summons, notice, order, pleading, or  
2038 other legal process relating to a Utah court or administrative agency upon the following:

2039 (a) an insurer authorized to do business in this state, while authorized to do business in  
2040 this state, and thereafter in a proceeding arising from or related to a transaction having a

2041 connection with this state;

2042 (b) a surplus lines insurer for a proceeding arising out of a contract of insurance that is  
2043 subject to the surplus lines law, or out of a certificate, cover note, or other confirmation of that  
2044 type of insurance;

2045 (c) an unauthorized insurer or other person assisting an unauthorized insurer under  
2046 Subsection 31A-15-102(1) by doing an act specified in Subsection 31A-15-102(2), for a  
2047 proceeding arising out of a transaction that is subject to the unauthorized insurance law;

2048 (d) a nonresident producer, consultant, adjuster, or third party administrator, while  
2049 authorized to do business in this state, and thereafter in a proceeding arising from or related to  
2050 a transaction having a connection with this state; and

2051 (e) a reinsurer submitting to the commissioner's jurisdiction under Subsection  
2052 31A-17-404~~(9)~~(11).

2053 (2) The following is considered to have irrevocably appointed the commissioner and  
2054 lieutenant governor as that person's agents in accordance with Subsection (1):

2055 (a) a licensed insurer by applying for and receiving a certificate of authority;

2056 (b) a surplus lines insurer by entering into a contract subject to the surplus lines law;

2057 (c) an unauthorized insurer by doing in this state an act prohibited by Section  
2058 31A-15-103; and

2059 (d) a nonresident producer, consultant, adjuster, and third party administrator.

2060 (3) The commissioner and lieutenant governor are also agents for an executor,  
2061 administrator, personal representative, receiver, trustee, or other successor in interest of a  
2062 person specified under Subsection (1).

2063 (4) A litigant serving process on the commissioner or lieutenant governor under this  
2064 section shall pay the fee applicable under Section 31A-3-103.

2065 (5) The right to substituted service under this section does not limit the right to serve a  
2066 summons, notice, order, pleading, demand, or other process upon a person in another manner  
2067 provided by law.

2068 Section 11. Section 31A-2-403 is amended to read:

2069 **31A-2-403. Title and Escrow Commission created.**

2070 (1) (a) Subject to Subsection (1)(b), there is created within the department the Title and  
2071 Escrow Commission that is comprised of five members appointed by the governor with the

2072 consent of the Senate as follows:

2073 (i) except as provided in Subsection ~~[(1)(e)]~~ (1)(d), two members shall be employees of  
2074 a title insurer;

2075 (ii) two members shall:

2076 (A) be employees of a Utah agency title insurance producer;

2077 (B) be or have been licensed under the title insurance line of authority;

2078 (C) as of the day on which the member is appointed, be or have been licensed with the  
2079 title examination or escrow subline of authority for at least five years; and

2080 (D) as of the day on which the member is appointed, not be from the same county as  
2081 another member appointed under this Subsection (1)(a)(ii); and

2082 (iii) one member shall be a member of the general public from any county in the state.

2083 (b) No more than one commission member may be appointed from a single company  
2084 or an affiliate or subsidiary of the company.

2085 (c) No more than two commission members may be employees of an entity operating  
2086 under an affiliated business arrangement, as defined in Section [31A-23a-1001](#).

2087 ~~[(e)]~~ (d) If the governor is unable to identify more than one individual who is an  
2088 employee of a title insurer and willing to serve as a member of the commission, the  
2089 commission shall include the following members in lieu of the members described in  
2090 Subsection (1)(a)(i):

2091 (i) one member who is an employee of a title insurer; and

2092 (ii) one member who is an employee of a Utah agency title insurance producer.

2093 (2) (a) Subject to Subsection (2)(c), a commission member shall file with the  
2094 commissioner a disclosure of any position of employment or ownership interest that the  
2095 commission member has with respect to a person that is subject to the jurisdiction of the  
2096 commissioner.

2097 (b) The disclosure statement required by this Subsection (2) shall be:

2098 (i) filed by no later than the day on which the person begins that person's appointment;  
2099 and

2100 (ii) amended when a significant change occurs in any matter required to be disclosed  
2101 under this Subsection (2).

2102 (c) A commission member is not required to disclose an ownership interest that the

2103 commission member has if the ownership interest is in a publicly traded company or held as  
2104 part of a mutual fund, trust, or similar investment.

2105 (3) (a) Except as required by Subsection (3)(b), as terms of current commission  
2106 members expire, the governor shall appoint each new commission member to a four-year term  
2107 ending on June 30.

2108 (b) Notwithstanding the requirements of Subsection (3)(a), the governor shall, at the  
2109 time of appointment, adjust the length of terms to ensure that the terms of the commission  
2110 members are staggered so that approximately half of the members appointed under Subsection  
2111 (1)(a)(i) and half of the members appointed under Subsection (1)(a)(ii) are appointed every two  
2112 years.

2113 (c) A commission member may not serve more than one consecutive term.

2114 (d) When a vacancy occurs in the membership for any reason, the governor, with the  
2115 consent of the Senate, shall appoint a replacement for the unexpired term.

2116 (e) Notwithstanding the other provisions of this Subsection (3), a commission member  
2117 serves until a successor is appointed by the governor with the consent of the Senate.

2118 (4) A commission member may not receive compensation or benefits for the  
2119 commission member's service, but may receive per diem and travel expenses in accordance  
2120 with:

2121 (a) Section [63A-3-106](#);

2122 (b) Section [63A-3-107](#); and

2123 (c) rules made by the Division of Finance pursuant to Sections [63A-3-106](#) and  
2124 [63A-3-107](#).

2125 (5) Members of the commission shall annually select one commission member to serve  
2126 as chair.

2127 (6) (a) (i) Except as provided in Subsection (6)(b), the commission shall meet at least  
2128 monthly.

2129 (ii) (A) The commissioner shall, with the concurrence of the chair of the commission,  
2130 designate at least one monthly meeting per quarter as an in-person meeting.

2131 (B) Notwithstanding Section [52-4-207](#), a commission member shall physically attend a  
2132 meeting designated as an in-person meeting under Subsection (6)(a)(ii)(A) and may not attend  
2133 through electronic means. A commission member may attend any other commission meeting,

2134 subcommittee meeting, or emergency meeting by electronic means in accordance with Section  
2135 [52-4-207](#).

2136 (b) (i) Except as provided in Subsection (6)(b)(ii), the commissioner may, with the  
2137 concurrence of the chair of the commission, cancel a monthly meeting of the commission if,  
2138 due to the number or nature of pending title insurance matters, the monthly meeting is not  
2139 necessary.

2140 (ii) The commissioner may not cancel a monthly meeting designated as an in-person  
2141 meeting under Subsection (6)(a)(ii)(A).

2142 (c) The commissioner may call additional meetings:

2143 (i) at the commissioner's discretion;

2144 (ii) upon the request of the chair of the commission; or

2145 (iii) upon the written request of three or more commission members.

2146 (d) (i) Three commission members constitute a quorum for the transaction of business.

2147 (ii) The action of a majority of the commission members when a quorum is present is  
2148 the action of the commission.

2149 (7) The commissioner shall staff the commission.

2150 Section 12. Section **31A-6a-101** is amended to read:

2151 **31A-6a-101. Definitions.**

2152 As used in this chapter:

2153 (1) "Home warranty service contract" means a service contract that requires a person to  
2154 repair or replace a component, system, or appliance of a home or make indemnification to the  
2155 contract holder for the repair or replacement of a component, system, or appliance of the home:

2156 (a) upon mechanical or operational failure of the component, system, or appliance;

2157 (b) for a predetermined fee; and

2158 (c) if:

2159 (i) the person is not the builder, seller, or lessor of the home that is the subject of the  
2160 contract; and

2161 (ii) the failure described in Subsection (1)(a) occurs within a specified period of time.

2162 [(+)] (2) (a) "Incidental cost" means a cost, incurred by a warranty holder in relation to  
2163 a vehicle protection product warranty, that is in addition to the cost of purchasing the warranty.

2164 (b) "Incidental cost" includes an insurance policy deductible, a rental vehicle charge,

2165 the difference between the actual value of the stolen vehicle at the time of theft and the cost of  
2166 a replacement vehicle, sales tax, a registration fee, a transaction fee, a mechanical inspection  
2167 fee, or damage a theft causes to a vehicle.

2168 ~~[(2)]~~ (3) "Mechanical breakdown insurance" means a policy, contract, or agreement  
2169 issued by an insurance company that has complied with either Chapter 5, Domestic Stock and  
2170 Mutual Insurance Corporations, or Chapter 14, Foreign Insurers, that undertakes to perform or  
2171 provide repair or replacement service on goods or property, or indemnification for repair or  
2172 replacement service, for the operational or structural failure of the goods or property due to a  
2173 defect in materials, workmanship, or normal wear and tear.

2174 ~~[(3)]~~ (4) "Nonmanufacturers' parts" means replacement parts not made for or by the  
2175 original manufacturer of the goods commonly referred to as "after market parts."

2176 ~~[(4)]~~ (5) (a) "Road hazard" means a hazard that is encountered while driving a motor  
2177 vehicle.

2178 (b) "Road hazard" includes potholes, rocks, wood debris, metal parts, glass, plastic,  
2179 curbs, or composite scraps.

2180 ~~[(5)]~~ (6) (a) "Service contract" means a contract or agreement to perform or reimburse  
2181 for the repair or maintenance of goods or property, for their operational or structural failure due  
2182 to a defect in materials, workmanship, normal wear and tear, power surge or interruption, or  
2183 accidental damage from handling, with or without additional provision for incidental payment  
2184 of indemnity under limited circumstances, including towing, providing a rental car, providing  
2185 emergency road service, and covering food spoilage.

2186 (b) "Service contract" does not include:

2187 (i) mechanical breakdown insurance; or

2188 (ii) a prepaid contract of limited duration that provides for scheduled maintenance  
2189 only, regardless of whether the contract is executed before, on, or after May 9, 2017.

2190 (c) "Service contract" includes any contract or agreement to perform or reimburse the  
2191 service contract holder for any one or more of the following services:

2192 (i) the repair or replacement of tires, wheels, or both on a motor vehicle damaged as a  
2193 result of coming into contact with a road hazard;

2194 (ii) the removal of dents, dings, or creases on a motor vehicle that can be repaired using  
2195 the process of paintless dent removal without affecting the existing paint finish and without

2196 replacing vehicle body panels, sanding, bonding, or painting;

2197 (iii) the repair of chips or cracks in or the replacement of a motor vehicle windshield as  
2198 a result of damage caused by a road hazard, that is primary to the coverage offered by the motor  
2199 vehicle owner's motor vehicle insurance policy; or

2200 (iv) the replacement of a motor vehicle key or key-fob if the key or key-fob becomes  
2201 inoperable, lost, or stolen, except that the replacement of lost or stolen property is limited to  
2202 only the replacement of a lost or stolen motor vehicle key or key-fob.

2203 [~~(6)~~] (7) "Service contract holder" or "contract holder" means a person who purchases a  
2204 service contract.

2205 [~~(7)~~] (8) "Service contract provider" means a person who issues, makes, provides,  
2206 administers, sells or offers to sell a service contract, or who is contractually obligated to  
2207 provide service under a service contract.

2208 [~~(8)~~] (9) "Service contract reimbursement policy" or "reimbursement insurance policy"  
2209 means a policy of insurance providing coverage for all obligations and liabilities incurred by  
2210 the service contract provider or warrantor under the terms of the service contract or vehicle  
2211 protection product warranty issued by the provider or warrantor.

2212 [~~(9)~~] (10) (a) "Vehicle protection product" means a device or system that is:

2213 (i) installed on or applied to a motor vehicle; and

2214 (ii) designed to:

2215 (A) prevent the theft of the vehicle; or

2216 (B) if the vehicle is stolen, aid in the recovery of the vehicle.

2217 (b) "Vehicle protection product" includes:

2218 (i) a vehicle protection product warranty;

2219 (ii) an alarm system;

2220 (iii) a body part marking product;

2221 (iv) a steering lock;

2222 (v) a window etch product;

2223 (vi) a pedal and ignition lock;

2224 (vii) a fuel and ignition kill switch; and

2225 (viii) an electronic, radio, or satellite tracking device.

2226 [~~(10)~~] (11) "Vehicle protection product warranty" means a written agreement by a



2227 warrantor that provides that if the vehicle protection product fails to prevent the theft of the  
2228 motor vehicle, or aid in the recovery of the motor vehicle within a time period specified in the  
2229 warranty, not exceeding 30 days after the day on which the motor vehicle is reported stolen, the  
2230 warrantor will reimburse the warranty holder for incidental costs specified in the warranty, not  
2231 exceeding \$5,000, or in a specified fixed amount not exceeding \$5,000.

2232 (12) "Vehicle service contract" means a service contract for the repair or maintenance  
2233 of a vehicle:

2234 (a) for operational or structural failure because of a defect in materials, workmanship,  
2235 normal wear and tear, or accidental damage from handling; and

2236 (b) with or without additional provision for incidental payment of indemnity under  
2237 limited circumstances, including towing, providing a rental car, or providing emergency road  
2238 service.

2239 [~~(11)~~] (13) "Warrantor" means a person who is contractually obligated to the warranty  
2240 holder under the terms of a vehicle protection product warranty.

2241 [~~(12)~~] (14) "Warranty holder" means the person who purchases a vehicle protection  
2242 product, any authorized transferee or assignee of the purchaser, or any other person legally  
2243 assuming the purchaser's rights under the vehicle protection product warranty.

2244 Section 13. Section **31A-6a-103** is amended to read:

2245 **31A-6a-103. Requirements for doing business.**

2246 (1) A service contract or vehicle protection product warranty may not be issued, sold,  
2247 or offered for sale in this state unless the service contract or vehicle protection product  
2248 warranty is insured under a reimbursement insurance policy issued by:

2249 (a) an insurer authorized to do business in this state; or  
2250 (b) a recognized surplus lines carrier.

2251 (2) (a) A service contract or vehicle protection product warranty may not be issued,  
2252 sold, or offered for sale unless the service contract provider or warrantor completes the  
2253 registration process described in this Subsection (2).

2254 (b) To register, a service contract provider or warrantor shall submit to the department  
2255 the following:

2256 (i) an application for registration;  
2257 (ii) a fee established in accordance with Section **31A-3-103**;

2258 (iii) a copy of any service contract or vehicle protection product warranty that the  
2259 service contract provider or warrantor offers in this state; and

2260 (iv) a copy of the service contract provider's or warrantor's reimbursement insurance  
2261 policy.

2262 (c) A service provider or warrantor shall submit the information described in  
2263 Subsection (2)(b) no less than 30 days before the day on which the service provider or  
2264 warrantor issues, sells, offers for sale, or uses a service contract, vehicle protection product  
2265 warranty, or reimbursement insurance policy in this state.

2266 (d) A service provider or warrantor shall file any modification of the terms of a service  
2267 contract, vehicle protection product warranty, or reimbursement insurance policy 30 days  
2268 before the day on which it is used in this state.

2269 (e) A person complying with this chapter is not required to comply with:

2270 (i) Subsections 31A-21-201(1) and 31A-23a-402(3); or

2271 (ii) Chapter 19a, Utah Rate Regulation Act.

2272 (f) (i) Each year before March 1, a service provider shall pay an annual registration fee  
2273 established in accordance with Section 31A-3-103.

2274 (ii) If a service provider does not pay the annual registration fee described in this  
2275 Subsection (2)(f) before March 1:

2276 (A) the service provider's registration is expired; and

2277 (B) the service provider may apply for registration in accordance with this Subsection  
2278 (2).

2279 (3) (a) Premiums collected on a service contract are not subject to premium taxes.

2280 (b) Premiums collected by an issuer of a reimbursement insurance policy are subject to  
2281 premium taxes.

2282 (4) A person marketing, selling, or offering to sell a service contract or vehicle  
2283 protection product warranty for a service contract provider or warrantor that complies with this  
2284 chapter is exempt from the licensing requirements of this title.

2285 (5) A service contract provider or warrantor complying with this chapter is not required  
2286 to comply with:

2287 (a) Chapter 5, Domestic Stock and Mutual Insurance Corporations;

2288 (b) Chapter 7, Nonprofit Health Service Insurance Corporations;

2289 (c) Chapter 8, Health Maintenance Organizations and Limited Health Plans;

2290 (d) Chapter 9, Insurance Fraternal;

2291 (e) Chapter 10, Annuities;

2292 (f) Chapter 11, Motor Clubs;

2293 (g) Chapter 12, State Risk Management Fund;

2294 (h) Chapter 14, Foreign Insurers;

2295 (i) Chapter 19a, Utah Rate Regulation Act;

2296 (j) Chapter 25, Third Party Administrators; and

2297 (k) Chapter 28, Guaranty Associations.

2298 Section 14. Section **31A-6a-104** is amended to read:

2299 **31A-6a-104. Required disclosures.**

2300 (1) A reimbursement insurance policy insuring a service contract or a vehicle  
2301 protection product warranty that is issued, sold, or offered for sale in this state shall  
2302 conspicuously state that, upon failure of the service contract provider or warrantor to perform  
2303 under the contract, the issuer of the policy shall:

2304 (a) pay on behalf of the service contract provider or warrantor any sums the service  
2305 contract provider or warrantor is legally obligated to pay according to the service contract  
2306 provider's or warrantor's contractual obligations under the service contract or a vehicle  
2307 protection product warranty issued or sold by the service contract provider or warrantor; or

2308 (b) provide the service which the service contract provider is legally obligated to  
2309 perform, according to the service contract provider's contractual obligations under the service  
2310 contract issued or sold by the service contract provider.

2311 (2) (a) A service contract may not be issued, sold, or offered for sale in this state unless  
2312 the service contract contains the following statements in substantially the following form:

2313 (i) "Obligations of the provider under this service contract are guaranteed under a  
2314 service contract reimbursement insurance policy. Should the provider fail to pay or provide  
2315 service on any claim within 60 days after proof of loss has been filed, the contract holder is  
2316 entitled to make a claim directly against the Insurance Company.";

2317 (ii) "This service contract or warranty is subject to limited regulation by the Utah  
2318 Insurance Department. To file a complaint, contact the Utah Insurance Department."; and

2319 (iii) A service contract or reimbursement insurance policy may not be issued, sold, or

2320 offered for sale in this state unless the contract contains a statement in substantially the  
2321 following form, "Coverage afforded under this contract is not guaranteed by the Property and  
2322 Casualty Guaranty Association."

2323 (b) A vehicle protection product warranty may not be issued, sold, or offered for sale in  
2324 this state unless the vehicle protection product warranty contains the following statements in  
2325 substantially the following form:

2326 (i) "Obligations of the warrantor under this vehicle protection product warranty are  
2327 guaranteed under a reimbursement insurance policy. Should the warrantor fail to pay on any  
2328 claim within 60 days after proof of loss has been filed, the warranty holder is entitled to make a  
2329 claim directly against the Insurance Company.";

2330 (ii) "This vehicle protection product warranty is subject to limited regulation by the  
2331 Utah Insurance Department. To file a complaint, contact the Utah Insurance Department."; and

2332 (iii) as applicable:

2333 (A) "The warrantor under this vehicle protection product warranty will reimburse the  
2334 warranty holder as specified in the warranty upon the theft of the vehicle."; or

2335 (B) "The warrantor under this vehicle protection product warranty will reimburse the  
2336 warranty holder as specified in the warranty and at the end of the time period specified in the  
2337 warranty if, following the theft of the vehicle, the stolen vehicle is not recovered within a time  
2338 period specified in the warranty, not to exceed 30 days after the day on which the vehicle is  
2339 reported stolen."

2340 (c) A vehicle protection product warranty, or reimbursement insurance policy, may not  
2341 be issued, sold, or offered for sale in this state unless the warranty contains a statement in  
2342 substantially the following form, "Coverage afforded under this warranty is not guaranteed by  
2343 the Property and Casualty Guaranty Association."

2344 (3) (a) A service contract and a vehicle protection product warranty shall:

2345 [(a)] (i) conspicuously state the name, address, and a toll free claims service telephone  
2346 number of the reimbursement insurer;

2347 [(b)-(i)] (ii) (A) identify the service contract provider, the seller, and the service  
2348 contract holder; or

2349 [(ii)] (B) identify the warrantor, the seller, and the warranty holder;

2350 [(c)] (iii) conspicuously state the total purchase price and the terms under which the

2351 service contract or warranty is to be paid;

2352 ~~[(d)]~~ (iv) conspicuously state the existence of any deductible amount;

2353 ~~[(e)]~~ (v) specify the merchandise, service to be provided, and any limitation, exception,  
2354 or exclusion;

2355 ~~[(f)]~~ (vi) state a term, restriction, or condition governing the transferability of the  
2356 service contract or warranty; and

2357 ~~[(g)]~~ (vii) state a term, restriction, or condition that governs cancellation of the service  
2358 contract as provided in Sections 31A-21-303 through 31A-21-305 by either the contract holder  
2359 or service contract provider.

2360 (b) Beginning January 1, 2021, a service contract shall contain a conspicuous statement  
2361 in substantially the following form: "Purchase of this product is optional and is not required in  
2362 order to finance, lease, or purchase a motor vehicle."

2363 (4) If prior approval of repair work is required~~[, a service]~~ under a home protection  
2364 service contract or a vehicle service contract, the contract shall conspicuously state the  
2365 procedure for obtaining prior approval and for making a claim, including:

2366 (a) a toll free telephone number for claim service; and

2367 (b) a procedure for obtaining reimbursement for emergency repairs performed outside  
2368 of normal business hours.

2369 (5) A preexisting condition clause in a service contract shall specifically state which  
2370 preexisting condition is excluded from coverage.

2371 (6) (a) Except as provided in Subsection (6)(c), a service contract shall state the  
2372 conditions upon which the use of a nonmanufacturers' part is allowed.

2373 (b) A condition described in Subsection (6)(a) shall comply with applicable state and  
2374 federal laws.

2375 (c) This Subsection (6) does not apply to:

2376 (i) a home warranty service contract~~[-]~~; or

2377 (ii) a service contract that does not impose an obligation to provide parts.

2378 (7) This section applies to a vehicle protection product warranty, except for the  
2379 requirements of Subsections (3)(d) and (g), (4), (5), and (6). The department may make rules  
2380 in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement  
2381 the application of this section to a vehicle protection product warranty.

2382 (8) (a) As used in this Subsection (8), "conspicuous statement" means a disclosure that:

2383 (i) appears in all-caps, bold, and 14-point font; and

2384 (ii) provides a space to be initialed by the consumer:

2385 (A) immediately below the printed disclosure; and

2386 (B) at or before the time the consumer purchases the vehicle protection product.

2387 (b) A vehicle protection product warranty shall contain a conspicuous statement in

2388 substantially the following form: "Purchase of this product is optional and is not required in

2389 order to finance, lease, or purchase a motor vehicle."

2390 (9) If a vehicle protection product warranty states that the warrantor will reimburse the

2391 warranty holder for incidental costs, the vehicle protection product warranty shall state how

2392 incidental costs paid under the warranty are calculated.

2393 (10) If a vehicle protection product warranty states that the warrantor will reimburse

2394 the warranty holder in a fixed amount, the vehicle protection product warranty shall state the

2395 fixed amount.

2396 Section 15. Section **31A-8-211** is amended to read:

2397 **31A-8-211. Deposit.**

2398 (1) Except as provided in Subsection (2), each health maintenance organization

2399 authorized in this state shall maintain a deposit with the commissioner under Section

2400 [31A-2-206](#) in an amount equal to the sum of:

2401 (a) \$100,000; and

2402 (b) 50% of the greater of:

2403 (i) \$900,000;

2404 (ii) 2% of the annual premium revenues as reported on the most recent annual financial

2405 statement filed with the commissioner; or

2406 (iii) an amount equal to the sum of three months uncovered health care expenditures as

2407 reported on the most recent financial statement filed with the commissioner.

2408 (2) (a) ~~[After a hearing the]~~ The commissioner may exempt a health maintenance

2409 organization from the deposit requirement of Subsection (1) if:

2410 (i) the commissioner determines that the enrollees' interests are adequately protected;

2411 (ii) the health maintenance organization has been continuously authorized to do

2412 business in this state for at least five years; and

2413 (iii) the health maintenance organization has \$5,000,000 surplus in excess of the health  
2414 maintenance organization's company action level RBC as defined in Subsection  
2415 [31A-17-601](#)(8)(b).

2416 (b) The commissioner may rescind an exemption given under Subsection (2)(a).

2417 (3) (a) Each limited health plan authorized in this state shall maintain a deposit with  
2418 the commissioner under Section [31A-2-206](#) in an amount equal to the minimum capital or  
2419 permanent surplus plus 50% of the greater of:

2420 (i) .5 times minimum required capital or minimum permanent surplus; or

2421 (ii) (A) during the first year of operation, 10% of the limited health plan's projected  
2422 uncovered expenditures for the first year of operation;

2423 (B) during the second year of operation, 12% of the limited health plan's projected  
2424 uncovered expenditures for the second year of operation;

2425 (C) during the third year of operation, 14% of the limited health plan's projected  
2426 uncovered expenditures for the third year of operation;

2427 (D) during the fourth year of operation, 18% of the limited health plan's projected  
2428 uncovered expenditures during the fourth year of operation; or

2429 (E) during the fifth year of operation, and during all subsequent years, 20% of the  
2430 limited health plan's projected uncovered expenditures for the previous 12 months.

2431 (b) Projections of future uncovered expenditures shall be established in a manner that  
2432 is approved by the commissioner.

2433 (4) A deposit required by this section may be counted toward the minimum capital or  
2434 minimum permanent surplus required under Section [31A-8-209](#).

2435 Section 16. Section [31A-17-404](#) is amended to read:

2436 **[31A-17-404. Credit allowed a domestic ceding insurer against reserves for](#)**  
2437 **reinsurance.**

2438 (1) A domestic ceding insurer is allowed credit for reinsurance as either an asset or a  
2439 reduction from liability for reinsurance ceded only if the reinsurer meets the requirements of  
2440 Subsection (3), (4), (5), (6), (7), ~~or~~ (8), or (9) subject to the following:

2441 (a) Credit is allowed under Subsection (3), (4), or (5) only with respect to a cession of a  
2442 kind or class of business that the assuming insurer is licensed or otherwise permitted to write or  
2443 assume:

- 2444 (i) in its state of domicile; or
- 2445 (ii) in the case of a United States branch of an alien assuming insurer, in the state
- 2446 through which it is entered and licensed to transact insurance or reinsurance.
- 2447 (b) Credit is allowed under Subsection (5) or (6) only if the applicable requirements of
- 2448 Subsection [~~(9)~~] (11) are met.
- 2449 (2) A domestic ceding insurer is allowed credit for reinsurance ceded:
- 2450 (a) only if the reinsurance is payable in a manner consistent with Section 31A-22-1201;
- 2451 (b) only to the extent that the accounting:
- 2452 (i) is consistent with the terms of the reinsurance contract; and
- 2453 (ii) clearly reflects:
- 2454 (A) the amount and nature of risk transferred; and
- 2455 (B) liability, including contingent liability, of the ceding insurer;
- 2456 (c) only to the extent the reinsurance contract shifts insurance policy risk from the
- 2457 ceding insurer to the assuming reinsurer in fact and not merely in form; and
- 2458 (d) only if the reinsurance contract contains a provision placing on the reinsurer the
- 2459 credit risk of all dealings with intermediaries regarding the reinsurance contract.
- 2460 (3) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an
- 2461 assuming insurer that is licensed to transact insurance or reinsurance in this state.
- 2462 (4) (a) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an
- 2463 assuming insurer that is accredited by the commissioner as a reinsurer in this state.
- 2464 (b) An insurer is accredited as a reinsurer if the insurer:
- 2465 (i) files with the commissioner evidence of the insurer's submission to this state's
- 2466 jurisdiction;
- 2467 (ii) submits to the commissioner's authority to examine the insurer's books and records;
- 2468 (iii) (A) is licensed to transact insurance or reinsurance in at least one state; or
- 2469 (B) in the case of a United States branch of an alien assuming insurer, is entered
- 2470 through and licensed to transact insurance or reinsurance in at least one state;
- 2471 (iv) files annually with the commissioner a copy of the insurer's:
- 2472 (A) annual statement filed with the insurance department of its state of domicile; and
- 2473 (B) most recent audited financial statement; and
- 2474 (v) (A) (I) has not had its accreditation denied by the commissioner within 90 days [of]



2475 after the day on which the insurer submits the information required by this Subsection (4); and

2476 (II) maintains a surplus with regard to policyholders in an amount not less than

2477 \$20,000,000; or

2478 (B) (I) has its accreditation approved by the commissioner; and

2479 (II) maintains a surplus with regard to policyholders in an amount less than

2480 \$20,000,000.

2481 (c) Credit may not be allowed a domestic ceding insurer if the assuming insurer's

2482 accreditation is revoked by the commissioner after a notice and hearing.

2483 (5) (a) A domestic ceding insurer is allowed a credit if:

2484 (i) the reinsurance is ceded to an assuming insurer that is:

2485 (A) domiciled in a state meeting the requirements of Subsection (5)(a)(ii); or

2486 (B) in the case of a United States branch of an alien assuming insurer, is entered

2487 through a state meeting the requirements of Subsection (5)(a)(ii);

2488 (ii) the state described in Subsection (5)(a)(i) employs standards regarding credit for

2489 reinsurance substantially similar to those applicable under this section; and

2490 (iii) the assuming insurer or United States branch of an alien assuming insurer:

2491 (A) maintains a surplus with regard to policyholders in an amount not less than

2492 \$20,000,000; and

2493 (B) submits to the authority of the commissioner to examine its books and records.

2494 (b) The requirements of Subsections (5)(a)(i) and (ii) do not apply to reinsurance ceded

2495 and assumed pursuant to a pooling arrangement among insurers in the same holding company

2496 system.

2497 (6) (a) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an

2498 assuming insurer that maintains a trust fund:

2499 (i) created in accordance with rules made by the commissioner pursuant to Title 63G,

2500 Chapter 3, Utah Administrative Rulemaking Act; and

2501 (ii) in a qualified United States financial institution for the payment of a valid claim of:

2502 (A) a United States ceding insurer of the assuming insurer;

2503 (B) an assign of the United States ceding insurer; and

2504 (C) a successor in interest to the United States ceding insurer.

2505 (b) To enable the commissioner to determine the sufficiency of the trust fund described

2506 in Subsection (6)(a), the assuming insurer shall:

2507 (i) report annually to the commissioner information substantially the same as that  
2508 required to be reported on the National Association of Insurance Commissioners Annual  
2509 Statement form by a licensed insurer; and

2510 (ii) (A) submit to examination of its books and records by the commissioner; and  
2511 (B) pay the cost of an examination.

2512 (c) (i) Credit for reinsurance may not be granted under this Subsection (6) unless the  
2513 form of the trust and any amendment to the trust is approved by:

2514 (A) the commissioner of the state where the trust is domiciled; or

2515 (B) the commissioner of another state who, pursuant to the terms of the trust  
2516 instrument, accepts principal regulatory oversight of the trust.

2517 (ii) The form of the trust and an amendment to the trust shall be filed with the  
2518 commissioner of every state in which a ceding insurer beneficiary of the trust is domiciled.

2519 (iii) The trust instrument shall provide that a contested claim is valid and enforceable  
2520 upon the final order of a court of competent jurisdiction in the United States.

2521 (iv) The trust shall vest legal title to its assets in its one or more trustees for the benefit  
2522 of:

2523 (A) a United States ceding insurer of the assuming insurer;

2524 (B) an assign of the United States ceding insurer; or

2525 (C) a successor in interest to the United States ceding insurer.

2526 (v) The trust and the assuming insurer are subject to examination as determined by the  
2527 commissioner.

2528 (vi) The trust shall remain in effect for as long as the assuming insurer has an  
2529 outstanding obligation due under a reinsurance agreement subject to the trust.

2530 (vii) No later than February 28 of each year, the trustee of the trust shall:

2531 (A) report to the commissioner in writing the balance of the trust;

2532 (B) list the trust's investments at the end of the preceding calendar year; and

2533 (C) (I) certify the date of termination of the trust, if so planned; or

2534 (II) certify that the trust will not expire [~~prior to~~] before the following December 31.

2535 (d) The following requirements apply to the following categories of assuming insurer:

2536 (i) For a single assuming insurer:

2537 (A) the trust fund shall consist of funds in trust in an amount not less than the assuming  
2538 insurer's liabilities attributable to reinsurance ceded by United States ceding insurers; and

2539 (B) the assuming insurer shall maintain a trustee surplus of not less than \$20,000,000,  
2540 except as provided in Subsection (6)(d)(ii).

2541 (ii) (A) At any time after the assuming insurer has permanently discontinued  
2542 underwriting new business secured by the trust for at least three full years, the commissioner  
2543 with principal regulatory oversight of the trust may authorize a reduction in the required  
2544 trustee surplus, but only after a finding, based on an assessment of the risk, that the new  
2545 required surplus level is adequate for the protection of United States ceding insurers,  
2546 policyholders, and claimants in light of reasonably foreseeable adverse loss development.

2547 (B) The risk assessment may involve an actuarial review, including an independent  
2548 analysis of reserves and cash flows, and shall consider all material risk factors, including, when  
2549 applicable, the lines of business involved, the stability of the incurred loss estimates, and the  
2550 effect of the surplus requirements on the assuming insurer's liquidity or solvency.

2551 (C) The minimum required trustee surplus may not be reduced to an amount less than  
2552 30% of the assuming insurer's liabilities attributable to reinsurance ceded by United States  
2553 ceding insurers covered by the trust.

2554 (iii) For a group acting as assuming insurer, including incorporated and individual  
2555 unincorporated underwriters:

2556 (A) for reinsurance ceded under a reinsurance agreement with an inception,  
2557 amendment, or renewal date on or after August 1, 1995, the trust shall consist of a trustee  
2558 account in an amount not less than the respective underwriters' several liabilities attributable to  
2559 business ceded by the one or more United States domiciled ceding insurers to an underwriter of  
2560 the group;

2561 (B) for reinsurance ceded under a reinsurance agreement with an inception date on or  
2562 before July 31, 1995, and not amended or renewed after July 31, 1995, notwithstanding the  
2563 other provisions of this chapter, the trust shall consist of a trustee account in an amount not  
2564 less than the respective underwriters' several insurance and reinsurance liabilities attributable to  
2565 business written in the United States;

2566 (C) in addition to a trust described in Subsection (6)(d)(iii)(A) or (B), the group shall  
2567 maintain in trust a trustee surplus of which \$100,000,000 is held jointly for the benefit of the

2568 one or more United States domiciled ceding insurers of a member of the group for all years of  
2569 account;

2570 (D) the incorporated members of the group:

2571 (I) may not be engaged in a business other than underwriting as a member of the group;  
2572 and

2573 (II) are subject to the same level of regulation and solvency control by the group's  
2574 domiciliary regulator as are the unincorporated members; and

2575 (E) within 90 days after the day on which the group's financial statements are due to be  
2576 filed with the group's domiciliary regulator, the group shall provide to the commissioner:

2577 (I) an annual certification by the group's domiciliary regulator of the solvency of each  
2578 underwriter member; or

2579 (II) if a certification is unavailable, a financial statement, prepared by an independent  
2580 public accountant, of each underwriter member of the group.

2581 (iv) For a group of incorporated underwriters under common administration, the group  
2582 shall:

2583 (A) have continuously transacted an insurance business outside the United States for at  
2584 least three years immediately preceding the day on which the group makes application for  
2585 accreditation;

2586 (B) maintain aggregate policyholders' surplus of at least \$10,000,000,000;

2587 (C) maintain a trust fund in an amount not less than the group's several liabilities  
2588 attributable to business ceded by the one or more United States domiciled ceding insurers to a  
2589 member of the group pursuant to a reinsurance contract issued in the name of the group;

2590 (D) in addition to complying with the other provisions of this Subsection (6)(d)(iv),  
2591 maintain a joint trusted surplus of which \$100,000,000 is held jointly for the benefit of the one  
2592 or more United States domiciled ceding insurers of a member of the group as additional  
2593 security for these liabilities; and

2594 (E) within 90 days after the day on which the group's financial statements are due to be  
2595 filed with the group's domiciliary regulator, make available to the commissioner:

2596 (I) an annual certification of each underwriter member's solvency by the member's  
2597 domiciliary regulator; and

2598 (II) a financial statement of each underwriter member of the group prepared by an

2599 independent public accountant.

2600 ~~[(7) If reinsurance is ceded to an assuming insurer not meeting the requirements of~~  
2601 ~~Subsection (3), (4), (5), or (6), a domestic ceding insurer is allowed credit only as to the~~  
2602 ~~insurance of a risk located in a jurisdiction where the reinsurance is required by applicable law~~  
2603 ~~or regulation of that jurisdiction.]~~

2604 [(8)] (7) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an  
2605 assuming insurer that secures its obligations in accordance with this Subsection [(8)] (7):

2606 (a) The insurer shall be certified by the commissioner as a reinsurer in this state.

2607 (b) To be eligible for certification, the assuming insurer shall:

2608 (i) be domiciled and licensed to transact insurance or reinsurance in a qualified  
2609 jurisdiction, as determined by the commissioner pursuant to Subsection [(8)] (7)(d);

2610 (ii) maintain minimum capital and surplus, or its equivalent, in an amount to be  
2611 determined by the commissioner pursuant to rules made in accordance with Title 63G, Chapter  
2612 3, Utah Administrative Rulemaking Act;

2613 (iii) maintain financial strength ratings from two or more rating agencies considered  
2614 acceptable by the commissioner pursuant to rules made in accordance with Title 63G, Chapter  
2615 3, Utah Administrative Rulemaking Act; and

2616 (iv) agree to:

2617 (A) submit to the jurisdiction of this state;

2618 (B) appoint the commissioner as its agent for service of process in this state;

2619 (C) provide security for 100% of the assuming insurer's liabilities attributable to  
2620 reinsurance ceded by United States ceding insurers if it resists enforcement of a final United  
2621 States judgment;

2622 (D) agree to meet applicable information filing requirements as determined by the  
2623 commissioner including an application for certification, a renewal and on an ongoing basis; and

2624 (E) any other requirements for certification considered relevant by the commissioner.

2625 (c) An association, including incorporated and individual unincorporated underwriters,  
2626 may be a certified reinsurer. To be eligible for certification, in addition to satisfying  
2627 requirements of Subsections [(8)] (7)(a) and (b), the association:

2628 (i) shall satisfy its minimum capital and surplus requirements through the capital and  
2629 surplus equivalents, net of liabilities, of the association and its members, which shall include a

2630 joint central fund that may be applied to any unsatisfied obligation of the association or any of  
2631 its members in an amount determined by the commissioner to provide adequate protection;

2632 (ii) may not have incorporated members of the association engaged in any business  
2633 other than underwriting as a member of the association;

2634 (iii) shall be subject to the same level of regulation and solvency control of the  
2635 incorporated members of the association by the association's domiciliary regulator as are the  
2636 unincorporated members; and

2637 (iv) within 90 days after its financial statements are due to be filed with the  
2638 association's domiciliary regulator provide:

2639 (A) to the commissioner an annual certification by the association's domiciliary  
2640 regulator of the solvency of each underwriter member; or

2641 (B) if a certification is unavailable, financial statements prepared by independent  
2642 public accountants, of each underwriter member of the association.

2643 (d) The commissioner shall create and publish a list of qualified jurisdictions under  
2644 which an assuming insurer licensed and domiciled in the jurisdiction is eligible to be  
2645 considered for certification by the commissioner as a certified reinsurer.

2646 (i) To determine whether the domiciliary jurisdiction of a non-United States assuming  
2647 insurer is eligible to be recognized as a qualified jurisdiction, the commissioner:

2648 (A) shall evaluate the appropriateness and effectiveness of the reinsurance supervisory  
2649 system of the jurisdiction, both initially and on an ongoing basis;

2650 (B) shall consider the rights, the benefits, and the extent of reciprocal recognition  
2651 afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the  
2652 United States;

2653 (C) shall require the qualified jurisdiction to share information and cooperate with the  
2654 commissioner with respect to all certified reinsurers domiciled within that jurisdiction; and

2655 (D) may not recognize a jurisdiction as a qualified jurisdiction if the commissioner has  
2656 determined that the jurisdiction does not adequately and promptly enforce final United States  
2657 judgments and arbitration awards.

2658 (ii) The commissioner may consider additional factors in determining a qualified  
2659 jurisdiction.

2660 (iii) A list of qualified jurisdictions shall be published through the National

2661 Association of Insurance Commissioners' Committee Process and the commissioner shall:

2662 (A) consider this list in determining qualified jurisdictions; and

2663 (B) if the commissioner approves a jurisdiction as qualified that does not appear on the

2664 National Association of Insurance Commissioner's list of qualified jurisdictions, provide

2665 thoroughly documented justification in accordance with criteria to be developed by rule made

2666 in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

2667 (iv) United States jurisdictions that meet the requirement for accreditation under the

2668 National Association of Insurance Commissioners' financial standards and accreditation

2669 program shall be recognized as qualified jurisdictions.

2670 (v) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction,

2671 the commissioner may suspend the reinsurer's certification indefinitely, in lieu of revocation.

2672 (e) The commissioner shall:

2673 (i) assign a rating to each certified reinsurer, giving due consideration to the financial

2674 strength ratings that have been assigned by rating agencies considered acceptable to the

2675 commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative

2676 Rulemaking Act; and

2677 (ii) publish a list of all certified reinsurers and their ratings.

2678 (f) A certified reinsurer shall secure obligations assumed from United States ceding

2679 insurers under this Subsection [~~(8)~~] (7) at a level consistent with its rating, as specified in rules

2680 made by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative

2681 Rulemaking Act.

2682 (i) For a domestic ceding insurer to qualify for full financial statement credit for

2683 reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a

2684 form acceptable to the commissioner and consistent with Section 31A-17-404.1, or in a

2685 multibeneficiary trust in accordance with Subsections (5), (6), and [~~(7)~~] (9), except as

2686 otherwise provided in this Subsection [~~(8)~~] (7).

2687 (ii) If a certified reinsurer maintains a trust to fully secure its obligations subject to

2688 Subsections (5), (6), and [~~(7)~~] (9), and chooses to secure its obligations incurred as a certified

2689 reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate

2690 trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a

2691 certified reinsurer with reduced security as permitted by this Subsection [~~(8)~~] (7) or comparable

2692 laws of other United States jurisdictions and for its obligations subject to Subsections (5), (6),  
2693 and ~~[(7)]~~ (9).

2694 (iii) It shall be a condition to the grant of certification under this Subsection ~~[(8)]~~ (7)  
2695 that the certified reinsurer shall have bound itself:

2696 (A) by the language of the trust and agreement with the commissioner with principal  
2697 regulatory oversight of the trust account; and

2698 (B) upon termination of the trust account, to fund, out of the remaining surplus of the  
2699 trust, any deficiency of any other trust account.

2700 (iv) The minimum trustee surplus requirements provided in Subsections (5), (6), and  
2701 ~~[(7)]~~ (9) are not applicable with respect to a multibeneficiary trust maintained by a certified  
2702 reinsurer for the purpose of securing obligations incurred under this Subsection ~~[(8)]~~ (7),  
2703 except that the trust shall maintain a minimum trustee surplus of \$10,000,000.

2704 (v) With respect to obligations incurred by a certified reinsurer under this Subsection  
2705 ~~[(8)]~~ (7), if the security is insufficient, the commissioner:

2706 (A) shall reduce the allowable credit by an amount proportionate to the deficiency; and

2707 (B) may impose further reductions in allowable credit upon finding that there is a  
2708 material risk that the certified reinsurer's obligations will not be paid in full when due.

2709 (vi) For purposes of this Subsection ~~[(8)]~~ (7), a certified reinsurer whose certification  
2710 has been terminated for any reason shall be treated as a certified reinsurer required to secure  
2711 100% of its obligations.

2712 (A) As used in this Subsection ~~[(8)]~~ (7), the term "terminated" refers to revocation,  
2713 suspension, voluntary surrender, and inactive status.

2714 (B) If the commissioner continues to assign a higher rating as permitted by other  
2715 provisions of this section, the requirement under this Subsection ~~[(8)]~~ (7)(f)(vi) does not apply  
2716 to a certified reinsurer in inactive status or to a reinsurer whose certification has been  
2717 suspended.

2718 (g) If an applicant for certification has been certified as a reinsurer in a National  
2719 Association of Insurance Commissioners' accredited jurisdiction, the commissioner may:

2720 (i) defer to that jurisdiction's certification;

2721 (ii) defer to the rating assigned by that jurisdiction; and

2722 (iii) consider such reinsurer to be a certified reinsurer in this state.



2723 (h) (i) A certified reinsurer that ceases to assume new business in this state may request  
2724 to maintain its certification in inactive status in order to continue to qualify for a reduction in  
2725 security for its in-force business.

2726 (ii) An inactive certified reinsurer shall continue to comply with all applicable  
2727 requirements of this Subsection [~~(8)~~] (7).

2728 (iii) The commissioner shall assign a rating to a reinsurer that qualifies under this  
2729 Subsection [~~(8)~~] (7)(h), that takes into account, if relevant, the reasons why the reinsurer is not  
2730 assuming new business.

2731 (8) (a) As used in this Subsection (8):

2732 (i) "Covered agreement" means an agreement entered into pursuant to Dodd-Frank  
2733 Wall Street Reform and Consumer Protection Act, 31 U.S.C. Sections 313 and 314, that is  
2734 currently in effect or in a period of provisional application and addresses the elimination, under  
2735 specified conditions, of collateral requirements as a condition for entering into any reinsurance  
2736 agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to  
2737 recognize credit for reinsurance.

2738 (ii) "Reciprocal jurisdiction" means a jurisdiction that is:

2739 (A) a non-United States jurisdiction that is subject to an in-force covered agreement  
2740 with the United States, each within its legal authority, or, in the case of a covered agreement  
2741 between the United States and European Union, is a member state of the European Union;

2742 (B) a United States jurisdiction that meets the requirements for accreditation under the  
2743 National Association of Insurance Commissioners' financial standards and accreditation  
2744 program; or

2745 (C) a qualified jurisdiction, as determined by the commissioner in accordance with  
2746 Subsection (7)(d), that is not otherwise described in this Subsection (8)(a)(ii) and meets certain  
2747 additional requirements, consistent with the terms and conditions of in-force covered  
2748 agreements, as specified by the commissioner in rule made in accordance with Title 63G,  
2749 Chapter 3, Utah Administrative Rulemaking Act.

2750 (b) (i) Credit shall be allowed when the reinsurance is ceded to an assuming insurer  
2751 meeting each of the conditions set forth in this Subsection (8)(b).

2752 (ii) The assuming insurer must have its head office or be domiciled in, as applicable,  
2753 and be licensed in a reciprocal jurisdiction.

2754 (iii) (A) The assuming insurer must have and maintain, on an ongoing basis, minimum  
2755 capital and surplus, or its equivalent, calculated according to the methodology of its  
2756 domiciliary jurisdiction, in an amount to be set forth in regulation.

2757 (B) If the assuming insurer is an association, including incorporated and individual  
2758 unincorporated underwriters, it must have and maintain, on an ongoing basis, minimum capital  
2759 and surplus equivalents (net of liabilities), calculated according to the methodology applicable  
2760 in its domiciliary jurisdiction, and a central fund containing a balance in amounts to be set forth  
2761 in regulation.

2762 (iv) (A) The assuming insurer must have and maintain, on an ongoing basis, a  
2763 minimum solvency or capital ration, as applicable, which will be set forth in regulation.

2764 (B) If the assuming insurer is an association, including incorporated and individual  
2765 unincorporated underwriters, it must have and maintain, on an ongoing basis, a minimum  
2766 solvency or capital ratio in the reciprocal jurisdiction where the assuming insurer has its head  
2767 office or is domiciled, as applicable, and is also licensed.

2768 (v) The assuming insurer must agree and provide adequate assurance to the  
2769 commissioner, in a form specified by the commissioner by rule made in accordance with Title  
2770 63G, Chapter 3, Utah Administrative Rulemaking Act, as follows:

2771 (A) the assuming insurer must provide prompt written notice and explanation to the  
2772 commissioner if it falls below the minimum requirements set forth in Subsections (8)(c) or (d),  
2773 or if any regulatory action is taken against it for serious noncompliance with applicable law;

2774 (B) the assuming insurer must consent in writing to the jurisdiction of the courts of this  
2775 state and to the appointment of the commissioner as agent for service of process, however the  
2776 commissioner may require that consent for service of process be provided to the commissioner  
2777 and included in each reinsurance agreement and nothing in this provision shall limit, or in any  
2778 way alter, the capacity of parties to a reinsurance agreement to agree to alternative dispute  
2779 resolution mechanisms, except to the extent such agreements are unenforceable under  
2780 applicable insolvency or delinquency laws;

2781 (C) the assuming insurer must consent in writing to pay all final judgments, wherever  
2782 enforcement is sought, obtained by a ceding insurer or its legal successor, that have been  
2783 declared enforceable in the jurisdiction where the judgment was obtained;

2784 (D) each reinsurance agreement must include a provision requiring the assuming

2785 insurer to provide security in an amount equal to 100% of the assuming insurer's liabilities  
2786 attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists  
2787 enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it  
2788 was obtained or a properly enforceable arbitration award, whether obtained by the ceding  
2789 insurer or by its legal successor on behalf of its resolution estate; and

2790 (E) the assuming insurer must confirm that it is not presently participating in any  
2791 solvent scheme of arrangement which involved this state's ceding insurers, and agree to notify  
2792 the ceding insurer and the commissioner and to provide security:

2793 (I) in an amount equal to 100% of the assuming insurer's liabilities to the ceding  
2794 insurer, should the assuming insurer enter into such a solvent scheme of arrangement; and

2795 (II) in a form consistent with the provisions of Subsections (7) and (10) and as  
2796 specified by the commissioner in regulation.

2797 (vi) The assuming insurer or its legal successor must provide, if requested by the  
2798 commissioner, on behalf of itself and any legal predecessors, certain documentation to the  
2799 commissioner, as specified by the commissioner by rule made in accordance with Title 63G,  
2800 Chapter 3, Utah Administrative Rulemaking Act.

2801 (vii) The assuming insurer must maintain a practice of prompt payment of claims under  
2802 reinsurance agreements, pursuant to criteria set forth in rule made in accordance with Title  
2803 63G, Chapter 3, Utah Administrative Rulemaking Act.

2804 (viii) The assuming insurer's supervisory authority must confirm to the commissioner  
2805 on an annual basis, as of the preceding December 31 or at the annual date otherwise statutorily  
2806 reported to the reciprocal jurisdiction, that the assuming insurer complies with the requirements  
2807 set forth in Subsections (8)(c) and (d).

2808 (ix) Nothing in this provision precludes an assuming insurer from providing the  
2809 commissioner with information on a voluntary basis.

2810 (c) (i) The commissioner shall timely create and publish a list of reciprocal  
2811 jurisdictions.

2812 (ii) (A) A list of reciprocal jurisdictions is published through the National Association  
2813 of Insurance Commissioners' Committee Process.

2814 (B) The commissioner's list of reciprocal jurisdictions shall include any reciprocal  
2815 jurisdiction as defined in this Subsection (8), and shall consider any other reciprocal

2816 jurisdictions in accordance with the criteria developed under rule made in accordance with  
2817 Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

2818 (iii) (A) The commissioner may remove a jurisdiction from the list of reciprocal  
2819 jurisdictions upon a determination that the jurisdiction no longer meets the requirements of a  
2820 reciprocal jurisdiction, in accordance with a process set forth in rule made in accordance with  
2821 Title 63G, Chapter 3, Utah Administrative Rulemaking Act, except that the commissioner shall  
2822 not remove from the list a reciprocal jurisdiction.

2823 (B) Upon removal of a reciprocal jurisdiction from this list, credit for reinsurance  
2824 ceded to an assuming insurer which has its home office or is domiciled in that jurisdiction shall  
2825 be allowed, if otherwise allowed under this chapter.

2826 (d) (i) The commissioner shall timely create and publish a list of assuming insurers that  
2827 have satisfied the conditions set forth in this subsection and to which cessions shall be granted  
2828 credit in accordance with this Subsection (8).

2829 (ii) The commissioner may add an assuming insurer to such list if a National  
2830 Association of Insurance Commissioners accredited jurisdiction has added such assuming  
2831 insurer to a list of such assuming insurers or if, upon initial eligibility, the assuming insurer  
2832 submits the information to the commissioner as required under this Subsection (8) and  
2833 complies with any additional requirements that the commissioner may impose by rule made in  
2834 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, except to the  
2835 extent that they conflict with an applicable covered agreement.

2836 (e) (i) If the commissioner determines that an assuming insurer no longer meets one or  
2837 more of the requirements under this Subsection (8), the commissioner may revoke or suspend  
2838 the eligibility of the assuming insurer for recognition under this Subsection (8) in accordance  
2839 with procedures established in rule made in accordance with Title 63G, Chapter 3, Utah  
2840 Administrative Rulemaking Act.

2841 (ii) (A) While an assuming insurer's eligibility is suspended, no reinsurance agreement  
2842 issued, amended, or renewed after the effective date of the suspension qualifies for credit  
2843 except to the extent that the assuming insurer's obligations under the contract are secured in  
2844 accordance with Subsection (10).

2845 (B) If an assuming insurer's eligibility is revoked, no credit for reinsurance may be  
2846 granted after the effective date of the revocation with respect to any reinsurance agreements

2847 entered into by the assuming insurer, including reinsurance agreements entered into prior to the  
2848 date of revocation, except to the extent that the assuming insurer's obligations under the  
2849 contract are secured in a form acceptable to the commissioner and consistent with the  
2850 provisions of Subsection (10).

2851 (f) If subject to a legal process of rehabilitation, liquidation, or conservation, as  
2852 applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by  
2853 the court in which the proceedings are pending, may obtain an order requiring that the  
2854 assuming insurer post security for all outstanding ceded liabilities.

2855 (g) Nothing in this Subsection (8) limits or in any way alters the capacity of parties to a  
2856 reinsurance agreement to agree on requirements for security or other terms in that reinsurance  
2857 agreement, except as expressly prohibited by this chapter or other applicable law or regulation.

2858 (h) (i) Credit may be taken under this Subsection (8) only for reinsurance agreements  
2859 entered into, amended, or renewed on or after the effective date of the statute adding this  
2860 Subsection (8), and only with respect to losses incurred and reserves reported on or after the  
2861 later of:

2862 (A) the date on which the assuming insurer has met all eligibility requirements  
2863 pursuant to Subsection (8)(b); and

2864 (B) the effective date of the new reinsurance agreement, amendment or renewal.

2865 (ii) This Subsection (8) does not alter or impair a ceding insurer's right to take credit  
2866 for reinsurance, to the extent that credit is not available under this Subsection (8), as long as the  
2867 reinsurance qualifies for credit under any other applicable provision of this chapter.

2868 (iii) Nothing in this Subsection (8) authorizes an assuming insurer to withdraw or  
2869 reduce the security provided under any reinsurance agreement except as permitted by the terms  
2870 of the agreement.

2871 (iv) Nothing in this Subsection (8) limits, or in any way alters, the capacity of parties to  
2872 any reinsurance agreement to renegotiate the agreement.

2873 (9) If reinsurance is ceded to an assuming insurer not meeting the requirements of  
2874 Subsection (3), (4), (5), (6), (7), or (8), a domestic ceding insurer is allowed credit only as to  
2875 the insurance of a risk located in a jurisdiction where the reinsurance is required by applicable  
2876 law or regulation of that jurisdiction.

2877 (10) (a) An asset or a reduction from liability for the reinsurance ceded by a domestic

2878 insurer to an assuming insurer not meeting the requirements of Subsection (3), (4), (5), (6), (7),  
2879 or (8) shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer.

2880 (b) The commissioner may adopt by rule made in accordance with Title 63G, Chapter  
2881 3, Utah Administrative Rulemaking Act, specific additional requirements relating to or setting  
2882 forth:

2883 (i) the valuation of assets or reserve credits;

2884 (ii) the amount and forms of security supporting reinsurance arrangements; and

2885 (iii) the circumstances pursuant to which credit will be reduced or eliminated.

2886 (c) (i) The reduction shall be in the amount of funds held by or on behalf of the ceding  
2887 insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with  
2888 the assuming insurer as security for the payment of obligations thereunder, if the security is:

2889 (A) held in the United States subject to withdrawal solely by, and under the exclusive  
2890 control of, the ceding insurer; or

2891 (B) in the case of a trust, held in a qualified United States financial institution.

2892 (ii) The security described in this Subsection (10)(c) may be in the form of:

2893 (A) cash;

2894 (B) securities listed by the Securities Valuation Office of the National Association of  
2895 Insurance Commissioners, including those deemed exempt from filing as defined by the  
2896 Purposes and Procedures Manual of the Securities Valuation Office, and qualifying as admitted  
2897 assets;

2898 (C) clean, irrevocable, unconditional letters of credit, issued or confirmed by a  
2899 qualified United States financial institution effective no later than December 31 of the year for  
2900 which the filing is being made, and in the possession of, or in trust for, the ceding insurer on or  
2901 before the filing date of its annual statement;

2902 (D) letters of credit meeting applicable standards of issuer acceptability as of the dates  
2903 of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's  
2904 subsequent failure to meet applicable standards of issuer acceptability, continue to be  
2905 acceptable as security until their expiration, extension, renewal, modification or amendment,  
2906 whichever first occurs; or

2907 (E) any other form of security acceptable to the commissioner.

2908 [~~(9)~~] (11) Reinsurance credit may not be allowed a domestic ceding insurer unless the

2909 assuming insurer under the reinsurance contract submits to the jurisdiction of Utah courts by:

2910 (a) (i) being an admitted insurer; and

2911 (ii) submitting to jurisdiction under Section 31A-2-309;

2912 (b) having irrevocably appointed the commissioner as the domestic ceding insurer's  
2913 agent for service of process in an action arising out of or in connection with the reinsurance,  
2914 which appointment is made under Section 31A-2-309; or

2915 (c) agreeing in the reinsurance contract:

2916 (i) that if the assuming insurer fails to perform its obligations under the terms of the  
2917 reinsurance contract, the assuming insurer, at the request of the ceding insurer, shall:

2918 (A) submit to the jurisdiction of a court of competent jurisdiction in a state of the  
2919 United States;

2920 (B) comply with all requirements necessary to give the court jurisdiction; and

2921 (C) abide by the final decision of the court or of an appellate court in the event of an  
2922 appeal; and

2923 (ii) to designate the commissioner or a specific attorney licensed to practice law in this  
2924 state as its attorney upon whom may be served lawful process in an action, suit, or proceeding  
2925 instituted by or on behalf of the ceding company.

2926 ~~[(10)]~~ (12) Submitting to the jurisdiction of Utah courts under Subsection ~~[(9)]~~ (11)  
2927 does not override a duty or right of a party under the reinsurance contract, including a  
2928 requirement that the parties arbitrate their disputes.

2929 ~~[(11)]~~ (13) If an assuming insurer does not meet the requirements of Subsection (3),  
2930 (4), ~~[(5)]~~ (5), ~~or (8)]~~, the credit permitted by Subsection (6) or ~~[(8)]~~ (7) may not be allowed  
2931 unless the assuming insurer agrees in the trust instrument to the following conditions:

2932 (a) (i) Notwithstanding any other provision in the trust instrument, if an event  
2933 described in Subsection ~~[(11)]~~ (13)(a)(ii) occurs the trustee shall comply with:

2934 (A) an order of the commissioner with regulatory oversight over the trust; or

2935 (B) an order of a court of competent jurisdiction directing the trustee to transfer to the  
2936 commissioner with regulatory oversight all of the assets of the trust fund.

2937 (ii) This Subsection ~~[(11)]~~ (13)(a) applies if:

2938 (A) the trust fund is inadequate because the trust contains an amount less than the  
2939 amount required by Subsection (6)(d); or

2940 (B) the grantor of the trust is:  
2941 (I) declared insolvent; or  
2942 (II) placed into receivership, rehabilitation, liquidation, or similar proceeding under the  
2943 laws of its state or country of domicile.

2944 (b) The assets of a trust fund described in Subsection [~~(11)~~] (13)(a) shall be distributed  
2945 by and a claim shall be filed with and valued by the commissioner with regulatory oversight in  
2946 accordance with the laws of the state in which the trust is domiciled that are applicable to the  
2947 liquidation of a domestic insurance company.

2948 (c) If the commissioner with regulatory oversight determines that the assets of the trust  
2949 fund, or any part of the assets, are not necessary to satisfy the claims of the one or more United  
2950 States ceding insurers of the grantor of the trust, the assets, or a part of the assets, shall be  
2951 returned by the commissioner with regulatory oversight to the trustee for distribution in  
2952 accordance with the trust instrument.

2953 (d) A grantor shall waive any right otherwise available to it under United States law  
2954 that is inconsistent with this Subsection [~~(11)~~] (13).

2955 [~~(12)~~] (14) If an accredited or certified reinsurer ceases to meet the requirements for  
2956 accreditation or certification, the commissioner may suspend or revoke the reinsurer's  
2957 accreditation or certification.

2958 (a) The commissioner shall give the reinsurer notice and opportunity for hearing.

2959 (b) The suspension or revocation may not take effect until after the commissioner's  
2960 order after a hearing, unless:

2961 (i) the reinsurer waives its right to hearing;

2962 (ii) the commissioner's order is based on:

2963 (A) regulatory action by the reinsurer's domiciliary jurisdiction; or

2964 (B) the voluntary surrender or termination of the reinsurer's eligibility to transact  
2965 insurance or reinsurance business in its domiciliary jurisdiction or primary certifying state  
2966 under Subsection [~~(8)~~] (7)(g); or

2967 (iii) the commissioner's finding that an emergency requires immediate action and a  
2968 court of competent jurisdiction has not stayed the commissioner's action.

2969 (c) While a reinsurer's accreditation or certification is suspended, no reinsurance  
2970 contract issued or renewed after the effective date of the suspension qualifies for credit except



2971 to the extent that the reinsurer's obligations under the contract are secured in accordance with  
 2972 Section [31A-17-404.1](#).

2973 (d) If a reinsurer's accreditation or certification is revoked, no credit for reinsurance  
 2974 may be granted after the effective date of the revocation except to the extent that the reinsurer's  
 2975 obligations under the contract are secured in accordance with Subsection ~~[(8)]~~ (7)(f) or Section  
 2976 [31A-17-404.1](#).

2977 ~~[(13)]~~ (15) (a) A ceding insurer shall take steps to manage its reinsurance recoverables  
 2978 proportionate to its own book of business.

2979 (b) (i) A domestic ceding insurer shall notify the commissioner within 30 days after  
 2980 reinsurance recoverables from any single assuming insurer, or group of affiliated assuming  
 2981 insurers:

2982 (A) exceeds 50% of the domestic ceding insurer's last reported surplus to  
 2983 policyholders; or

2984 (B) after it is determined that reinsurance recoverables from any single assuming  
 2985 insurer, or group of affiliated assuming insurers, is likely to exceed 50% of the domestic ceding  
 2986 insurer's last reported surplus to policyholders.

2987 (ii) The notification required by Subsection ~~[(13)]~~ (15)(b)(i) shall demonstrate that the  
 2988 exposure is safely managed by the domestic ceding insurer.

2989 (c) A ceding insurer shall take steps to diversify its reinsurance program.

2990 (d) (i) A domestic ceding insurer shall notify the commissioner within 30 days after  
 2991 ceding or being likely to cede more than 20% of the ceding insurer's gross written premium in  
 2992 the prior calendar year to any:

2993 (A) single assuming insurer; or

2994 (B) group of affiliated assuming insurers.

2995 (ii) The notification shall demonstrate that the exposure is safely managed by the  
 2996 domestic ceding insurer.

2997 Section 17. Section **31A-17-404.3** is amended to read:

2998 **31A-17-404.3. Rules.**

2999 (1) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and  
 3000 this chapter, the commissioner may make rules prescribing:

3001 (a) the form of a letter of credit required under this chapter;

- 3002 (b) the requirements for a trust or trust instrument required by this chapter;
- 3003 (c) the procedures for licensing and accrediting;
- 3004 (d) minimum capital and surplus requirements;
- 3005 (e) additional requirements relating to calculation of credit allowed a domestic ceding
- 3006 insurer against reserves for reinsurance under Section 31A-17-404; and
- 3007 (f) additional requirements relating to calculation of asset reduction from liability for
- 3008 reinsurance ceded by a domestic insurer to other ceding insurers under Section 31A-17-404.1.

3009 (2) A rule made pursuant to Subsection (1)(e) or (f) may apply to reinsurance relating

3010 to:

3011 (a) a life insurance policy with guaranteed nonlevel gross premiums or guaranteed

3012 nonlevel benefits;

3013 (b) a universal life insurance policy with provisions resulting in the ability of a

3014 policyholder to keep a policy in force over a secondary guarantee period;

3015 (c) a variable annuity with guaranteed death or living benefits;

3016 (d) a long-term care insurance policy; or

3017 (e) such other life and health insurance or annuity product as to which the National

3018 Association of Insurance Commissioners adopts model regulatory requirements with respect

3019 for credit for reinsurance.

3020 (3) A rule adopted pursuant to Subsection (1)(e) or (f) may apply to a treaty containing:

3021 (a) a policy issued on or after January 1, 2015; and

3022 (b) a policy issued before January 1, 2015, if risk pertaining to the policy is ceded in

3023 connection with the treaty, either in whole or in part, on or after January 1, 2015.

3024 (4) A rule adopted pursuant to Subsection (1)(e) or (f) may require the ceding insurer,

3025 in calculating the amounts or forms of security required to be held under rules made under this

3026 section, to use the Valuation Manual adopted by the National Association of Insurance

3027 Commissioners under Section 11B(1) of the National Association of Insurance Commissioners

3028 Standard Valuation Law, including all amendments adopted by the National Association of

3029 Insurance Commissioners and in effect on the date as of which the calculation is made, to the

3030 extent applicable.

3031 (5) A rule adopted pursuant to Subsection (1)(e) or (f) may not apply to cessions to an

3032 assuming insurer that:

3033 (a) meets the conditions established in Subsection 31A-17-404(8);  
3034 ~~[(a)] (b) is certified in this state [or, if this state has not adopted provisions~~  
3035 ~~substantially equivalent to Section 2E of the Credit for Reinsurance Model Law, certified in a~~  
3036 ~~minimum of five other states]; or~~  
3037 ~~[(b)] (c) maintains at least \$250,000,000 in capital and surplus when determined in~~  
3038 ~~accordance with the National Association of Insurance Commissioners Accounting Practices~~  
3039 ~~and Procedures Manual, including all amendments thereto adopted by the National Association~~  
3040 ~~of Insurance Commissioners, excluding the impact of any permitted or prescribed practices and~~  
3041 ~~is:~~  
3042 (i) licensed in at least 26 states; or  
3043 (ii) licensed in at least 10 states, and licensed or accredited in a total of at least 35  
3044 states.  
3045 (6) The authority to adopt rules pursuant to Subsection (1)(e) or (f) does not otherwise  
3046 limit the commissioner's general authority to make rules pursuant to Subsection (1).  
3047 Section 18. Section **31A-17-601** is amended to read:  
3048 **31A-17-601. Definitions.**  
3049 As used in this part:  
3050 (1) "Adjusted RBC report" means an RBC report that has been adjusted by the  
3051 commissioner in accordance with Subsection 31A-17-602(5).  
3052 (2) "Corrective order" means an order issued by the commissioner specifying  
3053 corrective action that the commissioner determines is required.  
3054 (3) "Health organization" means:  
3055 (a) an entity that is authorized under Chapter 7, Nonprofit Health Service Insurance  
3056 Corporations, or Chapter 8, Health Maintenance Organizations and Limited Health Plans; and  
3057 (b) that is:  
3058 (i) a health maintenance organization;  
3059 (ii) a limited health service organization;  
3060 (iii) a dental or vision plan;  
3061 (iv) a hospital, medical, and dental indemnity or service corporation; or  
3062 (v) other managed care organization.  
3063 (4) "Life or accident and health insurer" means:

3064 (a) an insurance company licensed to write life insurance, disability insurance, or both;  
3065 or

3066 (b) a licensed property casualty insurer writing only disability insurance.

3067 (5) "Property and casualty insurer" means any insurance company licensed to write  
3068 lines of insurance other than life but does not include a monoline mortgage guaranty insurer,  
3069 financial guaranty insurer, or title insurer.

3070 (6) "RBC" means risk-based capital.

3071 (7) "RBC instructions" means the RBC report including the National Association of  
3072 Insurance Commissioner's risk-based capital instructions [~~adopted by the department by rule~~]  
3073 that govern the year for which an RBC report is prepared.

3074 (8) "RBC level" means an insurer's or health organization's authorized control level  
3075 RBC, company action level RBC, mandatory control level RBC, or regulatory action level  
3076 RBC.

3077 (a) "Authorized control level RBC" means the number determined under the risk-based  
3078 capital formula in accordance with the RBC instructions;

3079 (b) "Company action level RBC" means the product of 2.0 and its authorized control  
3080 level RBC;

3081 (c) "Mandatory control level RBC" means the product of .70 and the authorized control  
3082 level RBC; and

3083 (d) "Regulatory action level RBC" means the product of 1.5 and its authorized control  
3084 level RBC.

3085 (9) (a) "RBC plan" means a comprehensive financial plan containing the elements  
3086 specified in Subsection [31A-17-603\(2\)](#).

3087 (b) Notwithstanding Subsection (9)(a), the plan is a "revised RBC plan" if:

3088 (i) the commissioner rejects the RBC plan; and

3089 (ii) the plan is revised by the insurer or health organization, with or without the  
3090 commissioner's recommendation.

3091 (10) "RBC report" means the report required in Section [31A-17-602](#).

3092 Section 19. Section [31A-19a-404](#) is amended to read:

3093 **31A-19a-404. Designated rate service organization.**

3094 (1) For purposes of workers' compensation insurance, the commissioner shall designate

3095 one rate service organization to:

3096 (a) develop and administer the uniform statistical plan, uniform classification plan, and  
3097 uniform experience rating plan filed with and approved by the commissioner;

3098 (b) assist the commissioner in gathering, compiling, and reporting relevant statistical  
3099 information on an aggregate basis;

3100 (c) develop and file manual rules, subject to the approval of the commissioner, that are  
3101 reasonably related to the recording and reporting of data pursuant to the uniform statistical  
3102 plan, uniform experience rating plan, and the uniform classification plan; and

3103 (d) develop and file the [~~prospective~~] advisory loss costs pursuant to Section  
3104 [31A-19a-406](#).

3105 (2) The uniform experience rating plan shall:

3106 (a) contain reasonable eligibility standards;

3107 (b) provide adequate incentives for loss prevention; and

3108 (c) provide for sufficient premium differentials so as to encourage safety.

3109 (3) Each workers' compensation insurer, directly or through its selected rate service  
3110 organization, shall:

3111 (a) record and report its workers' compensation experience to the designated rate  
3112 service organization as set forth in the uniform statistical plan approved by the commissioner;  
3113 and

3114 (b) adhere to a uniform classification plan and uniform experience rating plan filed  
3115 with the commissioner by the rate service organization designated by the commissioner[~~; and~~].

3116 [~~(c) adhere to the prospective loss costs filed by the designated rate service~~  
3117 ~~organization.~~]

3118 (4) The commissioner may adopt rules for:

3119 (a) the development and administration by the designated rate service organization of  
3120 the:

3121 (i) uniform statistical plan;

3122 (ii) uniform experience rating plan; and

3123 (iii) uniform classification plan;

3124 (b) the recording and reporting of statistical data and experience rating data by the  
3125 various insurers writing workers' compensation insurance;

3126 (c) the selection, retention, and termination of the designated rate service organization;  
3127 and

3128 (d) providing for the equitable sharing and recovery of the expense of the designated  
3129 rate service organization to develop, maintain, and provide the plans, services, and filings that  
3130 are used by the various insurers writing workers' compensation insurance.

3131 (5) (a) Notwithstanding Subsection (3), an insurer may develop directly or through its  
3132 selected rate service organization subclassifications of the uniform classification system upon  
3133 which a rate may be made.

3134 (b) A subclassification shall be filed with the commissioner 30 days before its use.

3135 (c) The commissioner shall disapprove subclassifications if the insurer fails to  
3136 demonstrate that the data produced by the subclassifications can be reported consistently with  
3137 the uniform statistical plan and uniform classification plan.

3138 (6) Notwithstanding Subsection (3), an insurer may, directly or though its selected rate  
3139 service organization, develop its own experience modifications based on the uniform statistical  
3140 plan, uniform classification plan, and uniform rating plan filed by the rate service organization  
3141 designated by the commissioner under Subsection (1).

3142 Section 20. Section **31A-19a-405** is amended to read:

3143 **31A-19a-405. Filing of rates and other rating information.**

3144 (1) (a) All workers' compensation rates, supplementary rate information, and supporting  
3145 information shall be filed at least 30 days before the effective date of the rate or information.

3146 (b) Notwithstanding Subsection (1)(a), on application by the filer, the commissioner  
3147 may authorize an earlier effective date.

3148 (2) The loss and loss adjustment expense factors included in the rates filed under  
3149 Subsection (1) shall be:

3150 (a) the [prospective] advisory loss costs filed by the designated rate service  
3151 organization under Section 31A-19a-406[-]; or

3152 (b) a percent modification of the advisory loss costs filed by the designated rate service  
3153 organization under Section 31A-19a-406.

3154 (3) A modification filed under Subsection (2)(b) shall be accompanied by adequate  
3155 support as required by Part 2, General Rate Regulation.

3156 Section 21. Section **31A-19a-406** is amended to read:

3157 **31A-19a-406. Filing requirements for designated rate service organization.**

3158 (1) The rate service organization designated under Section 31A-19a-404 shall file with  
3159 the commissioner the following items proposed for use in this state at least 30 calendar days  
3160 before the ~~[date they]~~ day on which the items are distributed to members, subscribers, or  
3161 others:

- 3162 (a) each ~~[prospective]~~ advisory loss cost with its supporting information;  
3163 (b) the uniform classification plan and rating manual;  
3164 (c) the uniform experience rating plan manual;  
3165 (d) the uniform statistical plan manual; and  
3166 (e) each change, amendment, or modification of any of the items listed in Subsections  
3167 (1)(a) through (d).

3168 (2) (a) If the commissioner believes that ~~[prospective]~~ advisory loss costs filed violate  
3169 the excessive, inadequate, or unfair discriminatory standard in Section 31A-19a-201 or any  
3170 other applicable requirement of this part, the commissioner may require that the rate service  
3171 organization file additional supporting information.

3172 (b) If, after reviewing the supporting information, the commissioner determines that  
3173 the ~~[prospective]~~ advisory loss costs violate these requirements, the commissioner may:

- 3174 (i) require that adjustments to the ~~[prospective]~~ advisory loss costs be made; or  
3175 (ii) call a hearing for any purpose regarding the filing.

3176 Section 22. Section 31A-21-201 is amended to read:

3177 **31A-21-201. Filing of forms.**

3178 (1) (a) Except as exempted under Subsections 31A-21-101(2) through (6), a form may  
3179 not be used, sold, or offered for sale until the form is filed with the commissioner.

3180 (b) A form is considered filed with the commissioner when the commissioner receives:

- 3181 (i) the form;  
3182 (ii) the applicable filing fee as prescribed under Section 31A-3-103; and  
3183 (iii) the applicable transmittal forms as required by the commissioner.

3184 (2) In filing a form for use in this state the insurer is responsible for assuring that the  
3185 form is in compliance with this title and rules adopted by the commissioner.

3186 (3) (a) The commissioner may prohibit the use of a form at any time upon a finding  
3187 that:

3188 (i) the form:  
3189 (A) is inequitable;  
3190 (B) is unfairly discriminatory;  
3191 (C) is misleading;  
3192 (D) is deceptive;  
3193 (E) is obscure;  
3194 (F) is unfair;  
3195 (G) encourages misrepresentation; or  
3196 (H) is not in the public interest;  
3197 (ii) the form provides benefits or contains another provision that endangers the solidity  
3198 of the insurer;  
3199 (iii) except for a life or accident and health insurance policy form, the form is an  
3200 insurance policy or application for an insurance policy, that fails to conspicuously, as defined  
3201 by rule, provide:  
3202 (A) the exact name of the insurer; and  
3203 (B) the state of domicile of the insurer filing the insurance policy or application for the  
3204 insurance policy;  
3205 ~~[(iii)]~~ (iv) except an application required by Section 31A-22-635, ~~[the form is an~~  
3206 ~~insurance policy or application for an insurance policy]~~ the form is a life or accident and health  
3207 insurance policy form that fails to conspicuously, as defined by rule, provide:  
3208 (A) the exact name of the insurer;  
3209 (B) the state of domicile of the insurer filing the insurance policy or application for the  
3210 insurance policy; and  
3211 (C) for a life insurance ~~[and annuity insurance]~~ policy only, the address of the  
3212 administrative office of the insurer filing the ~~[insurance policy or application for the insurance~~  
3213 ~~policy]~~ form;  
3214 ~~[(iv)]~~ (v) the form violates a statute or a rule adopted by the commissioner; or  
3215 ~~[(v)]~~ (vi) the form is otherwise contrary to law.  
3216 (b) (i) When the commissioner prohibits the use of a form under Subsection (3)(a), the  
3217 commissioner may order that, on or before a date not less than 15 days after the order, the use  
3218 of the form be discontinued.



3219 (ii) Once use of a form is prohibited, the form may not be used until appropriate  
3220 changes are filed with and reviewed by the commissioner.

3221 (iii) When the commissioner prohibits the use of a form under Subsection (3)(a), the  
3222 commissioner may require the insurer to disclose contract deficiencies to the existing  
3223 policyholders.

3224 (c) If the commissioner prohibits use of a form under this Subsection (3), the  
3225 prohibition shall:

3226 (i) be in writing;

3227 (ii) constitute an order; and

3228 (iii) state the reasons for the prohibition.

3229 (4) (a) If, after a hearing, the commissioner determines that it is in the public interest,  
3230 the commissioner may require by rule or order that a form be subject to the commissioner's  
3231 approval before its use.

3232 (b) The rule or order described in Subsection (4)(a) shall prescribe the filing  
3233 procedures for a form if the procedures are different from the procedures stated in this section.

3234 (c) The type of form that under Subsection (4)(a) the commissioner may require  
3235 approval of before use includes:

3236 (i) a form for a particular class of insurance;

3237 (ii) a form for a specific line of insurance;

3238 (iii) a specific type of form; or

3239 (iv) a form for a specific market segment.

3240 (5) (a) An insurer shall maintain a complete and accurate record of the following for  
3241 the time period described in Subsection (5)(b):

3242 (i) a form:

3243 (A) filed under this section for use; or

3244 (B) that is in use; and

3245 (ii) a document filed under this section with a form described in Subsection (5)(a)(i).

3246 (b) The insurer shall maintain a record required under Subsection (5)(a) for the balance  
3247 of the current year, plus five years from:

3248 (i) the last day on which the form is used; or

3249 (ii) the last day an insurance policy that is issued using the form is in effect.

3250 Section 23. Section 31A-21-301 is amended to read:

3251 **31A-21-301. Clauses required to be in a prominent position.**

3252 (1) The following portions of insurance policies shall appear conspicuously in the  
3253 policy:

3254 (a) as required by ~~[Subsection]~~ Subsections 31A-21-201(3)(a)(iii) and (iv):

3255 (i) the exact name of the insurer;

3256 (ii) the state of domicile of the insurer; and

3257 (iii) for life insurance and annuity policies only, the address of the administrative office  
3258 of the insurer;

3259 (b) information that two or more insurers under Subsection (1)(a) undertake only  
3260 several liability, as required by Section 31A-21-306;

3261 (c) if a policy is assessable, a statement of that;

3262 (d) a statement that benefits are variable, as required by Section 31A-22-411; however,  
3263 the methods of calculation need not be in a prominent position;

3264 (e) the right to return a life or accident and health insurance policy under Sections  
3265 31A-22-423 and 31A-22-606; and

3266 (f) the beginning and ending dates of insurance protection.

3267 (2) Each clause listed in Subsection (1) shall be displayed conspicuously and separately  
3268 from any other clause.

3269 Section 24. Section 31A-21-313 is amended to read:

3270 **31A-21-313. Limitation of actions.**

3271 (1) (a) An action on a written policy or contract of first party insurance shall be  
3272 commenced within three years after the inception of the loss.

3273 (b) The inception of the loss on a fidelity bond is the date the insurer first denies all or  
3274 part of a claim made under the fidelity bond.

3275 (2) Except as provided in Subsection (1) or elsewhere in this title, the law applicable to  
3276 limitation of actions in Title 78B, Chapter 2, Statutes of Limitations, applies to actions on  
3277 insurance policies.

3278 (3) An insurance policy may not:

3279 (a) limit the time for beginning an action on the policy to a time less than that  
3280 authorized by statute;

3281 (b) prescribe in what court an action may be brought on the policy; or  
3282 (c) provide that no action may be brought, subject to permissible arbitration provisions  
3283 in contracts.

3284 (4) (a) Unless by verified complaint it is alleged that prejudice to the complainant will  
3285 arise from a delay in bringing suit against an insurer, which prejudice is other than the delay  
3286 itself, no action may be brought against an insurer on an insurance policy to compel payment  
3287 under the policy until the earlier of:

3288 [~~(a)~~] (i) 60 days after proof of loss has been furnished as required under the policy;

3289 [~~(b)~~] (ii) waiver by the insurer of proof of loss; or

3290 [~~(c)~~] (iii) (A) the insurer's denial of full payment~~[-];~~ or

3291 (B) for an accident and health insurance policy, the insurer's denial of payment.

3292 (b) Under an accident and health insurance policy, an insurer may not require the  
3293 completion of an appeals process that exceeds the provisions in 29 C.F.R. Sec. 2560.503-1 to  
3294 bring suit under this Subsection (4).

3295 (5) The period of limitation is tolled during the period in which the parties conduct an  
3296 appraisal or arbitration procedure prescribed by the insurance policy, by law, or as agreed to by  
3297 the parties.

3298 Section 25. Section **31A-22-205** is enacted to read:

3299 **31A-22-205. Applicability of Restatement of the Law of Liability Insurance.**

3300 (1) As used in this section, "restatement" means the American Law Institute's

3301 Restatement of the Law of Liability Insurance.

3302 (2) The restatement is not the law or public policy of this state if the restatement is  
3303 inconsistent or in conflict with or otherwise not addressed by:

3304 (a) the Constitution of the United States;

3305 (b) the Utah Constitution;

3306 (c) a state statute;

3307 (d) state case law; or

3308 (e) state-adopted common law.

3309 (3) The restatement is not a source of Utah law.

3310 Section 26. Section **31A-22-305** is amended to read:

3311 **31A-22-305. Uninsured motorist coverage.**

- 3312 (1) As used in this section, "covered persons" includes:
- 3313 (a) the named insured;
- 3314 (b) for a claim arising on or after May 13, 2014, the named insured's dependent minor
- 3315 children;
- 3316 (c) persons related to the named insured by blood, marriage, adoption, or guardianship,
- 3317 who are residents of the named insured's household, including those who usually make their
- 3318 home in the same household but temporarily live elsewhere;
- 3319 (d) any person occupying or using a motor vehicle:
- 3320 (i) referred to in the policy; or
- 3321 (ii) owned by a self-insured; and
- 3322 (e) any person who is entitled to recover damages against the owner or operator of the
- 3323 uninsured or underinsured motor vehicle because of bodily injury to or death of persons under
- 3324 Subsection (1)(a), (b), (c), or (d).
- 3325 (2) As used in this section, "uninsured motor vehicle" includes:
- 3326 (a) (i) a motor vehicle, the operation, maintenance, or use of which is not covered
- 3327 under a liability policy at the time of an injury-causing occurrence; or
- 3328 (ii) (A) a motor vehicle covered with lower liability limits than required by Section
- 3329 [31A-22-304](#); and
- 3330 (B) the motor vehicle described in Subsection (2)(a)(ii)(A) is uninsured to the extent of
- 3331 the deficiency;
- 3332 (b) an unidentified motor vehicle that left the scene of an accident proximately caused
- 3333 by the motor vehicle operator;
- 3334 (c) a motor vehicle covered by a liability policy, but coverage for an accident is
- 3335 disputed by the liability insurer for more than 60 days or continues to be disputed for more than
- 3336 60 days; or
- 3337 (d) (i) an insured motor vehicle if, before or after the accident, the liability insurer of
- 3338 the motor vehicle is declared insolvent by a court of competent jurisdiction; and
- 3339 (ii) the motor vehicle described in Subsection (2)(d)(i) is uninsured only to the extent
- 3340 that the claim against the insolvent insurer is not paid by a guaranty association or fund.
- 3341 (3) Uninsured motorist coverage under Subsection [31A-22-302\(1\)\(b\)](#) provides
- 3342 coverage for covered persons who are legally entitled to recover damages from owners or

3343 operators of uninsured motor vehicles because of bodily injury, sickness, disease, or death.

3344 (4) (a) For new policies written on or after January 1, 2001, the limits of uninsured  
3345 motorist coverage shall be equal to the lesser of the limits of the named insured's motor vehicle  
3346 liability coverage or the maximum uninsured motorist coverage limits available by the insurer  
3347 under the named insured's motor vehicle policy, unless a named insured rejects or purchases  
3348 coverage in a lesser amount by signing an acknowledgment form that:

3349 (i) is filed with the department;

3350 (ii) is provided by the insurer;

3351 (iii) waives the higher coverage;

3352 (iv) need only state in this or similar language that uninsured motorist coverage  
3353 provides benefits or protection to you and other covered persons for bodily injury resulting  
3354 from an accident caused by the fault of another party where the other party has no liability  
3355 insurance; and

3356 (v) discloses the additional premiums required to purchase uninsured motorist  
3357 coverage with limits equal to the lesser of the limits of the named insured's motor vehicle  
3358 liability coverage or the maximum uninsured motorist coverage limits available by the insurer  
3359 under the named insured's motor vehicle policy.

3360 (b) Any selection or rejection under this Subsection (4) continues for that issuer of the  
3361 liability coverage until the insured requests, in writing, a change of uninsured motorist  
3362 coverage from that liability insurer.

3363 (c) (i) Subsections (4)(a) and (b) apply retroactively to any claim arising on or after  
3364 January 1, 2001, for which, as of May 14, 2013, an insured has not made a written demand for  
3365 arbitration or filed a complaint in a court of competent jurisdiction.

3366 (ii) The Legislature finds that the retroactive application of Subsections (4)(a) and (b)  
3367 clarifies legislative intent and does not enlarge, eliminate, or destroy vested rights.

3368 (d) For purposes of this Subsection (4), "new policy" means:

3369 (i) any policy that is issued which does not include a renewal or reinstatement of an  
3370 existing policy; or

3371 (ii) a change to an existing policy that results in:

3372 (A) a named insured being added to or deleted from the policy; or

3373 (B) a change in the limits of the named insured's motor vehicle liability coverage.

3374 (e) (i) As used in this Subsection (4)(e), "additional motor vehicle" means a change  
3375 that increases the total number of vehicles insured by the policy, and does not include  
3376 replacement, substitute, or temporary vehicles.

3377 (ii) The adding of an additional motor vehicle to an existing personal lines or  
3378 commercial lines policy does not constitute a new policy for purposes of Subsection (4)(d).

3379 (iii) If an additional motor vehicle is added to a personal lines policy where uninsured  
3380 motorist coverage has been rejected, or where uninsured motorist limits are lower than the  
3381 named insured's motor vehicle liability limits, the insurer shall provide a notice to a named  
3382 insured within 30 days after the day on which the additional motor vehicle is added that:

3383 (A) in the same manner as described in Subsection (4)(a)(iv), explains the purpose of  
3384 uninsured motorist coverage; and

3385 (B) encourages the named insured to contact the insurance company or insurance  
3386 producer for quotes as to the additional premiums required to purchase uninsured motorist  
3387 coverage with limits equal to the lesser of the limits of the named insured's motor vehicle  
3388 liability coverage or the maximum uninsured motorist coverage limits available by the insurer  
3389 under the named insured's motor vehicle policy.

3390 (f) A change in policy number resulting from any policy change not identified under  
3391 Subsection (4)(d)(ii) does not constitute a new policy.

3392 (g) (i) Subsection (4)(d) applies retroactively to any claim arising on or after January 1,  
3393 2001, for which, as of May 1, 2012, an insured has not made a written demand for arbitration  
3394 or filed a complaint in a court of competent jurisdiction.

3395 (ii) The Legislature finds that the retroactive application of Subsection (4):

3396 (A) does not enlarge, eliminate, or destroy vested rights; and

3397 (B) clarifies legislative intent.

3398 (h) A self-insured, including a governmental entity, may elect to provide uninsured  
3399 motorist coverage in an amount that is less than its maximum self-insured retention under  
3400 Subsections (4)(a) and (5)(a) by issuing a declaratory memorandum or policy statement from  
3401 the chief financial officer or chief risk officer that declares the:

3402 (i) self-insured entity's coverage level; and

3403 (ii) process for filing an uninsured motorist claim.

3404 (i) Uninsured motorist coverage may not be sold with limits that are less than the

3405 minimum bodily injury limits for motor vehicle liability policies under Section [31A-22-304](#).

3406 (j) The acknowledgment under Subsection (4)(a) continues for that issuer of the  
3407 uninsured motorist coverage until the named insured requests, in writing, different uninsured  
3408 motorist coverage from the insurer.

3409 (k) (i) In conjunction with the first two renewal notices sent after January 1, 2001, for  
3410 policies existing on that date, the insurer shall disclose in the same medium as the premium  
3411 renewal notice, an explanation of:

3412 (A) the purpose of uninsured motorist coverage in the same manner as described in  
3413 Subsection (4)(a)(iv); and

3414 (B) a disclosure of the additional premiums required to purchase uninsured motorist  
3415 coverage with limits equal to the lesser of the limits of the named insured's motor vehicle  
3416 liability coverage or the maximum uninsured motorist coverage limits available by the insurer  
3417 under the named insured's motor vehicle policy.

3418 (ii) The disclosure required under Subsection (4)(k)(i) shall be sent to all named  
3419 insureds that carry uninsured motorist coverage limits in an amount less than the named  
3420 insured's motor vehicle liability policy limits or the maximum uninsured motorist coverage  
3421 limits available by the insurer under the named insured's motor vehicle policy.

3422 (l) For purposes of this Subsection (4), a notice or disclosure sent to a named insured in  
3423 a household constitutes notice or disclosure to all insureds within the household.

3424 (5) (a) (i) Except as provided in Subsection (5)(b), the named insured may reject  
3425 uninsured motorist coverage by an express writing to the insurer that provides liability  
3426 coverage under Subsection [31A-22-302\(1\)\(a\)](#).

3427 (ii) This rejection shall be on a form provided by the insurer that includes a reasonable  
3428 explanation of the purpose of uninsured motorist coverage.

3429 (iii) This rejection continues for that issuer of the liability coverage until the insured in  
3430 writing requests uninsured motorist coverage from that liability insurer.

3431 (b) (i) All persons, including governmental entities, that are engaged in the business of,  
3432 or that accept payment for, transporting natural persons by motor vehicle, and all school  
3433 districts that provide transportation services for their students, shall provide coverage for all  
3434 motor vehicles used for that purpose, by purchase of a policy of insurance or by self-insurance,  
3435 uninsured motorist coverage of at least \$25,000 per person and \$500,000 per accident.

3436 (ii) This coverage is secondary to any other insurance covering an injured covered  
3437 person.

3438 (c) Uninsured motorist coverage:

3439 (i) does not cover any benefit paid or payable under Title 34A, Chapter 2, Workers'  
3440 Compensation Act, except that the covered person is credited an amount described in  
3441 Subsection [34A-2-106\(5\)](#);

3442 (ii) may not be subrogated by the workers' compensation insurance carrier;

3443 (iii) may not be reduced by any benefits provided by workers' compensation insurance;

3444 (iv) may be reduced by health insurance subrogation only after the covered person has  
3445 been made whole;

3446 (v) may not be collected for bodily injury or death sustained by a person:

3447 (A) while committing a violation of Section [41-1a-1314](#);

3448 (B) who, as a passenger in a vehicle, has knowledge that the vehicle is being operated  
3449 in violation of Section [41-1a-1314](#); or

3450 (C) while committing a felony; and

3451 (vi) notwithstanding Subsection (5)(c)(v), may be recovered:

3452 (A) for a person under 18 years of age who is injured within the scope of Subsection  
3453 (5)(c)(v) but limited to medical and funeral expenses; or

3454 (B) by a law enforcement officer as defined in Section [53-13-103](#), who is injured  
3455 within the course and scope of the law enforcement officer's duties.

3456 (d) As used in this Subsection (5), "motor vehicle" has the same meaning as under  
3457 Section [41-1a-102](#).

3458 (6) When a covered person alleges that an uninsured motor vehicle under Subsection  
3459 (2)(b) proximately caused an accident without touching the covered person or the motor  
3460 vehicle occupied by the covered person, the covered person shall show the existence of the  
3461 uninsured motor vehicle by clear and convincing evidence consisting of more than the covered  
3462 person's testimony.

3463 (7) (a) The limit of liability for uninsured motorist coverage for two or more motor  
3464 vehicles may not be added together, combined, or stacked to determine the limit of insurance  
3465 coverage available to an injured person for any one accident.

3466 (b) (i) Subsection (7)(a) applies to all persons except a covered person as defined under



3467 Subsection (8)(b)(ii).

3468 (ii) A covered person as defined under Subsection (8)(b)(ii) is entitled to the highest  
3469 limits of uninsured motorist coverage afforded for any one motor vehicle that the covered  
3470 person is the named insured or an insured family member.

3471 (iii) This coverage shall be in addition to the coverage on the motor vehicle the covered  
3472 person is occupying.

3473 (iv) Neither the primary nor the secondary coverage may be set off against the other.

3474 (c) Coverage on a motor vehicle occupied at the time of an accident shall be primary  
3475 coverage, and the coverage elected by a person described under Subsections (1)(a), (b), and (c)  
3476 shall be secondary coverage.

3477 (8) (a) (i) Uninsured motorist coverage under this section applies to bodily injury,  
3478 sickness, disease, or death of covered persons while occupying or using a motor vehicle only if  
3479 the motor vehicle is described in the policy under which a claim is made, or if the motor  
3480 vehicle is a newly acquired or replacement motor vehicle covered under the terms of the policy.

3481 (ii) Except as provided in Subsection (7) or this Subsection (8), a covered person  
3482 injured in a motor vehicle described in a policy that includes uninsured motorist benefits may  
3483 not elect to collect uninsured motorist coverage benefits from any other motor vehicle  
3484 insurance policy under which the person is a covered person.

3485 (b) Each of the following persons may also recover uninsured motorist benefits under  
3486 any one other policy in which they are described as a "covered person" as defined in Subsection  
3487 (1):

3488 (i) a covered person injured as a pedestrian by an uninsured motor vehicle; and

3489 (ii) except as provided in Subsection (8)(c), a covered person injured while occupying  
3490 or using a motor vehicle that is not owned, leased, or furnished:

3491 (A) to the covered person;

3492 (B) to the covered person's spouse; or

3493 (C) to the covered person's resident parent or resident sibling.

3494 (c) (i) A covered person may recover benefits from no more than two additional  
3495 policies, one additional policy from each parent's household if the covered person is:

3496 (A) a dependent minor of parents who reside in separate households; and

3497 (B) injured while occupying or using a motor vehicle that is not owned, leased, or

3498 furnished:

3499 (I) to the covered person;

3500 (II) to the covered person's resident parent; or

3501 (III) to the covered person's resident sibling.

3502 (ii) Each parent's policy under this Subsection (8)(c) is liable only for the percentage of  
3503 the damages that the limit of liability of each parent's policy of uninsured motorist coverage  
3504 bears to the total of both parents' uninsured coverage applicable to the accident.

3505 (d) A covered person's recovery under any available policies may not exceed the full  
3506 amount of damages.

3507 (e) A covered person in Subsection (8)(b) is not barred against making subsequent  
3508 elections if recovery is unavailable under previous elections.

3509 (f) (i) As used in this section, "interpolicy stacking" means recovering benefits for a  
3510 single incident of loss under more than one insurance policy.

3511 (ii) Except to the extent permitted by Subsection (7) and this Subsection (8),  
3512 interpolicy stacking is prohibited for uninsured motorist coverage.

3513 (9) (a) When a claim is brought by a named insured or a person described in  
3514 Subsection (1) and is asserted against the covered person's uninsured motorist carrier, the  
3515 claimant may elect to resolve the claim:

3516 (i) by submitting the claim to binding arbitration; or

3517 (ii) through litigation.

3518 (b) Unless otherwise provided in the policy under which uninsured benefits are  
3519 claimed, the election provided in Subsection (9)(a) is available to the claimant only, except that  
3520 if the policy under which insured benefits are claimed provides that either an insured or the  
3521 insurer may elect arbitration, the insured or the insurer may elect arbitration and that election to  
3522 arbitrate shall stay the litigation of the claim under Subsection (9)(a)(ii).

3523 (c) Once the claimant has elected to commence litigation under Subsection (9)(a)(ii),  
3524 the claimant may not elect to resolve the claim through binding arbitration under this section  
3525 without the written consent of the uninsured motorist carrier.

3526 (d) For purposes of the statute of limitations applicable to a claim described in  
3527 Subsection (9)(a), if the claimant does not elect to resolve the claim through litigation, the  
3528 claim is considered filed when the claimant submits the claim to binding arbitration in

3529 accordance with this Subsection (9).

3530 (e) (i) Unless otherwise agreed to in writing by the parties, a claim that is submitted to  
3531 binding arbitration under Subsection (9)(a)(i) shall be resolved by a single arbitrator.

3532 (ii) All parties shall agree on the single arbitrator selected under Subsection (9)(e)(i).

3533 (iii) If the parties are unable to agree on a single arbitrator as required under Subsection  
3534 (9)(e)(ii), the parties shall select a panel of three arbitrators.

3535 (f) If the parties select a panel of three arbitrators under Subsection (9)(e)(iii):

3536 (i) each side shall select one arbitrator; and

3537 (ii) the arbitrators appointed under Subsection (9)(f)(i) shall select one additional  
3538 arbitrator to be included in the panel.

3539 (g) Unless otherwise agreed to in writing:

3540 (i) each party shall pay an equal share of the fees and costs of the arbitrator selected  
3541 under Subsection (9)(e)(i); or

3542 (ii) if an arbitration panel is selected under Subsection (9)(e)(iii):

3543 (A) each party shall pay the fees and costs of the arbitrator selected by that party; and

3544 (B) each party shall pay an equal share of the fees and costs of the arbitrator selected  
3545 under Subsection (9)(f)(ii).

3546 (h) Except as otherwise provided in this section or unless otherwise agreed to in  
3547 writing by the parties, an arbitration proceeding conducted under this section shall be governed  
3548 by Title 78B, Chapter 11, Utah Uniform Arbitration Act.

3549 (i) (i) The arbitration shall be conducted in accordance with Rules 26(a)(4) through (f),  
3550 27 through 37, 54, and 68 of the Utah Rules of Civil Procedure, once the requirements of  
3551 Subsections (10)(a) through (c) are satisfied.

3552 (ii) The specified tier as defined by Rule 26(c)(3) of the Utah Rules of Civil Procedure  
3553 shall be determined based on the claimant's specific monetary amount in the written demand  
3554 for payment of uninsured motorist coverage benefits as required in Subsection (10)(a)(i)(A).

3555 (iii) Rules 26.1 and 26.2 of the Utah Rules of Civil Procedure do not apply to  
3556 arbitration claims under this part.

3557 (j) All issues of discovery shall be resolved by the arbitrator or the arbitration panel.

3558 (k) A written decision by a single arbitrator or by a majority of the arbitration panel  
3559 shall constitute a final decision.

3560 (l) (i) Except as provided in Subsection (10), the amount of an arbitration award may  
3561 not exceed the uninsured motorist policy limits of all applicable uninsured motorist policies,  
3562 including applicable uninsured motorist umbrella policies.

3563 (ii) If the initial arbitration award exceeds the uninsured motorist policy limits of all  
3564 applicable uninsured motorist policies, the arbitration award shall be reduced to an amount  
3565 equal to the combined uninsured motorist policy limits of all applicable uninsured motorist  
3566 policies.

3567 (m) The arbitrator or arbitration panel may not decide the issues of coverage or  
3568 extra-contractual damages, including:

3569 (i) whether the claimant is a covered person;

3570 (ii) whether the policy extends coverage to the loss; or

3571 (iii) any allegations or claims asserting consequential damages or bad faith liability.

3572 (n) The arbitrator or arbitration panel may not conduct arbitration on a class-wide or  
3573 class-representative basis.

3574 (o) If the arbitrator or arbitration panel finds that the action was not brought, pursued,  
3575 or defended in good faith, the arbitrator or arbitration panel may award reasonable attorney fees  
3576 and costs against the party that failed to bring, pursue, or defend the claim in good faith.

3577 (p) An arbitration award issued under this section shall be the final resolution of all  
3578 claims not excluded by Subsection (9)(m) between the parties unless:

3579 (i) the award was procured by corruption, fraud, or other undue means; or

3580 (ii) either party, within 20 days after [~~service of~~] the day on which the arbitration award  
3581 is served:

3582 (A) files a complaint requesting a trial de novo in the district court; and

3583 (B) serves the nonmoving party with a copy of the complaint requesting a trial de novo  
3584 under Subsection (9)(p)(ii)(A).

3585 (q) (i) Upon filing a complaint for a trial de novo under Subsection (9)(p), the claim  
3586 shall proceed through litigation pursuant to the Utah Rules of Civil Procedure and Utah Rules  
3587 of Evidence in the district court.

3588 (ii) In accordance with Rule 38, Utah Rules of Civil Procedure, either party may  
3589 request a jury trial with a complaint requesting a trial de novo under Subsection (9)(p)(ii)(A).

3590 (r) (i) If the claimant, as the moving party in a trial de novo requested under Subsection

3591 (9)(p), does not obtain a verdict that is at least \$5,000 and is at least 20% greater than the  
3592 arbitration award, the claimant is responsible for all of the nonmoving party's costs.

3593 (ii) If the uninsured motorist carrier, as the moving party in a trial de novo requested  
3594 under Subsection (9)(p), does not obtain a verdict that is at least 20% less than the arbitration  
3595 award, the uninsured motorist carrier is responsible for all of the nonmoving party's costs.

3596 (iii) Except as provided in Subsection (9)(r)(iv), the costs under this Subsection (9)(r)  
3597 shall include:

3598 (A) any costs set forth in Rule 54(d), Utah Rules of Civil Procedure; and

3599 (B) the costs of expert witnesses and depositions.

3600 (iv) An award of costs under this Subsection (9)(r) may not exceed \$2,500 unless  
3601 Subsection (10)(h)(iii) applies.

3602 (s) For purposes of determining whether a party's verdict is greater or less than the  
3603 arbitration award under Subsection (9)(r), a court may not consider any recovery or other relief  
3604 granted on a claim for damages if the claim for damages:

3605 (i) was not fully disclosed in writing prior to the arbitration proceeding; or

3606 (ii) was not disclosed in response to discovery contrary to the Utah Rules of Civil  
3607 Procedure.

3608 (t) If a district court determines, upon a motion of the nonmoving party, that the  
3609 moving party's use of the trial de novo process was filed in bad faith in accordance with  
3610 Section [78B-5-825](#), the district court may award reasonable attorney fees to the nonmoving  
3611 party.

3612 (u) Nothing in this section is intended to limit any claim under any other portion of an  
3613 applicable insurance policy.

3614 (v) If there are multiple uninsured motorist policies, as set forth in Subsection (8), the  
3615 claimant may elect to arbitrate in one hearing the claims against all the uninsured motorist  
3616 carriers.

3617 (10) (a) Within 30 days after the day on which a covered person elects to submit a  
3618 claim for uninsured motorist benefits to binding arbitration or files litigation, the covered  
3619 person shall provide to the uninsured motorist carrier:

3620 (i) a written demand for payment of uninsured motorist coverage benefits, setting forth:

3621 (A) subject to Subsection (10)(l), the specific monetary amount of the demand,

3622 including a computation of the covered person's claimed past medical expenses, claimed past  
3623 lost wages, and the other claimed past economic damages; and

3624 (B) the factual and legal basis and any supporting documentation for the demand;

3625 (ii) a written statement under oath disclosing:

3626 (A) (I) the names and last known addresses of all health care providers who have  
3627 rendered health care services to the covered person that are material to the claims for which  
3628 uninsured motorist benefits are sought for a period of five years preceding the date of the event  
3629 giving rise to the claim for uninsured motorist benefits up to the time the election for  
3630 arbitration or litigation has been exercised; and

3631 (II) the names and last known addresses of the health care providers who have rendered  
3632 health care services to the covered person, which the covered person claims are immaterial to  
3633 the claims for which uninsured motorist benefits are sought, for a period of five years  
3634 preceding the date of the event giving rise to the claim for uninsured motorist benefits up to the  
3635 time the election for arbitration or litigation has been exercised that have not been disclosed  
3636 under Subsection (10)(a)(ii)(A)(I);

3637 (B) (I) the names and last known addresses of all health insurers or other entities to  
3638 whom the covered person has submitted claims for health care services or benefits material to  
3639 the claims for which uninsured motorist benefits are sought, for a period of five years  
3640 preceding the date of the event giving rise to the claim for uninsured motorist benefits up to the  
3641 time the election for arbitration or litigation has been exercised; and

3642 (II) the names and last known addresses of the health insurers or other entities to whom  
3643 the covered person has submitted claims for health care services or benefits, which the covered  
3644 person claims are immaterial to the claims for which uninsured motorist benefits are sought,  
3645 for a period of five years preceding the date of the event giving rise to the claim for uninsured  
3646 motorist benefits up to the time the election for arbitration or litigation have not been disclosed;

3647 (C) if lost wages, diminished earning capacity, or similar damages are claimed, all  
3648 employers of the covered person for a period of five years preceding the date of the event  
3649 giving rise to the claim for uninsured motorist benefits up to the time the election for  
3650 arbitration or litigation has been exercised;

3651 (D) other documents to reasonably support the claims being asserted; and

3652 (E) all state and federal statutory lienholders including a statement as to whether the

3653 covered person is a recipient of Medicare or Medicaid benefits or Utah Children's Health  
3654 Insurance Program benefits under Title 26, Chapter 40, Utah Children's Health Insurance Act,  
3655 or if the claim is subject to any other state or federal statutory liens; and

3656 (iii) signed authorizations to allow the uninsured motorist carrier to only obtain records  
3657 and billings from the individuals or entities disclosed under Subsections (10)(a)(ii)(A)(I),  
3658 (B)(I), and (C).

3659 (b) (i) If the uninsured motorist carrier determines that the disclosure of undisclosed  
3660 health care providers or health care insurers under Subsection (10)(a)(ii) is reasonably  
3661 necessary, the uninsured motorist carrier may:

3662 (A) make a request for the disclosure of the identity of the health care providers or  
3663 health care insurers; and

3664 (B) make a request for authorizations to allow the uninsured motorist carrier to only  
3665 obtain records and billings from the individuals or entities not disclosed.

3666 (ii) If the covered person does not provide the requested information within 10 days:

3667 (A) the covered person shall disclose, in writing, the legal or factual basis for the  
3668 failure to disclose the health care providers or health care insurers; and

3669 (B) either the covered person or the uninsured motorist carrier may request the  
3670 arbitrator or arbitration panel to resolve the issue of whether the identities or records are to be  
3671 provided if the covered person has elected arbitration.

3672 (iii) The time periods imposed by Subsection (10)(c)(i) are tolled pending resolution of  
3673 the dispute concerning the disclosure and production of records of the health care providers or  
3674 health care insurers.

3675 (c) (i) An uninsured motorist carrier that receives an election for arbitration or a notice  
3676 of filing litigation and the demand for payment of uninsured motorist benefits under Subsection  
3677 (10)(a)(i) shall have a reasonable time, not to exceed 60 days from the date of the demand and  
3678 receipt of the items specified in Subsections (10)(a)(i) through (iii), to:

3679 (A) provide a written response to the written demand for payment provided for in  
3680 Subsection (10)(a)(i);

3681 (B) except as provided in Subsection (10)(c)(i)(C), tender the amount, if any, of the  
3682 uninsured motorist carrier's determination of the amount owed to the covered person; and

3683 (C) if the covered person is a recipient of Medicare or Medicaid benefits or Utah

3684 Children's Health Insurance Program benefits under Title 26, Chapter 40, Utah Children's  
3685 Health Insurance Act, or if the claim is subject to any other state or federal statutory liens,  
3686 tender the amount, if any, of the uninsured motorist carrier's determination of the amount owed  
3687 to the covered person less:

3688 (I) if the amount of the state or federal statutory lien is established, the amount of the  
3689 lien; or

3690 (II) if the amount of the state or federal statutory lien is not established, two times the  
3691 amount of the medical expenses subject to the state or federal statutory lien until such time as  
3692 the amount of the state or federal statutory lien is established.

3693 (ii) If the amount tendered by the uninsured motorist carrier under Subsection (10)(c)(i)  
3694 is the total amount of the uninsured motorist policy limits, the tendered amount shall be  
3695 accepted by the covered person.

3696 (d) A covered person who receives a written response from an uninsured motorist  
3697 carrier as provided for in Subsection (10)(c)(i), may:

3698 (i) elect to accept the amount tendered in Subsection (10)(c)(i) as payment in full of all  
3699 uninsured motorist claims; or

3700 (ii) elect to:

3701 (A) accept the amount tendered in Subsection (10)(c)(i) as partial payment of all  
3702 uninsured motorist claims; and

3703 (B) continue to litigate or arbitrate the remaining claim in accordance with the election  
3704 made under Subsections (9)(a), (b), and (c).

3705 (e) If a covered person elects to accept the amount tendered under Subsection (10)(c)(i)  
3706 as partial payment of all uninsured motorist claims, the final award obtained through  
3707 arbitration, litigation, or later settlement shall be reduced by any payment made by the  
3708 uninsured motorist carrier under Subsection (10)(c)(i).

3709 (f) In an arbitration proceeding on the remaining uninsured claims:

3710 (i) the parties may not disclose to the arbitrator or arbitration panel the amount paid  
3711 under Subsection (10)(c)(i) until after the arbitration award has been rendered; and

3712 (ii) the parties may not disclose the amount of the limits of uninsured motorist benefits  
3713 provided by the policy.

3714 (g) If the final award obtained through arbitration or litigation is greater than the



3715 average of the covered person's initial written demand for payment provided for in Subsection  
3716 (10)(a)(i) and the uninsured motorist carrier's initial written response provided for in  
3717 Subsection (10)(c)(i), the uninsured motorist carrier shall pay:

3718 (i) the final award obtained through arbitration or litigation, except that if the award  
3719 exceeds the policy limits of the subject uninsured motorist policy by more than \$15,000, the  
3720 amount shall be reduced to an amount equal to the policy limits plus \$15,000; and

3721 (ii) any of the following applicable costs:

3722 (A) any costs as set forth in Rule 54(d), Utah Rules of Civil Procedure;

3723 (B) the arbitrator or arbitration panel's fee; and

3724 (C) the reasonable costs of expert witnesses and depositions used in the presentation of  
3725 evidence during arbitration or litigation.

3726 (h) (i) The covered person shall provide an affidavit of costs within five days of an  
3727 arbitration award.

3728 (ii) (A) Objection to the affidavit of costs shall specify with particularity the costs to  
3729 which the uninsured motorist carrier objects.

3730 (B) The objection shall be resolved by the arbitrator or arbitration panel.

3731 (iii) The award of costs by the arbitrator or arbitration panel under Subsection  
3732 (10)(g)(ii) may not exceed \$5,000.

3733 (i) (i) A covered person shall disclose all material information, other than rebuttal  
3734 evidence, within 30 days after a covered person elects to submit a claim for uninsured motorist  
3735 coverage benefits to binding arbitration or files litigation as specified in Subsection (10)(a).

3736 (ii) If the information under Subsection (10)(i)(i) is not disclosed, the covered person  
3737 may not recover costs or any amounts in excess of the policy under Subsection (10)(g).

3738 (j) This Subsection (10) does not limit any other cause of action that arose or may arise  
3739 against the uninsured motorist carrier from the same dispute.

3740 (k) The provisions of this Subsection (10) only apply to motor vehicle accidents that  
3741 occur on or after March 30, 2010.

3742 (l) (i) The written demand requirement in Subsection (10)(a)(i)(A) does not affect the  
3743 covered person's requirement to provide a computation of any other economic damages  
3744 claimed, and the one or more respondents shall have a reasonable time after the receipt of the  
3745 computation of any other economic damages claimed to conduct fact and expert discovery as to

3746 any additional damages claimed. The changes made by Laws of Utah 2014, Chapter 290,  
3747 Section 10, and Chapter 300, Section 10, to this Subsection (10)(l) and Subsection  
3748 (10)(a)(i)(A) apply to a claim submitted to binding arbitration or through litigation on or after  
3749 May 13, 2014.

3750 (ii) The changes made by Laws of Utah 2014, Chapter 290, Section 10, and Chapter  
3751 300, Section 10, to Subsections (10)(a)(ii)(A)(II) and (B)(II) apply to any claim submitted to  
3752 binding arbitration or through litigation on or after May 13, 2014.

3753 (11) (a) Notwithstanding Section 31A-21-313, an action on a written policy or contract  
3754 for uninsured motorist coverage shall be commenced within four years after the inception of  
3755 loss.

3756 (b) Subsection (11)(a) shall apply to all claims that have not been time barred by  
3757 Subsection 31A-21-313(1)(a) as of May 14, 2019.

3758 Section 27. Section 31A-22-412 is amended to read:

3759 **31A-22-412. Assignment of life insurance rights.**

3760 (1) As used in this section, "final termination of a policy" means the day after which an  
3761 insurer will not reinstate a policy without requiring:

3762 (a) evidence of insurability; or

3763 (b) written application.

3764 ~~[(1)]~~ (2) (a) Except as provided under Subsection ~~[(3)]~~ (4), the owner of any rights in a  
3765 life insurance policy or annuity contract may assign any of those rights, including any right to  
3766 designate a beneficiary and the rights secured under Sections 31A-22-517 through 31A-22-521  
3767 and any other provision of this title.

3768 (b) An assignment, valid under general contract law, vests the assigned rights in the  
3769 assignee, subject, so far as reasonably necessary for the protection of the insurer, to any  
3770 provisions in the insurance policy or annuity contract inserted to protect the insurer against  
3771 double payment or obligation.

3772 ~~[(2)]~~ (3) The rights of a beneficiary under a life insurance policy or annuity contract are  
3773 subordinate to those of an assignee, unless the beneficiary was designated as an irrevocable  
3774 beneficiary prior to the assignment.

3775 ~~[(3)]~~ (4) Assignment of insurance rights may be expressly prohibited by an annuity  
3776 contract which provides annuities as retirement benefits related to employment contracts.

3777 ~~[(4)]~~ (5) (a) ~~[When]~~ After July 1, 1986, when a life insurance policy or annuity is[  
 3778 ~~after July 1, 1986;~~] assigned in writing as security for an indebtedness, the insurer shall~~[-in any~~  
 3779 ~~case in which it has received written notice of the assignment, the name and address of the~~  
 3780 ~~assignee, and a request for cancellation notice by the assignee;]~~ mail to the assignee a copy of  
 3781 any cancellation notice sent with respect to the policy~~[-]~~, if the insurer has received:

3782 (i) written notice of the assignment;

3783 (ii) the name and address of the assignee; and

3784 (iii) a request for assignment notice from the assignee.

3785 (b) An insurer shall mail the cancellation notice described in Subsection (5)(a):

3786 (i) [This notice shall be sent, postage] prepaid, and addressed to the assignee's address  
 3787 filed with the insured~~[-. The notice shall be mailed];~~

3788 (ii) not less than 10 days [prior to] before the final termination of the policy; and

3789 (iii) each time the insured [has failed or refused] fails or refuses to transmit a premium  
 3790 payment to the insurer before the commencement of the policy's grace period.

3791 (c) The insurer may charge the insured directly or charge against the policy the  
 3792 reasonable cost of complying with this section, but in no event to exceed \$5 for each notice.

3793 ~~[As used in this section, "final termination of the policy" means the date after which the policy~~  
 3794 ~~will not be reinstated by the insurer without requiring evidence of insurability or written~~  
 3795 ~~application;]~~

3796 ~~[(5)]~~ (6) In lieu of providing notices to assignees of final termination of the policy  
 3797 under Subsection ~~[(4)]~~ (5), an insurer may provide an assignee with an identical copy of all  
 3798 notices sent to the owner of the life insurance policy, provided these notices comply with the  
 3799 other requirements of this title.

3800 Section 28. Section **31A-22-413** is amended to read:

3801 **31A-22-413. Designation of beneficiary.**

3802 (1) Subject to Subsection **31A-22-412**~~[(2)]~~(3), no life insurance policy or annuity  
 3803 contract may restrict the right of a policyholder or certificate holder:

3804 (a) to make an irrevocable designation of beneficiary effective immediately or at some  
 3805 subsequent time; or

3806 (b) if the designation of beneficiary is not explicitly irrevocable, to change the  
 3807 beneficiary without the consent of the previously designated beneficiary. Subsection

3808 [75-6-201](#)(1)(c) applies to designations by will or by separate writing.

3809 (2) (a) An insurer may prescribe formalities to be complied with for the change of  
3810 beneficiaries, but those formalities may only be designed for the protection of the insurer.  
3811 Notwithstanding Section [75-2-804](#), the insurer discharges its obligation under the insurance  
3812 policy or certificate of insurance if it pays the properly designated beneficiary unless it has  
3813 actual notice of either an assignment or a change in beneficiary designation made pursuant to  
3814 Subsection (1)(b).

3815 (b) The insurer has actual notice if the formalities prescribed by the policy are  
3816 complied with, or if the change in beneficiary has been requested in the form prescribed by the  
3817 insurer and delivered to an agent representing the insurer at least three days prior to payment to  
3818 the earlier properly designated beneficiary.

3819 Section 29. Section [31A-22-430](#) is enacted to read:

3820 **[31A-22-430](#). Policy notification.**

3821 (1) (a) An insurer that delivers or issues for delivery an individual life insurance policy  
3822 in this state shall notify the applicant for the policy, in writing at the time of application for the  
3823 policy, of an applicant's right to designate a third party to receive notice of lapse or cancellation  
3824 of the policy based on nonpayment of premium.

3825 (b) An applicant may make a designation described in Subsection (1)(a) at the time of  
3826 application for the policy, or at any time the policy is in force, by submitting a written notice to  
3827 the insurer containing the name and address of the third-party designee.

3828 (2) An insurer shall transmit a copy of a notice of lapse or cancellation of the policy  
3829 based on nonpayment of premium to a third party designated in accordance with this section in  
3830 addition to the transmission of the notice of lapse or cancellation of the policy to the  
3831 policyholder.

3832 (3) The designation of a third party under this section does not constitute acceptance of  
3833 any liability on the part of the third party or insurer for a service provided to the policyholder.

3834 Section 30. Section [31A-22-505](#) is amended to read:

3835 **[31A-22-505](#)**. Association groups.

3836 (1) A policy is subject to the requirements of this section if the policy is issued as  
3837 policyholder to an association or to the trustees of a fund established, created, or maintained for  
3838 the benefit of members of one or more associations:

3839 (a) with a minimum membership of 100 persons;  
3840 (b) with a constitution and bylaws;  
3841 (c) having a shared [~~or common purpose that is not primarily a business or customer~~  
3842 ~~relationship; and~~] substantial common purpose that:

3843 (i) is the same profession, trade, occupation, or similar; or

3844 (ii) is by some common economic or representation of interest or genuine  
3845 organizational relationship unrelated to the provision of benefits; and

3846 (d) that has been in active existence for at least two years.

3847 (2) The policy may insure members and employees of the association, employees of the  
3848 members, one or more of the preceding entities, or all of any classes of these named entities for  
3849 the benefit of persons other than the employees' employer, or any officials, representatives,  
3850 trustees, or agents of the employer or association.

3851 (3) (a) The premiums shall be paid by:

3852 (i) the policyholder from funds contributed by the associations[~~;~~by];

3853 (ii) employer members, from funds contributed by the covered persons[~~;~~]; or

3854 (iii) from any combination of [~~these~~] Subsections (3)(a)(i) and (ii).

3855 (b) Except as provided under Section 31A-22-512, a policy on which no part of the  
3856 premium is contributed by the covered persons, specifically for their insurance, is required to  
3857 insure all eligible persons.

3858 Section 31. Section 31A-22-610.5 is amended to read:

3859 **31A-22-610.5. Dependent coverage.**

3860 (1) As used in this section, "child" has the same meaning as defined in Section  
3861 78B-12-102.

3862 (2) (a) Any individual or group accident and health insurance policy or managed care  
3863 organization contract that provides coverage for a policyholder's or certificate holder's  
3864 dependent;

3865 (i) may not terminate coverage of an unmarried dependent by reason of the dependent's  
3866 age before the dependent's 26th birthday; and

3867 (ii) shall, upon application, provide coverage for all unmarried dependents up to age  
3868 26.

3869 (b) The cost of coverage for unmarried dependents 19 to 26 years of age shall be

3870 included in the premium on the same basis as other dependent coverage.

3871 (c) This section does not prohibit the employer from requiring the employee to pay all  
3872 or part of the cost of coverage for unmarried dependents.

3873 (d) An individual or group health insurance policy or managed care organization shall  
3874 continue in force coverage for a dependent through the last day of the month in which the  
3875 dependent ceases to be a dependent:

3876 (i) if premiums are paid; and

3877 (ii) notwithstanding Sections [31A-22-618.6](#) and [31A-22-618.7](#).

3878 (3) (a) When a parent is required by a court or administrative order to provide health  
3879 insurance coverage for a child, an accident and health insurer may not deny enrollment of a  
3880 child under the accident and health insurance plan of the child's parent on the grounds the  
3881 child:

3882 (i) was born out of wedlock and is entitled to coverage under Subsection (4);

3883 (ii) was born out of wedlock and the custodial parent seeks enrollment for the child  
3884 under the custodial parent's policy;

3885 (iii) is not claimed as a dependent on the parent's federal tax return; ~~or~~

3886 (iv) does not reside with the parent; or

3887 (v) does not reside in the insurer's service area.

3888 (b) A child enrolled as required under Subsection (3)(a)(iv) is subject to the terms of  
3889 the accident and health insurance plan contract pertaining to services received outside of an  
3890 insurer's service area.

3891 (4) When a child has accident and health coverage through an insurer of a noncustodial  
3892 parent, and when requested by the noncustodial or custodial parent, the insurer shall:

3893 (a) provide information to the custodial parent as necessary for the child to obtain  
3894 benefits through that coverage, but the insurer or employer, or the agents or employees of either  
3895 of them, are not civilly or criminally liable for providing information in compliance with this  
3896 Subsection (4)(a), whether the information is provided pursuant to a verbal or written request;

3897 (b) permit the custodial parent or the service provider, with the custodial parent's  
3898 approval, to submit claims for covered services without the approval of the noncustodial  
3899 parent; and

3900 (c) make payments on claims submitted in accordance with Subsection (4)(b) directly

3901 to the custodial parent, the child who obtained benefits, the provider, or the state Medicaid  
3902 agency.

3903 (5) When a parent is required by a court or administrative order to provide health  
3904 coverage for a child, and the parent is eligible for family health coverage, the insurer shall:

3905 (a) permit the parent to enroll, under the family coverage, a child who is otherwise  
3906 eligible for the coverage without regard to an enrollment season restrictions;

3907 (b) if the parent is enrolled but fails to make application to obtain coverage for the  
3908 child, enroll the child under family coverage upon application of the child's other parent, the  
3909 state agency administering the Medicaid program, or the state agency administering 42 U.S.C.  
3910 Sec. 651 through 669, the child support enforcement program; and

3911 (c) (i) when the child is covered by an individual policy, not disenroll or eliminate  
3912 coverage of the child unless the insurer is provided satisfactory written evidence that:

3913 (A) the court or administrative order is no longer in effect; or

3914 (B) the child is or will be enrolled in comparable accident and health coverage through  
3915 another insurer which will take effect not later than the effective date of disenrollment; or

3916 (ii) when the child is covered by a group policy, not disenroll or eliminate coverage of  
3917 the child unless the employer is provided with satisfactory written evidence, which evidence is  
3918 also provided to the insurer, that Subsection (8)(c)(i), (ii), or (iii) has happened.

3919 (6) An insurer may not impose requirements on a state agency that has been assigned  
3920 the rights of an individual eligible for medical assistance under Medicaid and covered for  
3921 accident and health benefits from the insurer that are different from requirements applicable to  
3922 an agent or assignee of any other individual so covered.

3923 (7) Insurers may not reduce their coverage of pediatric vaccines below the benefit level  
3924 in effect on May 1, 1993.

3925 (8) When a parent is required by a court or administrative order to provide health  
3926 coverage, which is available through an employer doing business in this state, the employer  
3927 shall:

3928 (a) permit the parent to enroll under family coverage any child who is otherwise  
3929 eligible for coverage without regard to any enrollment season restrictions;

3930 (b) if the parent is enrolled but fails to make application to obtain coverage of the child,  
3931 enroll the child under family coverage upon application by the child's other parent, by the state

3932 agency administering the Medicaid program, or the state agency administering 42 U.S.C. Sec.  
3933 651 through 669, the child support enforcement program;

3934 (c) not disenroll or eliminate coverage of the child unless the employer is provided  
3935 satisfactory written evidence that:

3936 (i) the court order is no longer in effect;

3937 (ii) the child is or will be enrolled in comparable coverage which will take effect no  
3938 later than the effective date of disenrollment; or

3939 (iii) the employer has eliminated family health coverage for all of its employees; and

3940 (d) withhold from the employee's compensation the employee's share, if any, of  
3941 premiums for health coverage and to pay this amount to the insurer.

3942 (9) An order issued under Section [62A-11-326.1](#) may be considered a "qualified  
3943 medical support order" for the purpose of enrolling a dependent child in a group accident and  
3944 health insurance plan as defined in Section 609(a), Federal Employee Retirement Income  
3945 Security Act of 1974.

3946 (10) This section does not affect any insurer's ability to require as a precondition of any  
3947 child being covered under any policy of insurance that:

3948 (a) the parent continues to be eligible for coverage;

3949 (b) the child shall be identified to the insurer with adequate information to comply with  
3950 this section; and

3951 (c) the premium shall be paid when due.

3952 (11) This section applies to employee welfare benefit plans as defined in Section  
3953 [26-19-102](#).

3954 (12) (a) A policy that provides coverage to a child of a group member may not deny  
3955 eligibility for coverage to a child solely because:

3956 (i) the child does not reside with the insured; or

3957 (ii) the child is solely dependent on a former spouse of the insured rather than on the  
3958 insured.

3959 (b) A child who does not reside with the insured may be excluded on the same basis as  
3960 a child who resides with the insured.

3961 Section 32. Section [31A-22-615.5](#) is amended to read:

3962 **[31A-22-615.5. Insurance coverage for opioids -- Policies -- Reports.](#)**



- 3963 (1) For purposes of this section:
- 3964 (a) "Health care provider" means an individual, other than a veterinarian, who:
- 3965 (i) is licensed to prescribe a controlled substance under Title 58, Chapter 37, Utah
- 3966 Controlled Substances Act; and
- 3967 (ii) possesses the authority, in accordance with the individual's scope of practice, to
- 3968 prescribe Schedule II controlled substances and Schedule III controlled substances that are
- 3969 applicable to opioids and benzodiazapines.
- 3970 (b) "Health insurer" means:
- 3971 (i) an insurer who offers health care insurance as that term is defined in Section
- 3972 [31A-1-301](#);
- 3973 (ii) health benefits offered to state employees under Section [49-20-202](#); and
- 3974 (iii) a workers' compensation insurer:
- 3975 (A) authorized to provide workers' compensation insurance in the state; or
- 3976 (B) that is a self-insured employer as ~~defined~~ described in Section [34A-2-201](#).
- 3977 (c) "Opioid" has the same meaning as "opiate," as that term is defined in Section
- 3978 [58-37-2](#).
- 3979 (d) "Prescribing policy" means a policy developed by a health insurer that includes
- 3980 evidence based guidelines for prescribing opioids, and may include the 2016 Center for Disease
- 3981 Control Guidelines for Prescribing Opioids for Chronic Pain, or the Utah Clinical Guidelines
- 3982 on Prescribing Opioids for the treatment of pain.
- 3983 (2) A health insurer that provides prescription drug coverage may enact a policy to
- 3984 minimize the risk of opioid addiction and overdose from:
- 3985 (a) chronic co-prescription of opioids with benzodiazapines and other sedating
- 3986 substances;
- 3987 (b) prescription of very high dose opioids in the primary care setting; and
- 3988 (c) the inadvertent transition of short-term opioids for an acute injury into long-term
- 3989 opioid dependence.
- 3990 (3) A health insurer that provides prescription drug coverage may enact policies to
- 3991 facilitate:
- 3992 (a) non-narcotic treatment alternatives for patients who have chronic pain; and
- 3993 (b) medication-assisted treatment for patients who have opioid dependence disorder.

3994 (4) The requirements of this section apply to insurance plans entered into or renewed  
3995 on or after July 1, 2017.

3996 (5) (a) A health insurer subject to this section shall on or before [~~September 1, 2017~~]  
3997 July 15, 2020, and before each [~~September 1~~] July 15 thereafter, submit a written report to the  
3998 Utah Insurance Department regarding whether the insurer has adopted a policy and a general  
3999 description of the policy.

4000 (b) The Utah Insurance Department shall, on or before October 1, 2017, and before  
4001 each October 1 thereafter, submit a written summary of the information under Subsection (5)(a)  
4002 to the Health and Human Services Interim Committee.

4003 (6) A health insurer subject to this section may share the policies developed under this  
4004 section with other health insurers and the public.

4005 (7) This section sunsets in accordance with Section [63I-1-231](#).

4006 Section 33. Section **31A-22-2001** is enacted to read:

4007 **Part 20. Limited Long-Term Care Insurance Act**

4008 **31A-22-2001. Title.**

4009 This part is known as the "Limited Long-Term Care Insurance Act."

4010 Section 34. Section **31A-22-2002** is enacted to read:

4011 **31A-22-2002. Definitions.**

4012 As used in this part:

4013 (1) "Applicant" means:

4014 (a) when referring to an individual limited long-term care insurance policy, the person  
4015 who seeks to contract for benefits; and

4016 (b) when referring to a group limited long-term care insurance policy, the proposed  
4017 certificate holder.

4018 (2) "Elimination period" means the length of time between meeting the eligibility for  
4019 benefit payment and receiving benefit payments from an insurer.

4020 (3) "Group limited long-term care insurance" means a limited long-term care insurance  
4021 policy that is delivered or issued for delivery:

4022 (a) in this state; and

4023 (b) to an eligible group, as described under Subsection [31A-22-701\(2\)](#).

4024 (4) (a) "Limited long-term care insurance" means an insurance:

4025 (i) policy, endorsement, or rider that is advertised, marketed, offered, or designed to  
4026 provide coverage:

4027 (A) for less than 12 consecutive months for each covered person;

4028 (B) on an expense-incurred, indemnity, prepaid or other basis; and

4029 (C) for one or more necessary or medically necessary diagnostic, preventative,  
4030 therapeutic, rehabilitative, maintenance, or personal care services that is provided in a setting  
4031 other than an acute care unit of a hospital; or

4032 (ii) policy or rider that provides for payment of benefits based on cognitive impairment  
4033 or the loss of functional capacity.

4034 (b) "Limited long-term care insurance" does not include an insurance policy that is  
4035 offered primarily to provide:

4036 (i) basic Medicare supplement coverage;

4037 (ii) basic hospital expense coverage;

4038 (iii) basic medical-surgical expense coverage;

4039 (iv) hospital confinement indemnity coverage;

4040 (v) major medical expense coverage;

4041 (vi) disability income or related asset-protection coverage;

4042 (vii) accidental only coverage;

4043 (viii) specified disease or specified accident coverage; or

4044 (ix) limited benefit health coverage.

4045 (5) "Preexisting condition" means a condition for which medical advice or treatment is  
4046 recommended:

4047 (a) by, or received from, a provider of health care services; and

4048 (b) within six months before the day on which the coverage of an insured person  
4049 becomes effective.

4050 (6) "Waiting period" means the time an insured waits before some or all of the  
4051 insured's coverage becomes effective.

4052 Section 35. Section 31A-22-2003 is enacted to read:

4053 **31A-22-2003. Scope.**

4054 (1) The requirements of this part apply to limited long-term care insurance policies and  
4055 certificates marketed, delivered, or issued for delivery in this state on or after July 1, 2020.

4056 (2) Laws and regulations designed or intended to apply to Medicare supplement  
4057 insurance policies may not be applied to limited long-term care insurance.  
4058 Section 36. Section **31A-22-2004** is enacted to read:  
4059 **31A-22-2004. Disclosure and performance standards for limited long-term care**  
4060 **insurance.**  
4061 (1) A limited long-term care insurance policy may not:  
4062 (a) be cancelled, nonrenewed, or otherwise terminated because of the age, gender, or  
4063 the deterioration of the mental or physical health of the insured individual or certificate holder;  
4064 (b) contain a provision establishing a new waiting period if existing coverage is  
4065 converted to or replaced by a new or other form within the same insurer, or the insurer's  
4066 affiliates, except with respect to an increase in benefits voluntarily selected by the insured  
4067 individual or group policyholder; or  
4068 (c) provide coverage for skilled nursing care only or provide significantly more  
4069 coverage for skilled care in a facility than coverage for lower levels of care.  
4070 (2) (a) A limited long-term care insurance policy or certificate may not:  
4071 (i) use a definition of "preexisting condition" that is more restrictive than the definition  
4072 under this part; or  
4073 (ii) exclude coverage for a loss or confinement that is the result of a preexisting  
4074 condition, unless the loss or confinement begins within six months after the day on which the  
4075 coverage of the insured person becomes effective.  
4076 (b) A preexisting condition does not prohibit an insurer from:  
4077 (i) using an application form designed to elicit the complete health history of an  
4078 applicant; or  
4079 (ii) on the basis of the answers on the application described in Subsection (2)(c)(i),  
4080 underwriting in accordance with the insurer's established underwriting standards.  
4081 (c) (i) Unless otherwise provided in the policy or certificate, an insurer may exclude  
4082 coverage of a preexisting condition:  
4083 (A) for a time period of six months, beginning the day on which the coverage of the  
4084 insured person becomes effective; and  
4085 (B) regardless of whether the preexisting condition is disclosed on the application.  
4086 (ii) A limited long-term care insurance policy or certificate may not exclude or use

4087 waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically  
4088 named or described preexisting diseases or physical conditions for more than a time period of  
4089 six months, beginning the day on which the coverage of the insured person becomes effective.

4090 (3) (a) An insurer may not deliver or issue for delivery a limited long-term care  
4091 insurance policy that conditions eligibility for any benefits:

4092 (i) on a prior hospitalization requirement;

4093 (ii) provided in an institutional care setting, on the receipt of a higher level of  
4094 institutional care; or

4095 (iii) other than waiver of premium, post-confinement, post-acute care, or recuperative  
4096 benefits, on a prior institutionalization requirement.

4097 (b) A limited long-term care insurance policy or rider may not condition eligibility for  
4098 noninstitutional benefits on the prior or continuing receipt of skilled care services.

4099 (4) (a) If, after examination of a policy, certificate, or rider, a limited long-term care  
4100 insurance applicant is not satisfied for any reason, the applicant has the right to:

4101 (i) within 30 days after the day on which the applicant receives the policy, certificate,  
4102 endorsement, or rider, return the policy, certificate, endorsement, or rider to the company or a  
4103 producer of the company; and

4104 (ii) have the premium refunded.

4105 (b) (i) Each limited long-term care insurance policy, certificate, endorsement, and rider  
4106 shall:

4107 (A) have a notice prominently printed on the first page or attached thereto detailing  
4108 specific instructions to accomplish a return; and

4109 (B) include the following free-look statement or language substantially similar: "You  
4110 have 30 days from the day on which you receive this policy certificate, endorsement, or rider to  
4111 review it and return it to the company if you decide not to keep it. You do not have to tell the  
4112 company why you are returning it. If you decide not to keep it, simply return it to the company  
4113 at its administrative office. Or you may return it to the producer that you bought it from. You  
4114 must return it within 30 days of the day you first received it. The company will refund the full  
4115 amount of any premium paid within 30 days after it receives the returned policy, certificate, or  
4116 rider. The premium refund will be sent directly to the person who paid it. The policy certificate  
4117 or rider will be void as if it had never been issued."

4118 (ii) The requirements described in Subsection (4)(b)(i) do not apply to a certificate  
4119 issued to an employee under an employer group limited long-term care insurance policy.

4120 (5) (a) (i) An insurer shall deliver an outline of coverage to a prospective applicant for  
4121 limited long-term care insurance at the time of initial solicitation through means that  
4122 prominently direct the attention of the recipient to the document and the document's purpose.

4123 (ii) In the case of an agent solicitation, the agent shall deliver the outline of coverage  
4124 before the presentation of an application or enrollment form.

4125 (iii) In the case of a direct response solicitation, the outline of coverage shall be  
4126 presented in conjunction with any application or enrollment form.

4127 (iv) (A) In the case of a policy issued to a group, the outline of coverage is not required  
4128 to be delivered if the information described in Subsections (5)(b)(i) through (iii) is contained in  
4129 other materials relating to enrollment, including the certificate.

4130 (B) Upon request, an insurer shall make the other materials described in this  
4131 Subsection (5)(a)(iv) available to the commissioner.

4132 (b) An outline of coverage shall include:

4133 (i) a description of the principal benefits and coverage provided in the policy;

4134 (ii) a description of the eligibility triggers for benefits and how the eligibility triggers  
4135 are met;

4136 (iii) a statement of the principal exclusions, reductions, and limitations contained in the  
4137 policy;

4138 (iv) a statement of the terms under which the policy or certificate, or both, may be  
4139 continued in force or discontinued, including any reservation in the policy of a right to change  
4140 premium.

4141 (v) a specific description of each continuation or conversion provision of group  
4142 coverage;

4143 (vi) a statement that the outline of coverage is a summary only, not a contract of  
4144 insurance, and that the policy or group master policy contains governing contractual provisions;

4145 (vii) a description of the terms under which a person may return the policy or  
4146 certificate and have the premium refunded;

4147 (viii) a brief description of the relationship of cost of care and benefits; and

4148 (ix) a statement that discloses to the policyholder or certificate holder that the policy is

4149 not long-term care insurance.

4150 (6) A certificate pursuant to a group limited long-term care insurance policy that is  
4151 delivered or issued for delivery in this state shall include:

4152 (a) a description of the principal benefits and coverage provided in the policy;

4153 (b) a statement of the principal exclusions, reductions, and limitations contained in the  
4154 policy; and

4155 (c) a statement that the group master policy determines governing contractual  
4156 provisions.

4157 (7) If an application for a limited long-term care insurance contract or certificate is  
4158 approved, the issuer shall deliver the contract or certificate of insurance to the applicant no  
4159 later than 30 days after the day on which the application is approved.

4160 Section 37. Section **31A-22-2005** is enacted to read:

4161 **31A-22-2005. Nonforfeiture benefits.**

4162 (1) (a) A limited long-term care insurance policy may offer the option of purchasing a  
4163 policy or certificate including a nonforfeiture benefit.

4164 (b) The offer of a nonforfeiture benefit may be in the form of a rider that is attached to  
4165 the policy.

4166 (c) In the event the policy holder or certificate holder does not purchase a nonforfeiture  
4167 benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a  
4168 specified period of time following a substantial increase in premium rates.

4169 (2) If an insurer issues a group limited long-term care insurance policy, the insurer  
4170 shall:

4171 (a) make any offer of a nonforfeiture benefit to the group policyholder; and

4172 (b) make any offer to each proposed certificate holder.

4173 Section 38. Section **31A-22-2006** is enacted to read:

4174 **31A-22-2006. Rulemaking.**

4175 In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the  
4176 commissioner:

4177 (1) shall make rules:

4178 (a) in the event of a substantial rate increase, promoting premium adequacy and  
4179 protecting the policy holder;

- 4180 (b) establishing minimum standards for limited long-term care insurance marketing  
4181 practices, producer compensation, producer testing, independent review of benefit  
4182 determinations, penalties, and reporting practices;
- 4183 (c) prescribing a standard format, including style, arrangement, and overall appearance  
4184 of an outline of coverage;
- 4185 (d) prescribing the content of an outline of coverage, in accordance with the  
4186 requirements described in Subsection [31A-22-2004\(5\)\(b\)](#);
- 4187 (e) specifying the type of nonforfeiture benefits offered as part of a limited long-term  
4188 care insurance policy or certificate;
- 4189 (f) establishing the standards of nonforfeiture benefits; and
- 4190 (g) establishing the rules regarding contingent benefits upon lapse, including:
- 4191 (i) a determination of the specified period of time during which a contingent benefit  
4192 upon lapse will be available; and
- 4193 (ii) the substantial premium rate increase that triggers a contingent benefit upon lapse  
4194 as described in Subsection [31A-22-2005\(1\)](#); and
- 4195 (2) may make rules establishing loss-ratio standards for limited long-term care  
4196 insurance policies.
- 4197 Section 39. Section **31A-23a-111** is amended to read:
- 4198 **31A-23a-111. Revoking, suspending, surrendering, lapsing, limiting, or otherwise**  
4199 **terminating a license -- Forfeiture -- Rulemaking for renewal or reinstatement.**
- 4200 (1) A license type issued under this chapter remains in force until:
- 4201 (a) revoked or suspended under Subsection (5);
- 4202 (b) surrendered to the commissioner and accepted by the commissioner in lieu of  
4203 administrative action;
- 4204 (c) the licensee dies or is adjudicated incompetent as defined under:
- 4205 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
- 4206 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and  
4207 Minors;
- 4208 (d) lapsed under Section [31A-23a-113](#); or
- 4209 (e) voluntarily surrendered.
- 4210 (2) The following may be reinstated within one year after the day on which the license



4211 is no longer in force:

4212 (a) a lapsed license; or

4213 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may  
4214 not be reinstated after the license period in which the license is voluntarily surrendered.

4215 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a  
4216 license, submission and acceptance of a voluntary surrender of a license does not prevent the  
4217 department from pursuing additional disciplinary or other action authorized under:

4218 (a) this title; or

4219 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah  
4220 Administrative Rulemaking Act.

4221 (4) A line of authority issued under this chapter remains in force until:

4222 (a) the qualifications pertaining to a line of authority are no longer met by the licensee;

4223 or

4224 (b) the supporting license type:

4225 (i) is revoked or suspended under Subsection (5);

4226 (ii) is surrendered to the commissioner and accepted by the commissioner in lieu of  
4227 administrative action;

4228 (iii) lapses under Section [31A-23a-113](#); or

4229 (iv) is voluntarily surrendered; or

4230 (c) the licensee dies or is adjudicated incompetent as defined under:

4231 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

4232 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and  
4233 Minors.

4234 (5) (a) If the commissioner makes a finding under Subsection (5)(b), as part of an  
4235 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the  
4236 commissioner may:

4237 (i) revoke:

4238 (A) a license; or

4239 (B) a line of authority;

4240 (ii) suspend for a specified period of 12 months or less:

4241 (A) a license; or

- 4242 (B) a line of authority;
- 4243 (iii) limit in whole or in part:
- 4244 (A) a license; or
- 4245 (B) a line of authority;
- 4246 (iv) deny a license application;
- 4247 (v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or
- 4248 (vi) take a combination of actions under Subsections (5)(a)(i) through (iv) and
- 4249 Subsection (5)(a)(v).
- 4250 (b) The commissioner may take an action described in Subsection (5)(a) if the
- 4251 commissioner finds that the licensee or license applicant:
- 4252 (i) is unqualified for a license or line of authority under Section 31A-23a-104,
- 4253 31A-23a-105, or 31A-23a-107;
- 4254 (ii) violates:
- 4255 (A) an insurance statute;
- 4256 (B) a rule that is valid under Subsection 31A-2-201(3); or
- 4257 (C) an order that is valid under Subsection 31A-2-201(4);
- 4258 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other
- 4259 delinquency proceedings in any state;
- 4260 (iv) fails to pay a final judgment rendered against the person in this state within 60
- 4261 days after the day on which the judgment became final;
- 4262 (v) fails to meet the same good faith obligations in claims settlement that is required of
- 4263 admitted insurers;
- 4264 (vi) is affiliated with and under the same general management or interlocking
- 4265 directorate or ownership as another insurance producer that transacts business in this state
- 4266 without a license;
- 4267 (vii) refuses:
- 4268 (A) to be examined; or
- 4269 (B) to produce its accounts, records, and files for examination;
- 4270 (viii) has an officer who refuses to:
- 4271 (A) give information with respect to the insurance producer's affairs; or
- 4272 (B) perform any other legal obligation as to an examination;

- 4273 (ix) provides information in the license application that is:  
4274 (A) incorrect;  
4275 (B) misleading;  
4276 (C) incomplete; or  
4277 (D) materially untrue;  
4278 (x) violates an insurance law, valid rule, or valid order of another regulatory agency in  
4279 any jurisdiction;  
4280 (xi) obtains or attempts to obtain a license through misrepresentation or fraud;  
4281 (xii) improperly withholds, misappropriates, or converts money or properties received  
4282 in the course of doing insurance business;  
4283 (xiii) intentionally misrepresents the terms of an actual or proposed:  
4284 (A) insurance contract;  
4285 (B) application for insurance; or  
4286 (C) life settlement;  
4287 (xiv) has been convicted of:  
4288 (A) a felony; or  
4289 (B) a misdemeanor involving fraud, misrepresentation, theft, or dishonesty;  
4290 (xv) admits or is found to have committed an insurance unfair trade practice or fraud;  
4291 (xvi) in the conduct of business in this state or elsewhere:  
4292 (A) uses fraudulent, coercive, or dishonest practices; or  
4293 (B) demonstrates incompetence, untrustworthiness, or financial irresponsibility;  
4294 (xvii) has had an insurance license or other professional or occupational license, or an  
4295 equivalent to an insurance license or registration, or other professional or occupational license  
4296 or registration:  
4297 (A) denied;  
4298 (B) suspended;  
4299 (C) revoked; or  
4300 (D) surrendered to resolve an administrative action;  
4301 (xviii) forges another's name to:  
4302 (A) an application for insurance; or  
4303 (B) a document related to an insurance transaction;

4304 (xix) improperly uses notes or another reference material to complete an examination  
4305 for an insurance license;

4306 (xx) knowingly accepts insurance business from an individual who is not licensed;

4307 (xxi) fails to comply with an administrative or court order imposing a child support  
4308 obligation;

4309 (xxii) fails to:

4310 (A) pay state income tax; or

4311 (B) comply with an administrative or court order directing payment of state income  
4312 tax;

4313 (xxiii) has been convicted of violating the federal Violent Crime Control and Law  
4314 Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and has not obtained written consent to engage  
4315 in the business of insurance or participate in such business as required by 18 U.S.C. Sec. 1033;

4316 (xxiv) engages in a method or practice in the conduct of business that endangers the  
4317 legitimate interests of customers and the public; or

4318 (xxv) has been convicted of any criminal felony involving dishonesty or breach of trust  
4319 and has not obtained written consent to engage in the business of insurance or participate in  
4320 such business as required by 18 U.S.C. Sec. 1033.

4321 (c) For purposes of this section, if a license is held by an agency, both the agency itself  
4322 and any individual designated under the license are considered to be the holders of the license.

4323 (d) If an individual designated under the agency license commits an act or fails to  
4324 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,  
4325 the commissioner may suspend, revoke, or limit the license of:

4326 (i) the individual;

4327 (ii) the agency, if the agency:

4328 (A) is reckless or negligent in its supervision of the individual; or

4329 (B) knowingly participates in the act or failure to act that is the ground for suspending,  
4330 revoking, or limiting the license; or

4331 (iii) (A) the individual; and

4332 (B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).

4333 (6) A licensee under this chapter is subject to the penalties for acting as a licensee  
4334 without a license if:

- 4335 (a) the licensee's license is:
- 4336 (i) revoked;
- 4337 (ii) suspended;
- 4338 (iii) limited;
- 4339 (iv) surrendered in lieu of administrative action;
- 4340 (v) lapsed; or
- 4341 (vi) voluntarily surrendered; and
- 4342 (b) the licensee:
- 4343 (i) continues to act as a licensee; or
- 4344 (ii) violates the terms of the license limitation.
- 4345 (7) A licensee under this chapter shall immediately report to the commissioner:
- 4346 (a) a revocation, suspension, or limitation of the person's license in another state, the
- 4347 District of Columbia, or a territory of the United States;
- 4348 (b) the imposition of a disciplinary sanction imposed on that person by another state,
- 4349 the District of Columbia, or a territory of the United States; or
- 4350 (c) a judgment or injunction entered against that person on the basis of conduct
- 4351 involving:
- 4352 (i) fraud;
- 4353 (ii) deceit;
- 4354 (iii) misrepresentation; or
- 4355 (iv) a violation of an insurance law or rule.
- 4356 (8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a
- 4357 license in lieu of administrative action may specify a time, not to exceed five years, within
- 4358 which the former licensee may not apply for a new license.
- 4359 (b) If no time is specified in an order or agreement described in Subsection (8)(a), the
- 4360 former licensee may not apply for a new license for five years from the day on which the order
- 4361 or agreement is made without the express approval by the commissioner.
- 4362 (9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of
- 4363 a license issued under this part if so ordered by a court.
- 4364 (10) The commissioner shall by rule prescribe the license renewal and reinstatement
- 4365 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

4366 Section 40. Section 31A-23a-205 is amended to read:

4367 **31A-23a-205. Special requirements for bail bond producers and bail bond**  
4368 **enforcement agents.**

4369 (1) As used in this section, "bail bond producer" and "bail enforcement agent" have the  
4370 same definitions as in Section 31A-35-102.

4371 (2) A bail bond producer may not operate in this state without an appointment from  
4372 one or more authorized bail bond surety insurers or licensed bail bond [surety] companies.

4373 (3) A bail bond enforcement agent may not operate in this state without an appointment  
4374 from one or more licensed bail bond producers.

4375 Section 41. Section 31A-23a-415 is amended to read:

4376 **31A-23a-415. Assessment on agency title insurance producers or title insurers --**  
4377 **Account created.**

4378 (1) For purposes of this section:

4379 (a) "Premium" is as [defined] described in Subsection 59-9-101(3).

4380 (b) "Title insurer" means a person:

4381 (i) making any contract or policy of title insurance as:

4382 (A) insurer;

4383 (B) guarantor; or

4384 (C) surety;

4385 (ii) proposing to make any contract or policy of title insurance as:

4386 (A) insurer;

4387 (B) guarantor; or

4388 (C) surety; or

4389 (iii) transacting or proposing to transact any phase of title insurance, including:

4390 (A) soliciting;

4391 (B) negotiating preliminary to execution;

4392 (C) executing of a contract of title insurance;

4393 (D) insuring; and

4394 (E) transacting matters subsequent to the execution of the contract and arising out of  
4395 the contract.

4396 (c) "Utah risks" means insuring, guaranteeing, or indemnifying with regard to real or

4397 personal property located in Utah, an owner of real or personal property, the holders of liens or  
4398 encumbrances on that property, or others interested in the property against loss or damage  
4399 suffered by reason of:

4400 (i) liens or encumbrances upon, defects in, or the unmarketability of the title to the  
4401 property; or

4402 (ii) invalidity or unenforceability of any liens or encumbrances on the property.

4403 (2) (a) The commissioner may assess each title insurer, each individual title insurance  
4404 producer who is not an employee of a title insurer or who is not designated by an agency title  
4405 insurance producer, and each agency title insurance producer an annual assessment:

4406 (i) determined by the Title and Escrow Commission:

4407 (A) after consultation with the commissioner; and

4408 (B) in accordance with this Subsection (2); and

4409 (ii) to be used for the purposes described in Subsection (3).

4410 (b) An agency title insurance producer and individual title insurance producer who is  
4411 not an employee of a title insurer or who is not designated by an agency title insurance  
4412 producer shall be assessed up to:

4413 (i) \$250 for the first office in each county in which the agency title insurance producer  
4414 or individual title insurance producer maintains an office; and

4415 (ii) \$150 for each additional office the agency title insurance producer or individual  
4416 title insurance producer maintains in the county described in Subsection (2)(b)(i).

4417 (c) A title insurer shall be assessed up to:

4418 (i) \$250 for the first office in each county in which the title insurer maintains an office;

4419 (ii) \$150 for each additional office the title insurer maintains in the county described in  
4420 Subsection (2)(c)(i); and

4421 (iii) an amount calculated by:

4422 (A) aggregating the assessments imposed on:

4423 (I) agency title insurance producers and individual title insurance producers under  
4424 Subsection (2)(b); and

4425 (II) title insurers under Subsections (2)(c)(i) and (2)(c)(ii);

4426 (B) subtracting the amount determined under Subsection (2)(c)(iii)(A) from the total  
4427 costs and expenses determined under Subsection (2)(d); and

4428 (C) multiplying:  
4429 (I) the amount calculated under Subsection (2)(c)(iii)(B); and  
4430 (II) the percentage of total premiums for title insurance on Utah risk that are premiums  
4431 of the title insurer.

4432 (d) Notwithstanding Section 31A-3-103 and subject to Section 31A-2-404, the Title  
4433 and Escrow Commission by rule shall establish the amount of costs and expenses described  
4434 under Subsection (3) that will be covered by the assessment, except the costs or expenses to be  
4435 covered by the assessment may not exceed [~~\$100,000 annually~~] the cost of one full-time  
4436 equivalent position.

4437 (e) (i) An individual licensed to practice law in Utah is exempt from the requirements  
4438 of this Subsection (2) if that person issues 12 or less policies during a 12-month period.

4439 (ii) In determining the number of policies issued by an individual licensed to practice  
4440 law in Utah for purposes of Subsection (2)(e)(i), if the individual issues a policy to more than  
4441 one party to the same closing, the individual is considered to have issued only one policy.

4442 (3) (a) Money received by the state under this section shall be deposited into the Title  
4443 Licensee Enforcement Restricted Account.

4444 (b) There is created in the General Fund a restricted account known as the "Title  
4445 Licensee Enforcement Restricted Account."

4446 (c) The Title Licensee Enforcement Restricted Account shall consist of the money  
4447 received by the state under this section.

4448 (d) The commissioner shall administer the Title Licensee Enforcement Restricted  
4449 Account. Subject to appropriations by the Legislature, the commissioner shall use the money  
4450 deposited into the Title Licensee Enforcement Restricted Account only to pay for a cost or  
4451 expense incurred by the department in the administration, investigation, and enforcement of  
4452 laws governing individual title insurance producers, agency title insurance producers, or title  
4453 insurers.

4454 (e) An appropriation from the Title Licensee Enforcement Restricted Account is  
4455 nonlapsing.

4456 (4) The assessment imposed by this section shall be in addition to any premium  
4457 assessment imposed under Subsection 59-9-101(3).

4458 Section 42. Section 31A-23b-401 is amended to read:



4459           **31A-23b-401. Revoking, suspending, surrendering, lapsing, limiting, or otherwise**  
4460 **terminating a license -- Rulemaking for renewal or reinstatement.**

4461           (1) A license as a navigator under this chapter remains in force until:

4462           (a) revoked or suspended under Subsection (4);

4463           (b) surrendered to the commissioner and accepted by the commissioner in lieu of  
4464 administrative action;

4465           (c) the licensee dies or is adjudicated incompetent as defined under:

4466           (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

4467           (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and  
4468 Minors;

4469           (d) lapsed under this section; or

4470           (e) voluntarily surrendered.

4471           (2) The following may be reinstated within one year after the day on which the license  
4472 is no longer in force:

4473           (a) a lapsed license; or

4474           (b) a voluntarily surrendered license, except that a voluntarily surrendered license may  
4475 not be reinstated after the license period in which the license is voluntarily surrendered.

4476           (3) Unless otherwise stated in a written agreement for the voluntary surrender of a  
4477 license, submission and acceptance of a voluntary surrender of a license does not prevent the  
4478 department from pursuing additional disciplinary or other action authorized under:

4479           (a) this title; or

4480           (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah  
4481 Administrative Rulemaking Act.

4482           (4) (a) If the commissioner makes a finding under Subsection (4)(b), as part of an  
4483 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the  
4484 commissioner may:

4485           (i) revoke a license;

4486           (ii) suspend a license for a specified period of 12 months or less;

4487           (iii) limit a license in whole or in part;

4488           (iv) deny a license application;

4489           (v) assess a forfeiture under Subsection [31A-2-308\(1\)\(b\)\(i\)](#) or [\(1\)\(c\)\(i\)](#); or

- 4490 (vi) take a combination of actions under Subsections (4)(a)(i) through (iv) and
- 4491 Subsection (4)(a)(v).
- 4492 (b) The commissioner may take an action described in Subsection (4)(a) if the
- 4493 commissioner finds that the licensee or license applicant:
- 4494 (i) is unqualified for a license under Section 31A-23b-204, 31A-23b-205, or
- 4495 31A-23b-206;
- 4496 (ii) violated:
- 4497 (A) an insurance statute;
- 4498 (B) a rule that is valid under Subsection 31A-2-201(3); or
- 4499 (C) an order that is valid under Subsection 31A-2-201(4);
- 4500 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other
- 4501 delinquency proceedings in any state;
- 4502 (iv) failed to pay a final judgment rendered against the person in this state within 60
- 4503 days after the day on which the judgment became final;
- 4504 (v) refused:
- 4505 (A) to be examined; or
- 4506 (B) to produce its accounts, records, and files for examination;
- 4507 (vi) had an officer who refused to:
- 4508 (A) give information with respect to the navigator's affairs; or
- 4509 (B) perform any other legal obligation as to an examination;
- 4510 (vii) provided information in the license application that is:
- 4511 (A) incorrect;
- 4512 (B) misleading;
- 4513 (C) incomplete; or
- 4514 (D) materially untrue;
- 4515 (viii) violated an insurance law, valid rule, or valid order of another regulatory agency
- 4516 in any jurisdiction;
- 4517 (ix) obtained or attempted to obtain a license through misrepresentation or fraud;
- 4518 (x) improperly withheld, misappropriated, or converted money or properties received
- 4519 in the course of doing insurance business;
- 4520 (xi) intentionally misrepresented the terms of an actual or proposed:

- 4521 (A) insurance contract;
- 4522 (B) application for insurance; or
- 4523 (C) application for public program;
- 4524 (xii) has been convicted of:
  - 4525 (A) a felony; or
  - 4526 (B) a misdemeanor involving fraud, misrepresentation, theft, or dishonesty;
- 4527 (xiii) admitted or is found to have committed an insurance unfair trade practice or
- 4528 fraud;
- 4529 (xiv) in the conduct of business in this state or elsewhere:
  - 4530 (A) used fraudulent, coercive, or dishonest practices; or
  - 4531 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;
- 4532 (xv) has had an insurance license, navigator license, or other professional or
- 4533 occupational license or registration, or an equivalent of the same denied, suspended, revoked,
- 4534 or surrendered to resolve an administrative action;
- 4535 (xvi) forged another's name to:
  - 4536 (A) an application for insurance;
  - 4537 (B) a document related to an insurance transaction;
  - 4538 (C) a document related to an application for a public program; or
  - 4539 (D) a document related to an application for premium subsidies;
- 4540 (xvii) improperly used notes or another reference material to complete an examination
- 4541 for a license;
- 4542 (xviii) knowingly accepted insurance business from an individual who is not licensed;
- 4543 (xix) failed to comply with an administrative or court order imposing a child support
- 4544 obligation;
- 4545 (xx) failed to:
  - 4546 (A) pay state income tax; or
  - 4547 (B) comply with an administrative or court order directing payment of state income
  - 4548 tax;
- 4549 (xxi) has been convicted of violating the federal Violent Crime Control and Law
- 4550 Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and has not obtained written consent to engage
- 4551 in the business of insurance or participate in such business as required by 18 U.S.C. Sec. 1033;

4552 (xxii) engaged in a method or practice in the conduct of business that endangered the  
4553 legitimate interests of customers and the public; or

4554 (xxiii) has been convicted of any criminal felony involving dishonesty or breach of  
4555 trust and has not obtained written consent to engage in the business of insurance or participate  
4556 in such business as required by 18 U.S.C. Sec. 1033.

4557 (c) For purposes of this section, if a license is held by an agency, both the agency itself  
4558 and any individual designated under the license are considered to be the holders of the license.

4559 (d) If an individual designated under the agency license commits an act or fails to  
4560 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,  
4561 the commissioner may suspend, revoke, or limit the license of:

4562 (i) the individual;

4563 (ii) the agency, if the agency:

4564 (A) is reckless or negligent in its supervision of the individual; or

4565 (B) knowingly participates in the act or failure to act that is the ground for suspending,  
4566 revoking, or limiting the license; or

4567 (iii) (A) the individual; and

4568 (B) the agency if the agency meets the requirements of Subsection (4)(d)(ii).

4569 (5) A licensee under this chapter is subject to the penalties for acting as a licensee  
4570 without a license if:

4571 (a) the licensee's license is:

4572 (i) revoked;

4573 (ii) suspended;

4574 (iii) surrendered in lieu of administrative action;

4575 (iv) lapsed; or

4576 (v) voluntarily surrendered; and

4577 (b) the licensee:

4578 (i) continues to act as a licensee; or

4579 (ii) violates the terms of the license limitation.

4580 (6) A licensee under this chapter shall immediately report to the commissioner:

4581 (a) a revocation, suspension, or limitation of the person's license in another state, the  
4582 District of Columbia, or a territory of the United States;

4583 (b) the imposition of a disciplinary sanction imposed on that person by another state,  
4584 the District of Columbia, or a territory of the United States; or

4585 (c) a judgment or injunction entered against that person on the basis of conduct  
4586 involving:

4587 (i) fraud;

4588 (ii) deceit;

4589 (iii) misrepresentation; or

4590 (iv) a violation of an insurance law or rule.

4591 (7) (a) An order revoking a license under Subsection (4) or an agreement to surrender a  
4592 license in lieu of administrative action may specify a time, not to exceed five years, within  
4593 which the former licensee may not apply for a new license.

4594 (b) If no time is specified in an order or agreement described in Subsection (7)(a), the  
4595 former licensee may not apply for a new license for five years from the day on which the order  
4596 or agreement is made without the express approval of the commissioner.

4597 (8) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of  
4598 a license issued under this chapter if so ordered by a court.

4599 (9) The commissioner shall by rule prescribe the license renewal and reinstatement  
4600 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

4601 Section 43. Section **31A-25-208** is amended to read:

4602 **31A-25-208. Revoking, suspending, surrendering, lapsing, limiting, or otherwise**  
4603 **terminating a license -- Rulemaking for renewal and reinstatement.**

4604 (1) A license type issued under this chapter remains in force until:

4605 (a) revoked or suspended under Subsection (4);

4606 (b) surrendered to the commissioner and accepted by the commissioner in lieu of  
4607 administrative action;

4608 (c) the licensee dies or is adjudicated incompetent as defined under:

4609 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

4610 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and  
4611 Minors;

4612 (d) lapsed under Section [31A-25-210](#); or

4613 (e) voluntarily surrendered.

4614 (2) The following may be reinstated within one year after the day on which the license  
4615 is no longer in force:

4616 (a) a lapsed license; or

4617 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may  
4618 not be reinstated after the license period in which the license is voluntarily surrendered.

4619 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a  
4620 license, submission and acceptance of a voluntary surrender of a license does not prevent the  
4621 department from pursuing additional disciplinary or other action authorized under:

4622 (a) this title; or

4623 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah  
4624 Administrative Rulemaking Act.

4625 (4) (a) If the commissioner makes a finding under Subsection (4)(b), as part of an  
4626 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the  
4627 commissioner may:

4628 (i) revoke a license;

4629 (ii) suspend a license for a specified period of 12 months or less;

4630 (iii) limit a license in whole or in part; or

4631 (iv) deny a license application.

4632 (b) The commissioner may take an action described in Subsection (4)(a) if the  
4633 commissioner finds that the licensee or license applicant:

4634 (i) is unqualified for a license under Section [31A-25-202](#), [31A-25-203](#), or [31A-25-204](#);

4635 (ii) has violated:

4636 (A) an insurance statute;

4637 (B) a rule that is valid under Subsection [31A-2-201\(3\)](#); or

4638 (C) an order that is valid under Subsection [31A-2-201\(4\)](#);

4639 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other  
4640 delinquency proceedings in any state;

4641 (iv) fails to pay a final judgment rendered against the person in this state within 60  
4642 days after the day on which the judgment became final;

4643 (v) fails to meet the same good faith obligations in claims settlement that is required of  
4644 admitted insurers;

- 4645 (vi) is affiliated with and under the same general management or interlocking  
4646 directorate or ownership as another third party administrator that transacts business in this state  
4647 without a license;
- 4648 (vii) refuses:
- 4649 (A) to be examined; or
- 4650 (B) to produce its accounts, records, and files for examination;
- 4651 (viii) has an officer who refuses to:
- 4652 (A) give information with respect to the third party administrator's affairs; or
- 4653 (B) perform any other legal obligation as to an examination;
- 4654 (ix) provides information in the license application that is:
- 4655 (A) incorrect;
- 4656 (B) misleading;
- 4657 (C) incomplete; or
- 4658 (D) materially untrue;
- 4659 (x) has violated an insurance law, valid rule, or valid order of another regulatory  
4660 agency in any jurisdiction;
- 4661 (xi) has obtained or attempted to obtain a license through misrepresentation or fraud;
- 4662 (xii) has improperly withheld, misappropriated, or converted money or properties  
4663 received in the course of doing insurance business;
- 4664 (xiii) has intentionally misrepresented the terms of an actual or proposed:
- 4665 (A) insurance contract; or
- 4666 (B) application for insurance;
- 4667 (xiv) has been convicted of:
- 4668 (A) a felony; or
- 4669 (B) a misdemeanor involving fraud, misrepresentation, theft, or dishonesty;
- 4670 (xv) has admitted or been found to have committed an insurance unfair trade practice  
4671 or fraud;
- 4672 (xvi) in the conduct of business in this state or elsewhere has:
- 4673 (A) used fraudulent, coercive, or dishonest practices; or
- 4674 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;
- 4675 (xvii) has had an insurance license or other professional or occupational license or

4676 registration, or an equivalent of the same, denied, suspended, revoked, or surrendered to  
4677 resolve an administrative action;

4678 (xviii) has forged another's name to:

4679 (A) an application for insurance; or

4680 (B) a document related to an insurance transaction;

4681 (xix) has improperly used notes or any other reference material to complete an  
4682 examination for an insurance license;

4683 (xx) has knowingly accepted insurance business from an individual who is not  
4684 licensed;

4685 (xxi) has failed to comply with an administrative or court order imposing a child  
4686 support obligation;

4687 (xxii) has failed to:

4688 (A) pay state income tax; or

4689 (B) comply with an administrative or court order directing payment of state income  
4690 tax;

4691 (xxiii) ~~[has violated or permitted others to violate]~~ is convicted of violating the federal  
4692 Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and [therefore]  
4693 has not obtained written consent to engage in the business of insurance or participate in such  
4694 business as required under 18 U.S.C. Sec. 1033 ~~[is prohibited from engaging in the business of~~  
4695 ~~insurance; or];~~

4696 (xxiv) has engaged in methods and practices in the conduct of business that endanger  
4697 the legitimate interests of customers and the public[-]; or

4698 (xxv) has been convicted of a criminal felony involving dishonesty or breach of trust  
4699 and has not obtained written consent to engage in the business of insurance or participate in  
4700 such business as required under 18 U.S.C. Sec. 1033.

4701 (c) For purposes of this section, if a license is held by an agency, both the agency itself  
4702 and any individual designated under the license are considered to be the holders of the agency  
4703 license.

4704 (d) If an individual designated under the agency license commits an act or fails to  
4705 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,  
4706 the commissioner may suspend, revoke, or limit the license of:



- 4707 (i) the individual;
- 4708 (ii) the agency if the agency:
- 4709 (A) is reckless or negligent in its supervision of the individual; or
- 4710 (B) knowingly participated in the act or failure to act that is the ground for suspending,
- 4711 revoking, or limiting the license; or
- 4712 (iii) (A) the individual; and
- 4713 (B) the agency if the agency meets the requirements of Subsection (4)(d)(ii).
- 4714 (5) A licensee under this chapter is subject to the penalties for acting as a licensee
- 4715 without a license if:
- 4716 (a) the licensee's license is:
- 4717 (i) revoked;
- 4718 (ii) suspended;
- 4719 (iii) limited;
- 4720 (iv) surrendered in lieu of administrative action;
- 4721 (v) lapsed; or
- 4722 (vi) voluntarily surrendered; and
- 4723 (b) the licensee:
- 4724 (i) continues to act as a licensee; or
- 4725 (ii) violates the terms of the license limitation.
- 4726 (6) A licensee under this chapter shall immediately report to the commissioner:
- 4727 (a) a revocation, suspension, or limitation of the person's license in any other state, the
- 4728 District of Columbia, or a territory of the United States;
- 4729 (b) the imposition of a disciplinary sanction imposed on that person by any other state,
- 4730 the District of Columbia, or a territory of the United States; or
- 4731 (c) a judgment or injunction entered against the person on the basis of conduct
- 4732 involving:
- 4733 (i) fraud;
- 4734 (ii) deceit;
- 4735 (iii) misrepresentation; or
- 4736 (iv) a violation of an insurance law or rule.
- 4737 (7) (a) An order revoking a license under Subsection (4) or an agreement to surrender a

4738 license in lieu of administrative action may specify a time, not to exceed five years, within  
4739 which the former licensee may not apply for a new license.

4740 (b) If no time is specified in the order or agreement described in Subsection (7)(a), the  
4741 former licensee may not apply for a new license for five years from the day on which the order  
4742 or agreement is made without the express approval of the commissioner.

4743 (8) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of  
4744 a license issued under this part if so ordered by the court.

4745 (9) The commissioner shall by rule prescribe the license renewal and reinstatement  
4746 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

4747 Section 44. Section **31A-26-206** is amended to read:

4748 **31A-26-206. Continuing education requirements.**

4749 (1) Pursuant to this section, the commissioner shall by rule prescribe continuing  
4750 education requirements for each class of license under Section [31A-26-204](#).

4751 (2) (a) The commissioner shall impose continuing education requirements in  
4752 accordance with a two-year licensing period in which the licensee meets the requirements of  
4753 this Subsection (2).

4754 (b) (i) Except as otherwise provided in this section, the continuing education  
4755 requirements shall require:

4756 (A) that a licensee complete 24 credit hours of continuing education for every two-year  
4757 licensing period;

4758 (B) that 3 of the 24 credit hours described in Subsection (2)(b)(i)(A) be ethics courses;  
4759 and

4760 (C) that the licensee complete at least half of the required hours through classroom  
4761 hours of insurance-related instruction.

4762 (ii) A continuing education hour completed in accordance with Subsection (2)(b)(i)  
4763 may be obtained through:

4764 (A) classroom attendance;

4765 (B) home study;

4766 (C) watching a video recording;

4767 (D) experience credit; or

4768 (E) other methods provided by rule.

4769 (iii) Notwithstanding Subsections (2)(b)(i)(A) and (B), a title insurance adjuster is  
4770 required to complete 12 credit hours of continuing education for every two-year licensing  
4771 period, with 3 of the credit hours being ethics courses.

4772 (c) A licensee may obtain continuing education hours at any time during the two-year  
4773 licensing period.

4774 (d) (i) A licensee is exempt from the continuing education requirements of this section  
4775 if:

4776 (A) the licensee was first licensed before December 31, 1982;

4777 (B) the license does not have a continuous lapse for a period of more than one year,  
4778 except for a license for which the licensee has had an exemption approved before May 11,  
4779 2011;

4780 (C) the licensee requests an exemption from the department; and

4781 (D) the department approves the exemption.

4782 (ii) If the department approves the exemption under Subsection (2)(d)(i), the licensee is  
4783 not required to apply again for the exemption.

4784 (e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the  
4785 commissioner shall by rule:

4786 (i) publish a list of insurance professional designations whose continuing education  
4787 requirements can be used to meet the requirements for continuing education under Subsection  
4788 (2)(b); and

4789 (ii) authorize a professional adjuster association to:

4790 (A) offer a qualified program for a classification of license on a geographically  
4791 accessible basis; and

4792 (B) collect a reasonable fee for funding and administration of a qualified program,  
4793 subject to the review and approval of the commissioner.

4794 (f) (i) A fee permitted under Subsection (2)(e)(ii)(B) that is charged to fund and  
4795 administer a qualified program shall reasonably relate to the cost of administering the qualified  
4796 program.

4797 (ii) Nothing in this section shall prohibit a provider of a continuing education program  
4798 or course from charging a fee for attendance at a course offered for continuing education credit.

4799 (iii) A fee permitted under Subsection (2)(e)(ii)(B) that is charged for attendance at an

4800 association program may be less for an association member, on the basis of the member's  
4801 affiliation expense, but shall preserve the right of a nonmember to attend without affiliation.

4802 (3) The continuing education requirements of this section apply only to a licensee who  
4803 is an individual.

4804 (4) The continuing education requirements of this section do not apply to a member of  
4805 the Utah State Bar.

4806 (5) The commissioner shall designate a course that satisfies the requirements of this  
4807 section, including a course presented by an insurer.

4808 (6) A nonresident adjuster is considered to have satisfied this state's continuing  
4809 education requirements if:

4810 (a) the nonresident adjuster satisfies the nonresident [~~producer's~~] home state's  
4811 continuing education requirements for a licensed insurance adjuster; and

4812 (b) on the same basis the nonresident adjuster's home state considers satisfaction of  
4813 Utah's continuing education requirements for [~~a producer~~] an adjuster as satisfying the  
4814 continuing education requirements of the home state.

4815 (7) A licensee subject to this section shall keep documentation of completing the  
4816 continuing education requirements of this section for two years after the end of the two-year  
4817 licensing period to which the continuing education requirement applies.

4818 Section 45. Section **31A-26-213** is amended to read:

4819 **31A-26-213. Revoking, suspending, surrendering, lapsing, limiting, or otherwise**  
4820 **terminating a license -- Forfeiture -- Rulemaking for renewal or reinstatement.**

4821 (1) A license type issued under this chapter remains in force until:

4822 (a) revoked or suspended under Subsection (5);

4823 (b) surrendered to the commissioner and accepted by the commissioner in lieu of  
4824 administrative action;

4825 (c) the licensee dies or is adjudicated incompetent as defined under:

4826 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

4827 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and  
4828 Minors;

4829 (d) lapsed under Section [31A-26-214.5](#); or

4830 (e) voluntarily surrendered.

4831 (2) The following may be reinstated within one year after the day on which the license  
4832 is no longer in force:

4833 (a) a lapsed license; or

4834 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may  
4835 not be reinstated after the license period in which it is voluntarily surrendered.

4836 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a  
4837 license, submission and acceptance of a voluntary surrender of a license does not prevent the  
4838 department from pursuing additional disciplinary or other action authorized under:

4839 (a) this title; or

4840 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah  
4841 Administrative Rulemaking Act.

4842 (4) A license classification issued under this chapter remains in force until:

4843 (a) the qualifications pertaining to a license classification are no longer met by the  
4844 licensee; or

4845 (b) the supporting license type:

4846 (i) is revoked or suspended under Subsection (5); or

4847 (ii) is surrendered to the commissioner and accepted by the commissioner in lieu of  
4848 administrative action.

4849 (5) (a) If the commissioner makes a finding under Subsection (5)(b) as part of an  
4850 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the  
4851 commissioner may:

4852 (i) revoke:

4853 (A) a license; or

4854 (B) a license classification;

4855 (ii) suspend for a specified period of 12 months or less:

4856 (A) a license; or

4857 (B) a license classification;

4858 (iii) limit in whole or in part:

4859 (A) a license; or

4860 (B) a license classification;

4861 (iv) deny a license application;

- 4862 (v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or
- 4863 (vi) take a combination of actions under Subsections (5)(a)(i) through (iv) and
- 4864 Subsection (5)(a)(v).
- 4865 (b) The commissioner may take an action described in Subsection (5)(a) if the
- 4866 commissioner finds that the licensee or license applicant:
- 4867 (i) is unqualified for a license or license classification under Section 31A-26-202,
- 4868 31A-26-203, 31A-26-204, or 31A-26-205;
- 4869 (ii) has violated:
- 4870 (A) an insurance statute;
- 4871 (B) a rule that is valid under Subsection 31A-2-201(3); or
- 4872 (C) an order that is valid under Subsection 31A-2-201(4);
- 4873 (iii) is insolvent, or the subject of receivership, conservatorship, rehabilitation, or other
- 4874 delinquency proceedings in any state;
- 4875 (iv) fails to pay a final judgment rendered against the person in this state within 60
- 4876 days after the judgment became final;
- 4877 (v) fails to meet the same good faith obligations in claims settlement that is required of
- 4878 admitted insurers;
- 4879 (vi) is affiliated with and under the same general management or interlocking
- 4880 directorate or ownership as another insurance adjuster that transacts business in this state
- 4881 without a license;
- 4882 (vii) refuses:
- 4883 (A) to be examined; or
- 4884 (B) to produce its accounts, records, and files for examination;
- 4885 (viii) has an officer who refuses to:
- 4886 (A) give information with respect to the insurance adjuster's affairs; or
- 4887 (B) perform any other legal obligation as to an examination;
- 4888 (ix) provides information in the license application that is:
- 4889 (A) incorrect;
- 4890 (B) misleading;
- 4891 (C) incomplete; or
- 4892 (D) materially untrue;

- 4893 (x) has violated an insurance law, valid rule, or valid order of another regulatory
- 4894 agency in any jurisdiction;
- 4895 (xi) has obtained or attempted to obtain a license through misrepresentation or fraud;
- 4896 (xii) has improperly withheld, misappropriated, or converted money or properties
- 4897 received in the course of doing insurance business;
- 4898 (xiii) has intentionally misrepresented the terms of an actual or proposed:
- 4899 (A) insurance contract; or
- 4900 (B) application for insurance;
- 4901 (xiv) has been convicted of:
- 4902 (A) a felony; or
- 4903 (B) a misdemeanor involving fraud, misrepresentation, theft, or dishonesty;
- 4904 (xv) has admitted or been found to have committed an insurance unfair trade practice
- 4905 or fraud;
- 4906 (xvi) in the conduct of business in this state or elsewhere has:
- 4907 (A) used fraudulent, coercive, or dishonest practices; or
- 4908 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;
- 4909 (xvii) has had an insurance license or other professional or occupational license or
- 4910 registration, or equivalent, denied, suspended, revoked, or surrendered to resolve an
- 4911 administrative action;
- 4912 (xviii) has forged another's name to:
- 4913 (A) an application for insurance; or
- 4914 (B) a document related to an insurance transaction;
- 4915 (xix) has improperly used notes or any other reference material to complete an
- 4916 examination for an insurance license;
- 4917 (xx) has knowingly accepted insurance business from an individual who is not
- 4918 licensed;
- 4919 (xxi) has failed to comply with an administrative or court order imposing a child
- 4920 support obligation;
- 4921 (xxii) has failed to:
- 4922 (A) pay state income tax; or
- 4923 (B) comply with an administrative or court order directing payment of state income

4924 tax;

4925 (xxiii) has been convicted of a violation of the federal Violent Crime Control and Law  
4926 Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and has not obtained written consent in  
4927 accordance with 18 U.S.C. Sec. 1033 to engage in the business of insurance or participate in  
4928 such business;

4929 (xxiv) has engaged in methods and practices in the conduct of business that endanger  
4930 the legitimate interests of customers and the public; or

4931 (xxv) has been convicted of any criminal felony involving dishonesty or breach of trust  
4932 and has not obtained written consent in accordance with 18 U.S.C. Sec. 1033 to engage in the  
4933 business of insurance or participate in such business.

4934 (c) For purposes of this section, if a license is held by an agency, both the agency itself  
4935 and any individual designated under the license are considered to be the holders of the license.

4936 (d) If an individual designated under the agency license commits an act or fails to  
4937 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,  
4938 the commissioner may suspend, revoke, or limit the license of:

4939 (i) the individual;

4940 (ii) the agency, if the agency:

4941 (A) is reckless or negligent in its supervision of the individual; or

4942 (B) knowingly participated in the act or failure to act that is the ground for suspending,  
4943 revoking, or limiting the license; or

4944 (iii) (A) the individual; and

4945 (B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).

4946 (6) A licensee under this chapter is subject to the penalties for conducting an insurance  
4947 business without a license if:

4948 (a) the licensee's license is:

4949 (i) revoked;

4950 (ii) suspended;

4951 (iii) limited;

4952 (iv) surrendered in lieu of administrative action;

4953 (v) lapsed; or

4954 (vi) voluntarily surrendered; and



4955 (b) the licensee:

4956 (i) continues to act as a licensee; or

4957 (ii) violates the terms of the license limitation.

4958 (7) A licensee under this chapter shall immediately report to the commissioner:

4959 (a) a revocation, suspension, or limitation of the person's license in any other state, the  
4960 District of Columbia, or a territory of the United States;

4961 (b) the imposition of a disciplinary sanction imposed on that person by any other state,  
4962 the District of Columbia, or a territory of the United States; or

4963 (c) a judgment or injunction entered against that person on the basis of conduct  
4964 involving:

4965 (i) fraud;

4966 (ii) deceit;

4967 (iii) misrepresentation; or

4968 (iv) a violation of an insurance law or rule.

4969 (8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a  
4970 license in lieu of administrative action may specify a time not to exceed five years within  
4971 which the former licensee may not apply for a new license.

4972 (b) If no time is specified in the order or agreement described in Subsection (8)(a), the  
4973 former licensee may not apply for a new license for five years without the express approval of  
4974 the commissioner.

4975 (9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of  
4976 a license issued under this part if so ordered by a court.

4977 (10) The commissioner shall by rule prescribe the license renewal and reinstatement  
4978 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

4979 Section 46. Section **31A-26-301.6** is amended to read:

4980 **31A-26-301.6. Health care claims practices.**

4981 (1) As used in this section:

4982 [~~(a) "Articulate reason" may include a determination regarding;~~]

4983 [~~(i) eligibility for coverage;~~]

4984 [~~(ii) preexisting conditions;~~]

4985 [~~(iii) applicability of other public or private insurance;~~]

4986            [~~(iv) medical necessity; and~~  
4987            [~~(v) any other reason that would justify an extension of the time to investigate a claim.~~]  
4988            (a) "Dentist" means an individual licensed under Title 58, Chapter 69, Dentist and  
4989 Dental Hygienist Practice Act.  
4990            (b) "Health care provider" means a person licensed to provide health care under:  
4991            (i) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or  
4992            (ii) Title 58, Occupations and Professions.  
4993            (c) "Insurer" means an admitted or authorized insurer, as defined in Section  
4994 [31A-1-301](#), and includes:  
4995            (i) a health maintenance organization; and  
4996            (ii) a third party administrator that is subject to this title, provided that nothing in this  
4997 section may be construed as requiring a third party administrator to use its own funds to pay  
4998 claims that have not been funded by the entity for which the third party administrator is paying  
4999 claims.  
5000            (d) "Provider" means a health care provider to whom an insurer is obligated to pay  
5001 directly in connection with a claim by virtue of:  
5002            (i) an agreement between the insurer and the provider;  
5003            (ii) a health insurance policy or contract of the insurer; or  
5004            (iii) state or federal law.  
5005            (2) An insurer shall timely pay every valid insurance claim submitted by a provider in  
5006 accordance with this section.  
5007            (3) (a) Except as provided in Subsection (4), within 30 days of the day on which the  
5008 insurer receives a written claim, an insurer shall:  
5009            (i) pay the claim; or  
5010            (ii) deny the claim and provide a written explanation for the denial.  
5011            (b) (i) Subject to Subsection (3)(b)(ii), the time period described in Subsection (3)(a)  
5012 may be extended by 15 days if the insurer:  
5013            (A) determines that the extension is necessary due to matters beyond the control of the  
5014 insurer; and  
5015            (B) before the end of the 30-day period described in Subsection (3)(a), notifies the  
5016 provider and insured in writing of:

- 5017 (I) the circumstances requiring the extension of time; and  
5018 (II) the date by which the insurer expects to pay the claim or deny the claim with a  
5019 written explanation for the denial.
- 5020 (ii) If an extension is necessary due to a failure of the provider or insured to submit the  
5021 information necessary to decide the claim:
- 5022 (A) the notice of extension required by this Subsection (3)(b) shall specifically describe  
5023 the required information; and
- 5024 (B) the insurer shall give the provider or insured at least 45 days from the day on which  
5025 the provider or insured receives the notice before the insurer denies the claim for failure to  
5026 provide the information requested in Subsection (3)(b)(ii)(A).
- 5027 (4) (a) In the case of a claim for income replacement benefits, within 45 days of the day  
5028 on which the insurer receives a written claim, an insurer shall:
- 5029 (i) pay the claim; or  
5030 (ii) deny the claim and provide a written explanation of the denial.
- 5031 (b) Subject to Subsections (4)(d) and (e), the time period described in Subsection (4)(a)  
5032 may be extended for 30 days if the insurer:
- 5033 (i) determines that the extension is necessary due to matters beyond the control of the  
5034 insurer; and
- 5035 (ii) before the expiration of the 45-day period described in Subsection (4)(a), notifies  
5036 the insured of:
- 5037 (A) the circumstances requiring the extension of time; and  
5038 (B) the date by which the insurer expects to pay the claim or deny the claim with a  
5039 written explanation for the denial.
- 5040 (c) Subject to Subsections (4)(d) and (e), the time period for complying with  
5041 Subsection (4)(a) may be extended for up to an additional 30 days from the day on which the  
5042 30-day extension period provided in Subsection (4)(b) ends if before the day on which the  
5043 30-day extension period ends, the insurer:
- 5044 (i) determines that due to matters beyond the control of the insurer a decision cannot be  
5045 rendered within the 30-day extension period; and
- 5046 (ii) notifies the insured of:  
5047 (A) the circumstances requiring the extension; and

5048 (B) the date as of which the insurer expects to pay the claim or deny the claim with a  
5049 written explanation for the denial.

5050 (d) A notice of extension under this Subsection (4) shall specifically explain:

5051 (i) the standards on which entitlement to a benefit is based; and

5052 (ii) the unresolved issues that prevent a decision on the claim.

5053 (e) If an extension allowed by Subsection (4)(b) or (c) is necessary due to a failure of  
5054 the insured to submit the information necessary to decide the claim:

5055 (i) the notice of extension required by Subsection (4)(b) or (c) shall specifically  
5056 describe the necessary information; and

5057 (ii) the insurer shall give the insured at least 45 days from the day on which the insured  
5058 receives the notice before the insurer denies the claim for failure to provide the information  
5059 requested in Subsection (4)(b) or (c).

5060 (5) If a period of time is extended as permitted under Subsection (3)(b), (4)(b), or  
5061 (4)(c), due to an insured or provider failing to submit information necessary to decide a claim,  
5062 the period for making the benefit determination shall be tolled from the date on which the  
5063 notification of the extension is sent to the insured or provider until the date on which the  
5064 insured or provider responds to the request for additional information.

5065 (6) An insurer shall pay all sums to the provider or insured that the insurer is obligated  
5066 to pay on the claim, and provide a written explanation of the insurer's decision regarding any  
5067 part of the claim that is denied within 20 days of receiving the information requested under  
5068 Subsection (3)(b), (4)(b), or (4)(c).

5069 (7) (a) Whenever an insurer makes a payment to a provider on any part of a claim  
5070 under this section, the insurer shall also send to the insured an explanation of benefits paid.

5071 (b) Whenever an insurer denies any part of a claim under this section, the insurer shall  
5072 also send to the insured:

5073 (i) a written explanation of the part of the claim that was denied; and

5074 (ii) notice of the adverse benefit determination review process established under  
5075 Section [31A-22-629](#).

5076 (c) This Subsection (7) does not apply to a person receiving benefits under the state  
5077 Medicaid program as defined in Section [26-18-2](#), unless required by the Department of Health  
5078 or federal law.

5079 (8) (a) [~~Beginning with health care claims submitted on or after January 1, 2002, a~~] A  
5080 late fee shall be imposed on:

5081 (i) an insurer that fails to timely pay a claim in accordance with this section; and

5082 (ii) a provider that fails to timely provide information on a claim in accordance with  
5083 this section.

5084 (b) For the first 90 days that a claim payment or a provider response to a request for  
5085 information is late, the late fee shall be determined by multiplying together:

5086 (i) the total amount of the claim the insurer is obliged to pay;

5087 (ii) the total number of days the response or the payment is late; and

5088 (iii) [~~1%~~] 0.033% daily interest rate.

5089 (c) For a claim payment or a provider response to a request for information that is 91 or  
5090 more days late, the late fee shall be determined by adding together:

5091 (i) the late fee for a 90-day period under Subsection (8)(b); and

5092 (ii) the following multiplied together:

5093 (A) the total amount of the claim the insurer is obliged to pay;

5094 (B) the total number of days the response or payment was late beyond the initial 90-day  
5095 period; and

5096 [~~(C) the rate of interest set in accordance with Section 15-1-1.~~]

5097 (C) 0.55% daily interest rate.

5098 (d) Any late fee paid or collected under this section shall be separately identified on the  
5099 documentation used by the insurer to pay the claim.

5100 (e) For purposes of this Subsection (8), "late fee" does not include an amount that is  
5101 less than \$1.

5102 (9) Each insurer shall establish a review process to resolve claims-related disputes  
5103 between the insurer and providers.

5104 (10) An insurer or person representing an insurer may not engage in any unfair claim  
5105 settlement practice with respect to a provider. Unfair claim settlement practices include:

5106 (a) knowingly misrepresenting a material fact or the contents of an insurance policy in  
5107 connection with a claim;

5108 (b) failing to acknowledge and substantively respond within 15 days to any written  
5109 communication from a provider relating to a pending claim;

- 5110 (c) denying or threatening to deny the payment of a claim for any reason that is not  
5111 clearly described in the insured's policy;
- 5112 (d) failing to maintain a payment process sufficient to comply with this section;
- 5113 (e) failing to maintain claims documentation sufficient to demonstrate compliance with  
5114 this section;
- 5115 (f) failing, upon request, to give to the provider written information regarding the  
5116 specific rate and terms under which the provider will be paid for health care services;
- 5117 (g) failing to timely pay a valid claim in accordance with this section as a means of  
5118 influencing, intimidating, retaliating, or gaining an advantage over the provider with respect to  
5119 an unrelated claim, an undisputed part of a pending claim, or some other aspect of the  
5120 contractual relationship;
- 5121 (h) failing to pay the sum when required and as required under Subsection (8) when a  
5122 violation has occurred;
- 5123 (i) threatening to retaliate or actual retaliation against a provider for the provider  
5124 applying this section;
- 5125 (j) any material violation of this section; and
- 5126 (k) any other unfair claim settlement practice established in rule or law.
- 5127 (11) (a) The provisions of this section shall apply to each contract between an insurer  
5128 and a provider for the duration of the contract.
- 5129 (b) Notwithstanding Subsection (11)(a), this section may not be the basis for a bad  
5130 faith insurance claim.
- 5131 (c) Nothing in Subsection (11)(a) may be construed as limiting the ability of an insurer  
5132 and a provider from including provisions in their contract that are more stringent than the  
5133 provisions of this section.
- 5134 (12) (a) Pursuant to Chapter 2, Part 2, Duties and Powers of Commissioner, [~~and~~  
5135 ~~beginning January 1, 2002,~~] the commissioner may conduct examinations to determine an  
5136 insurer's level of compliance with this section and impose sanctions for each violation.
- 5137 (b) The commissioner may adopt rules only as necessary to implement this section.
- 5138 (c) The commissioner may establish rules to facilitate the exchange of electronic  
5139 confirmations when claims-related information has been received.
- 5140 (d) Notwithstanding Subsection (12)(b), the commissioner may not adopt rules

5141 regarding the review process required by Subsection (9).

5142 (13) Nothing in this section may be construed as limiting the collection rights of a  
5143 provider under Section 31A-26-301.5.

5144 (14) Nothing in this section may be construed as limiting the ability of an insurer to:

5145 (a) recover any amount improperly paid to a provider or an insured:

5146 (i) in accordance with Section 31A-31-103 or any other provision of state or federal  
5147 law;

5148 (ii) within 24 months of the amount improperly paid for a coordination of benefits  
5149 error;

5150 (iii) within 12 months of the amount improperly paid for any other reason not  
5151 identified in Subsection (14)(a)(i) or (ii); or

5152 (iv) within 36 months of the amount improperly paid when the improper payment was  
5153 due to a recovery by Medicaid, Medicare, the Children's Health Insurance Program, or any  
5154 other state or federal health care program;

5155 (b) take any action against a provider that is permitted under the terms of the provider  
5156 contract and not prohibited by this section;

5157 (c) report the provider to a state or federal agency with regulatory authority over the  
5158 provider for unprofessional, unlawful, or fraudulent conduct; or

5159 (d) enter into a mutual agreement with a provider to resolve alleged violations of this  
5160 section through mediation or binding arbitration.

5161 (15) A health care provider may only seek recovery from the insurer for an amount  
5162 improperly paid by the insurer within the same time frames as Subsections (14)(a) and (b).

5163 (16) (a) (i) An insurer shall remit in full the payment the insurer is obligated to pay to a  
5164 dentist or insured.

5165 (ii) An insurer's payment under this Subsection (16)(a) may not be reduced for fees  
5166 incurred for the method of payment, regardless of the payment method.

5167 (b) An insurer may offer the remittance of payment through a credit card or other  
5168 similar arrangement, if the dentist or insured is not charged a fee.

5169 (c) (i) A dentist may elect not to receive remittance through a credit card or other  
5170 similar arrangement.

5171 (ii) An insurer:

5172 (A) shall permit a dentist's election described in Subsection (c)(i) to apply to the  
5173 dentist's entire practice; and

5174 (B) may not require a dentist's election described in Subsection (c)(i) to be made on a  
5175 patient-by-patient basis.

5176 (d) An insurer may not require a dentist or insured to accept remittance through a credit  
5177 card or other similar arrangement.

5178 Section 47. Section **31A-27a-105** is amended to read:

5179 **31A-27a-105. Jurisdiction -- Venue.**

5180 (1) (a) A delinquency proceeding under this chapter may not be commenced by a  
5181 person other than the commissioner of this state.

5182 (b) No court has jurisdiction to entertain, hear, or determine a delinquency proceeding  
5183 commenced by any person other than the commissioner of this state.

5184 (2) Other than in accordance with this chapter, a court of this state has no jurisdiction  
5185 to entertain, hear, or determine any complaint:

5186 (a) requesting the liquidation, rehabilitation, seizure, sequestration, or receivership of  
5187 an insurer; or

5188 (b) requesting a stay, an injunction, a restraining order, or other relief preliminary to,  
5189 incidental to, or relating to a delinquency proceeding.

5190 (3) (a) The receivership court, as of the commencement of a delinquency proceeding  
5191 under this chapter, has exclusive jurisdiction of all property of the insurer, wherever located,  
5192 including property located outside the territorial limits of the state.

5193 (b) The receivership court has original but not exclusive jurisdiction of all civil  
5194 proceedings arising:

5195 (i) under this chapter; or

5196 (ii) in or related to a delinquency proceeding under this chapter.

5197 (4) In addition to other grounds for jurisdiction provided by the law of this state, a  
5198 court of this state having jurisdiction of the subject matter has jurisdiction over a person served  
5199 pursuant to the Utah Rules of Civil Procedure or other applicable provisions of law in an action  
5200 brought by the receiver if the person served:

5201 (a) in an action resulting from or incident to a relationship with the insurer described in  
5202 this Subsection (4)(a), is or has been an agent, broker, or other person who has at any time:



5203 (i) written a policy of insurance for an insurer against which a delinquency proceeding  
5204 is instituted; or

5205 (ii) acted in any manner whatsoever on behalf of an insurer against which a  
5206 delinquency proceeding is instituted;

5207 (b) in an action on or incident to a reinsurance contract described in this Subsection  
5208 (4)(b):

5209 (i) is or has been an insurer or reinsurer who has at any time entered into the contract of  
5210 reinsurance with an insurer against which a delinquency proceeding is instituted; or

5211 (ii) is an intermediary, agent, or broker of or for the reinsurer, or with respect to the  
5212 contract;

5213 (c) in an action resulting from or incident to a relationship with the insurer described in  
5214 this Subsection (4)(c), is or has been an officer, director, manager, trustee, organizer, promoter,  
5215 or other person in a position of comparable authority or influence over an insurer against which  
5216 a delinquency proceeding is instituted;

5217 (d) in an action concerning assets described in this Subsection (4)(d), is or was at the  
5218 time of the institution of the delinquency proceeding against the insurer, holding assets in  
5219 which the receiver claims an interest on behalf of the insurer; or

5220 (e) in any action on or incident to the obligation described in this Subsection (4)(e), is  
5221 obligated to the insurer in any way whatsoever.

5222 (5) (a) Subject to Subsection (5)(b), service shall be made upon the person named in  
5223 the petition in accordance with the Utah Rules of Civil Procedure.

5224 (b) In lieu of service under Subsection (5)(a), upon application to the receivership  
5225 court, service may be made in such a manner as the receivership court directs whenever it is  
5226 satisfactorily shown by the commissioner's affidavit:

5227 (i) in the case of a corporation, that the officers of the corporation cannot be served  
5228 because they have departed from the state or have otherwise concealed themselves with intent  
5229 to avoid service;

5230 (ii) in the case of an insurer whose business is conducted, at least in part, by an  
5231 attorney-in-fact, managing general agent, or other similar entity including a reciprocal, Lloyd's  
5232 association, or interinsurance exchange, that the individual attorney-in-fact, managing general  
5233 agent, or other entity, or its officers of the corporate attorney-in-fact cannot be served because

5234 of the individual's departure or concealment; or

5235 (iii) in the case of a natural person, that the person cannot be served because of the  
5236 person's departure or concealment.

5237 (6) If the receivership court on motion of any party finds that an action should as a  
5238 matter of substantial justice be tried in a forum outside this state, the receivership court may  
5239 enter an appropriate order to stay further proceedings on the action in this state.

5240 (7) (a) Nothing in this chapter deprives a reinsurer of any contractual right to pursue  
5241 arbitration except:

5242 (i) as to a claim against the estate; and

5243 (ii) in regard to a contract rejected by the receiver under Section [31A-27a-113](#).

5244 (b) A party in arbitration may bring a claim or counterclaim against the estate, but the  
5245 claim or counterclaim is subject to this chapter.

5246 (8) An action authorized by this chapter shall be brought in the Third District Court for  
5247 Salt Lake County.

5248 (9) (a) At any time after an order is entered pursuant to Section [31A-27a-201](#),  
5249 [31A-27a-301](#), or [31A-27a-401](#), the commissioner or receiver may transfer the case to the  
5250 county of the principal office of the person proceeded against.

5251 (b) In the event of a transfer under this Subsection (9), the court in which the  
5252 proceeding is commenced shall, upon application of the commissioner or receiver, direct its  
5253 clerk to transmit the court's file to the clerk of the court to which the case is to be transferred.

5254 (c) After a transfer under this Subsection (9), the proceeding shall be conducted in the  
5255 same manner as if it had been commenced in the court to which the matter is transferred.

5256 (10) (a) Except as provided in Subsection (10)(c), a person may not intervene in a  
5257 liquidation proceeding in this state for the purpose of seeking or obtaining payment of a  
5258 judgment, lien, or other claim of any kind.

5259 (b) Except as provided in Subsection (10)(c), the claims procedure set for this chapter  
5260 constitute the exclusive means for obtaining payment of claims from the liquidation estate.

5261 (c) (i) An affected guaranty association or the affected guaranty association's  
5262 representative may intervene as a party as a matter of right and otherwise appear and participate  
5263 in any court proceeding concerning a liquidation proceeding against an insurer.

5264 (ii) Intervention by an affected guaranty association or by an affected guaranty

5265 association's designated representative conferred by this Subsection (10)(c) may not constitute  
5266 grounds to establish general personal jurisdiction by the courts of this state.

5267 (iii) An intervening affected guaranty association or the affected guaranty association's  
5268 representative are subject to the receivership court's jurisdiction for the limited purpose for  
5269 which the affected guaranty association intervenes.

5270 (11) (a) Notwithstanding the other provisions of this section, this chapter does not  
5271 confer jurisdiction on the receivership court to resolve coverage disputes between an affected  
5272 guaranty association and those asserting claims against the affected guaranty association  
5273 resulting from the initiation of a receivership proceeding under this chapter, except to the  
5274 extent that the affected guaranty association otherwise expressly consents to the jurisdiction of  
5275 the receivership court pursuant to a plan of rehabilitation or liquidation that resolves its  
5276 obligations to covered policyholders.

5277 (b) The determination of a dispute with respect to the statutory coverage obligations of  
5278 an affected guaranty association by a court or administrative agency or body with jurisdiction  
5279 in the affected guaranty association's state of domicile is binding and conclusive as to the  
5280 affected guaranty association's claim in the liquidation proceeding.

5281 (12) Upon the request of the receiver, the receivership court or the presiding judge of  
5282 the Third District Court for Salt Lake County may order that one judge hear all cases and  
5283 controversies arising out of or related to the delinquency proceeding.

5284 (13) A delinquency proceeding is exempt from any program maintained for the early  
5285 closure of civil actions.

5286 (14) In a proceeding, case, or controversy arising out of or related to a delinquency  
5287 proceeding, to the extent there is a conflict between the Utah Rules of Civil Procedure and this  
5288 chapter, the provisions of this chapter govern the proceeding, case, or controversy.

5289 Section 48. Section **31A-27a-501** is amended to read:

5290 **31A-27a-501. Turnover of assets.**

5291 (1) (a) If the receiver determines that funds or property in the possession of another  
5292 person are rightfully the property of the estate, the receiver shall deliver to the person a written  
5293 demand for immediate delivery of the funds or property:

5294 (i) referencing this section by number;

5295 (ii) referencing the court and docket number of the receivership action; and

5296 (iii) notifying the person that any claim of right to the funds or property by the person  
5297 shall be presented to the receivership court within 20 days of the day on which the person  
5298 receives the written demand.

5299 (b) (i) A person who holds funds or other property belonging to an entity subject to an  
5300 order of receivership under this chapter shall deliver the funds or other property to the receiver  
5301 on demand.

5302 (ii) If the person described in Subsection (1)(b)(i) alleges a right to retain the funds or  
5303 other property, the person shall:

5304 (A) file [~~a pleading~~] an objection with the receivership court setting out that right  
5305 within 20 days of the day on which the person receives the demand that the funds or property  
5306 be delivered to the receiver; and

5307 (B) serve a copy of the [~~pleading~~] objection on the receiver.

5308 (iii) The [~~pleading~~] objection described in Subsection (1)(b)(ii) shall inform the  
5309 receivership court as to:

5310 (A) the nature of the claim to the funds or property;

5311 (B) the alleged value of the property or amount of funds held; and

5312 (C) what action has been taken by the person to preserve any funds or to preserve and  
5313 protect the property pending determination of the dispute.

5314 (c) The relinquishment of possession of funds or property by a person who receives a  
5315 demand pursuant to this section is not a waiver of a right to make a claim in the receivership.

5316 (2) (a) If requested by the receiver, the receivership court shall hold a hearing to  
5317 determine where and under what conditions the funds or property shall be held by a person  
5318 described in Subsection (1) pending determination of a dispute concerning the funds or  
5319 property.

5320 (b) The receivership court may impose the conditions the receivership court considers  
5321 necessary or appropriate for the preservation of the funds or property until the receivership  
5322 court can determine the validity of the person's claim to the funds or property.

5323 (c) If funds or property are allowed to remain in the possession of the person after  
5324 demand made by the receiver, that person is strictly liable to the estate for any waste, loss, or  
5325 damage to or diminution of value of the funds or property retained.

5326 (3) If a person files [~~a pleading~~] an objection alleging a right to retain funds or property

5327 as provided in Subsection (1), the receivership court shall hold a subsequent hearing to  
 5328 determine the entitlement of the person to the funds or property claimed by the receiver.

5329 (4) If a person fails to deliver the funds or property or to file the ~~[pleading]~~ objection  
 5330 described by Subsection (1) within the 20-day period, the receivership court may issue a  
 5331 summary order:

5332 (a) upon:

5333 (i) petition of the receiver; and

5334 (ii) a copy of the petition being served by the petitioner to that person;

5335 (b) directing the immediate delivery of the funds or property to the receiver; and

5336 (c) finding that the person waived all claims of right to the funds or property.

5337 (5) The liquidator shall reduce the assets to a degree of liquidity that is consistent with  
 5338 the effective execution of the liquidation.

5339 Section 49. Section **31A-30-117** is amended to read:

5340 **31A-30-117. Patient Protection and Affordable Care Act -- Market transition.**

5341 (1) (a) ~~[After complying with the reporting requirements of Section 63N-11-106, the]~~

5342 The commissioner may adopt administrative rules in accordance with Title 63G, Chapter 3,

5343 Utah Administrative Rulemaking Act, that change the rating and underwriting requirements of

5344 this chapter as necessary to transition the insurance market to meet federal qualified health plan

5345 standards and rating practices under PPACA.

5346 (b) Administrative rules adopted by the commissioner under this section may include:

5347 (i) the regulation of health benefit plans as described in ~~[Subsections 31A-2-212(5)(a)~~

5348 ~~and (b)]~~ Subsection 31A-2-212(5); and

5349 (ii) disclosure of records and information required by PPACA and state law.

5350 (c) (i) The commissioner shall establish by administrative rule one statewide open

5351 enrollment period that applies to the individual insurance market that is not on the PPACA

5352 certified individual exchange.

5353 (ii) The statewide open enrollment period:

5354 (A) may be shorter, but no longer than the open enrollment period established for the

5355 individual insurance market offered in the PPACA certified exchange; and

5356 (B) may not be extended beyond the dates of the open enrollment period established

5357 for the individual insurance market offered in the PPACA certified exchange.

5358 (2) A carrier that offers health benefit plans in the individual market that is not part of  
5359 the individual PPACA certified exchange:

5360 (a) shall open enrollment:

5361 (i) during the statewide open enrollment period established in Subsection (1)(c); and

5362 (ii) at other times, for qualifying events, as determined by administrative rule adopted  
5363 by the commissioner; and

5364 (b) may open enrollment at any time.

5365 (3) To the extent permitted by the Centers for Medicare and Medicaid Services policy,  
5366 or federal regulation, the commissioner shall allow a health insurer to choose to continue  
5367 coverage and individuals and small employers to choose to re-enroll in coverage in  
5368 nongrandfathered health coverage that is not in compliance with market reforms required by  
5369 PPACA.

5370 Section 50. Section **31A-30-118** is amended to read:

5371 **31A-30-118. Patient Protection and Affordable Care Act -- State insurance**  
5372 **mandates -- Cost of additional benefits.**

5373 (1) (a) The commissioner shall identify a new mandated benefit that is in excess of the  
5374 essential health benefits required by PPACA.

5375 (b) The state shall quantify the cost attributable to each additional mandated benefit  
5376 specified in Subsection (1)(a) based on a qualified health plan issuer's calculation of the cost  
5377 associated with the mandated benefit, which shall be:

5378 (i) calculated in accordance with generally accepted actuarial principles and  
5379 methodologies;

5380 (ii) conducted by a member of the American Academy of Actuaries; and

5381 (iii) reported to the commissioner and to the individual exchange operating in the state.

5382 (c) The commissioner may require a proponent of a new mandated benefit under  
5383 Subsection (1)(a) to provide the commissioner with a cost analysis conducted in accordance  
5384 with Subsection (1)(b). The commissioner may use the cost information provided under this  
5385 Subsection (1)(c) to establish estimates of the cost to the state under Subsection (2).

5386 (2) If the state is required to defray the cost of additional required benefits under the  
5387 provisions of 45 C.F.R. 155.170:

5388 (a) the state shall make the required payments:

- 5389 (i) in accordance with Subsection (3); and
- 5390 (ii) directly to the qualified health plan issuer in accordance with 45 C.F.R. 155.170;
- 5391 (b) an issuer of a qualified health plan that receives a payment under the provisions of
- 5392 Subsection (1) and 45 C.F.R. 155.170 shall:
- 5393 (i) reduce the premium charged to the individual on whose behalf the issuer will be
- 5394 paid under Subsection (1), in an amount equal to the amount of the payment under Subsection
- 5395 (1); or
- 5396 (ii) notwithstanding Subsection 31A-23a-402.5(5), provide a premium rebate to an
- 5397 individual on whose behalf the issuer received a payment under Subsection (1), in an amount
- 5398 equal to the amount of the payment under Subsection (1); and
- 5399 (c) a premium rebate made under this section is not a prohibited inducement under
- 5400 Section 31A-23a-402.5.
- 5401 (3) A payment required under 45 C.F.R. 155.170(c) shall:
- 5402 (a) unless otherwise required by PPACA, be based on a statewide average of the cost
- 5403 of the additional benefit for all issuers who are entitled to payment under the provisions of 45
- 5404 C.F.R. [~~155.70~~] 155.170; and
- 5405 (b) be submitted to an issuer through a process established [~~and administered by the~~
- 5406 ~~federal marketplace exchange for the state under PPACA for individual health plans~~] by the
- 5407 commissioner.
- 5408 (4) The commissioner may adopt rules in accordance with Title 63G, Chapter 3, Utah
- 5409 Administrative Rulemaking Act, to:
- 5410 (a) [~~adopt rules as necessary to~~] administer the provisions of this section and 45 C.F.R.
- 5411 155.170; and
- 5412 (b) establish or implement a process for submitting a payment to an issuer under
- 5413 Subsection (3)(b).
- 5414 Section 51. Section 31A-35-402 is amended to read:
- 5415 **31A-35-402. Authority related to bail bonds.**
- 5416 (1) A bail bond agency may only sell bail bonds.
- 5417 (2) In accordance with Section 31A-23a-205, a bail bond producer may not execute or
- 5418 issue a bail bond in this state without holding a current appointment from a surety insurer or a
- 5419 current designation from a bail bond agency.

5420 (3) A bail bond [~~surety~~] agency or surety insurer may not allow any person who is not a  
5421 bail bond producer to engage in the bail bond insurance business on the bail bond agency's or  
5422 surety insurer's behalf, except for individuals:

5423 (a) employed solely for the performance of clerical, stenographic, investigative, or  
5424 other administrative duties that do not require a license as:

5425 (i) a bail bond agency; or

5426 (ii) a bail bond producer; and

5427 (b) whose compensation is not related to or contingent upon the number of bail bonds  
5428 written.

5429 Section 52. Section **31A-37-303** is amended to read:

5430 **31A-37-303. Reinsurance.**

5431 (1) (a) A captive insurance company may cede risks to any insurance company  
5432 approved by the commissioner.

5433 (b) A captive insurance company may provide reinsurance, as authorized in this title,  
5434 on risks ceded [~~for the benefit of a parent, affiliate, or controlled unaffiliated business~~] by any  
5435 other insurer with prior approval of the commissioner.

5436 (2) (a) A captive insurance company may take credit for reserves on risks or portions of  
5437 risks ceded to reinsurers if the captive insurance company complies with Section [31A-17-404](#),  
5438 [31A-17-404.1](#), [31A-17-404.3](#), or [31A-17-404.4](#) or if the captive insurance company complies  
5439 with other requirements as the commissioner may establish by rule made in accordance with  
5440 Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

5441 (b) Unless the reinsurer is in compliance with Section [31A-17-404](#), [31A-17-404.1](#),  
5442 [31A-17-404.3](#), or [31A-17-404.4](#) or a rule adopted under Subsection (2)(a), a captive insurance  
5443 company may not take credit for:

5444 (i) reserves on risks ceded to a reinsurer; or

5445 (ii) portions of risks ceded to a reinsurer.

5446 Section 53. Section **31A-37-701** is amended to read:

5447 **31A-37-701. Certificate of dormancy.**

5448 (1) In accordance with the provisions of this section, a captive insurance company,  
5449 other than a risk retention group may apply, without fee, to the commissioner for a certificate  
5450 of dormancy.



5451 (2) (a) A captive insurance company, other than a risk retention group, is eligible for a  
5452 certificate of dormancy if the captive insurance company:

5453 (i) has ceased transacting the business of insurance, including the issuance of insurance  
5454 policies; and

5455 (ii) has no remaining insurance liabilities or obligations associated with insurance  
5456 business transactions or insurance policies.

5457 (b) For purposes of Subsection (2)(a)(ii), the commissioner may disregard liabilities or  
5458 obligations for which the captive insurance company has withheld sufficient funds or that are  
5459 otherwise sufficiently secured.

5460 (3) Except as provided in Subsection (5), a captive insurance company that holds a  
5461 certificate of dormancy is subject to all requirements of this chapter.

5462 (4) A captive insurance company that holds a certificate of dormancy:

5463 (a) shall possess and maintain unimpaired paid-in capital and unimpaired paid-in  
5464 surplus of:

5465 (i) in the case of a pure captive insurance company or a special purpose captive  
5466 insurance company, not less than \$25,000;

5467 (ii) in the case of an association captive insurance company, not less than \$75,000; or

5468 (iii) in the case of a sponsored captive insurance company, not less than \$100,000, of  
5469 which at least \$35,000 is provided by the sponsor; and

5470 (b) is not required to:

5471 (i) subject to Subsection (5), submit an annual audit or statement of actuarial opinion;

5472 (ii) maintain an active agreement with an independent auditor or actuary; or

5473 (iii) hold an annual meeting of the captive insurance company in the state.

5474 (5) The commissioner may require a captive insurance company that holds a certificate  
5475 of dormancy to submit an annual audit if the commissioner determines that there are concerns  
5476 regarding the captive insurance company's solvency or liquidity.

5477 (6) To maintain a certificate of dormancy and in lieu of a certificate of authority  
5478 renewal fee, no later than July 1 of each year, a captive insurance company shall pay an annual  
5479 dormancy renewal fee that is equal to 50% of the captive insurance's company's certificate of  
5480 authority renewal fee.

5481 (7) A captive insurance company may consecutively renew a certificate [~~or~~] of

5482 dormancy no more than five times.

5483 Section 54. Section **34A-2-202** is amended to read:

5484 **34A-2-202. Assessment on self-insured employers including the state, counties,**  
5485 **cities, towns, or school districts paying compensation direct.**

5486 (1) (a) (i) A self-insured employer, including a county, city, town, or school district,  
5487 shall pay annually, on or before March 31, an assessment in accordance with this section and  
5488 rules made by the commission under this section.

5489 (ii) For purposes of this section, "self-insured employer" is as defined in Section  
5490 [34A-2-201.5](#), except it includes the state if the state self-insures under Section [34A-2-203](#).

5491 (b) The assessment required by Subsection (1)(a) is:

5492 (i) to be collected by the State Tax Commission;

5493 (ii) paid by the State Tax Commission into the state treasury as provided in Subsection  
5494 [59-9-101\(2\)](#); and

5495 (iii) subject to the offset provided in Section [34A-2-202.5](#).

5496 (c) The assessment under Subsection (1)(a) shall be based on a total calculated  
5497 premium multiplied by the premium assessment rate established pursuant to Subsection  
5498 [59-9-101\(2\)](#).

5499 (d) The total calculated premium, for purposes of calculating the assessment under  
5500 Subsection (1)(a), shall be calculated by:

5501 (i) multiplying the total of the standard premium for each class code calculated in  
5502 Subsection (1)(e) by the self-insured employer's experience modification factor; and

5503 (ii) multiplying the total under Subsection (1)(d)(i) by a safety factor determined under  
5504 Subsection (1)(g).

5505 (e) A standard premium shall be calculated by:

5506 (i) multiplying the [~~prospective~~] advisory loss cost for the year being considered, as  
5507 filed with the insurance department pursuant to Section [31A-19a-406](#), for each applicable class  
5508 code by 1.10 to determine the manual rate for each class code; and

5509 (ii) multiplying the manual rate for each class code under Subsection (1)(e)(i) by each  
5510 \$100 of the self-insured employer's covered payroll for each class code.

5511 (f) (i) Each self-insured employer paying compensation direct shall annually obtain the  
5512 experience modification factor required in Subsection (1)(d)(i) by using:

5513 (A) the rate service organization designated by the insurance commissioner in Section  
5514 31A-19a-404; or

5515 (B) for a self-insured employer that is a public agency insurance mutual, an actuary  
5516 approved by the commission.

5517 (ii) If a self-insured employer's experience modification factor under Subsection  
5518 (1)(f)(i) is less than 0.50, the self-insured employer shall use an experience modification factor  
5519 of 0.50 in determining the total calculated premium.

5520 (g) To provide incentive for improved safety, the safety factor required in Subsection  
5521 (1)(d)(ii) shall be determined based on the self-insured employer's experience modification  
5522 factor as follows:

5523	EXPERIENCE MODIFICATION FACTOR	SAFETY FACTOR
5524	Less than or equal to 0.90	0.56
5525	Greater than 0.90 but less than or equal to 1.00	0.78
5526	Greater than 1.00 but less than or equal to 1.10	1.00
5527	Greater than 1.10 but less than or equal to 1.20	1.22
5528	Greater than 1.20	1.44

5529 (h) (i) A premium or premium assessment modification other than a premium or  
5530 premium assessment modification under this section may not be allowed.

5531 (ii) If a self-insured employer paying compensation direct fails to obtain an experience  
5532 modification factor as required in Subsection (1)(f)(i) within the reasonable time period  
5533 established by rule by the State Tax Commission, the State Tax Commission shall use an  
5534 experience modification factor of 2.00 and a safety factor of 2.00 to calculate the total  
5535 calculated premium for purposes of determining the assessment.

5536 (iii) ~~[Prior to]~~ Before calculating the total calculated premium under Subsection  
5537 (1)(h)(ii), the State Tax Commission shall provide the self-insured employer with written  
5538 notice that failure to obtain an experience modification factor within a reasonable time period,  
5539 as established by rule by the State Tax Commission:

5540 (A) shall result in the State Tax Commission using an experience modification factor  
5541 of 2.00 and a safety factor of 2.00 in calculating the total calculated premium for purposes of

5542 determining the assessment; and

5543 (B) may result in the division revoking the self-insured employer's right to pay  
5544 compensation direct.

5545 (i) The division may immediately revoke a self-insured employer's certificate issued  
5546 under Sections 34A-2-201 and 34A-2-201.5 that permits the self-insured employer to pay  
5547 compensation direct if the State Tax Commission assigns an experience modification factor  
5548 and a safety factor under Subsection (1)(h) because the self-insured employer failed to obtain  
5549 an experience modification factor.

5550 (2) Notwithstanding the annual payment requirement in Subsection (1)(a), a  
5551 self-insured employer whose total assessment obligation under Subsection (1)(a) for the  
5552 preceding year was \$10,000 or more shall pay the assessment in quarterly installments in the  
5553 same manner provided in Section 59-9-104 and subject to the same penalty provided in Section  
5554 59-9-104 for not paying or underpaying an installment.

5555 (3) (a) The State Tax Commission shall have access to all the records of the division  
5556 for the purpose of auditing and collecting any amounts described in this section.

5557 (b) Time periods for the State Tax Commission to allow a refund or make an  
5558 assessment shall be determined in accordance with Title 59, Chapter 1, Part 14, Assessment,  
5559 Collections, and Refunds Act.

5560 (4) (a) A review of appropriate use of job class assignment and calculation  
5561 methodology may be conducted as directed by the division at any reasonable time as a  
5562 condition of the self-insured employer's certification of paying compensation direct.

5563 (b) The State Tax Commission shall make any records necessary for the review  
5564 available to the commission.

5565 (c) The commission shall make the results of any review available to the State Tax  
5566 Commission.

5567 Section 55. Section 36-29-106 is amended to read:

5568 **36-29-106. Health Reform Task Force.**

5569 (1) There is created the Health Reform Task Force consisting of the following 11  
5570 members:

5571 (a) four members of the Senate appointed by the president of the Senate, no more than  
5572 three of whom are from the same political party; and

5573 (b) seven members of the House of Representatives appointed by the speaker of the  
5574 House of Representatives, no more than five of whom are from the same political party.

5575 (2) (a) The president of the Senate shall designate a member of the Senate appointed  
5576 under Subsection (1)(a) as a cochair of the task force.

5577 (b) The speaker of the House of Representatives shall designate a member of the House  
5578 of Representatives appointed under Subsection (1)(b) as a cochair of the task force.

5579 (3) Salaries and expenses of the members of the task force shall be paid in accordance  
5580 with Section 36-2-2 and Legislative Joint Rules, Title 5, Chapter 3, Legislator Compensation.

5581 (4) The Office of Legislative Research and General Counsel shall provide staff support  
5582 to the task force.

5583 (5) The task force shall review and make recommendations on health system reform,  
5584 including the following issues:

5585 (a) the need for state statutory and regulatory changes in response to federal actions  
5586 affecting health care;

5587 (b) Medicaid and reforms to the Medicaid program;

5588 (c) options for increasing state flexibility, including the use of federal waivers;

5589 (d) the state's health insurance marketplace;

5590 (e) health insurance code modifications;

5591 (f) insurance network adequacy standards and balance billing; and

5592 [~~(g) health care provider workforce in the state;~~]

5593 [~~(h)~~] (g) rising health care costs[~~;~~ and].

5594 [~~(i) non-opiate pain management options.~~]

5595 (6) A final report, including any proposed legislation, shall be presented to the  
5596 Business and Labor Interim Committee and Health and Human Services Interim Committee  
5597 before November 30, 2019, and November 30, 2020.

5598 Section 56. Section **63A-5-205.5** is amended to read:

5599 **63A-5-205.5. Health insurance requirements -- Penalties.**

5600 (1) As used in this section:

5601 (a) "Aggregate" means the sum of all contracts, change orders, and modifications  
5602 related to a single project.

5603 (b) "Change order" means the same as that term is defined in Section **63G-6a-103**.

5604 (c) "Employee" means, as defined in Section 34A-2-104, an "employee," "worker," or  
5605 "operative" who:

5606 (i) works at least 30 hours per calendar week; and

5607 (ii) meets employer eligibility waiting requirements for health care insurance, which  
5608 may not exceed the first day of the calendar month following 60 days after the day on which  
5609 the individual is hired.

5610 (d) "Health benefit plan" means:

5611 (i) the same as that term is defined in Section 31A-1-301[-]; or

5612 (ii) an employee welfare benefit plan:

5613 (A) established under the Employee Retirement Income Security Act of 1974, 29  
5614 U.S.C. Sec. 1001 et seq.;

5615 (B) for an employer with 100 or more employees; and

5616 (C) in which the employer establishes a self-funded or partially self-funded group  
5617 health plan to provide medical care for the employer's employees and dependents of the  
5618 employees.

5619 (e) "Qualified health [~~insurance~~] coverage" means the same as that term is defined in  
5620 Section 26-40-115.

5621 (f) "Subcontractor" means the same as that term is defined in Section 63A-5-208.

5622 (g) "Third party administrator" or "administrator" means the same as that term is  
5623 defined in Section 31A-1-301.

5624 (2) Except as provided in Subsection (3), the requirements of this section apply to:

5625 (a) a contractor of a design or construction contract entered into by the division or the  
5626 State Building Board on or after July 1, 2009, if the prime contract is in an aggregate amount  
5627 equal to or greater than \$2,000,000; and

5628 (b) a subcontractor of a contractor of a design or construction contract entered into by  
5629 the division or State Building Board on or after July 1, 2009, if the subcontract is in an  
5630 aggregate amount equal to or greater than \$1,000,000.

5631 (3) The requirements of this section do not apply to a contractor or subcontractor  
5632 described in Subsection (2) if:

5633 (a) the application of this section jeopardizes the receipt of federal funds;

5634 (b) the contract is a sole source contract; or

5635 (c) the contract is an emergency procurement.

5636 (4) A person that intentionally uses change orders, contract modifications, or multiple  
5637 contracts to circumvent the requirements of this section is guilty of an infraction.

5638 (5) (a) A contractor that is subject to the requirements of this section shall demonstrate  
5639 to the director that the contractor has and will maintain an offer of qualified health [~~insurance~~]  
5640 coverage for the contractor's employees and the employees' dependents by submitting to the  
5641 director a written statement that:

5642 (i) the contractor offers qualified health [~~insurance~~] coverage that complies with  
5643 Section [26-40-115](#);

5644 (ii) is from:

5645 (A) an actuary selected by the contractor or the contractor's insurer; [~~or~~]

5646 (B) an underwriter who is responsible for developing the employer group's premium  
5647 rates; [~~and~~] or

5648 (C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii),  
5649 an actuary or underwriter selected by a third party administrator; and

5650 (iii) was created within one year before the day on which the statement is submitted.

5651 (b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii)  
5652 shall provide the actuary or underwriter selected by an administrator, as described in  
5653 Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's  
5654 contribution to the health benefit plan and the actuarial value of the health benefit plan meet the  
5655 requirements of qualified health coverage.

5656 (ii) A contractor may not make a change to the contractor's contribution to the health  
5657 benefit plan, unless the contractor provides notice to:

5658 (A) the actuary or underwriter selected by an administrator, as described in Subsection  
5659 (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in  
5660 Subsection (5)(a) in compliance with this section; and

5661 (B) the division.

5662 [~~(b)~~] (c) A contractor that is subject to the requirements of this section shall:

5663 (i) place a requirement in each of the contractor's subcontracts that a subcontractor that  
5664 is subject to the requirements of this section shall obtain and maintain an offer of qualified  
5665 health [~~insurance~~] coverage for the subcontractor's employees and the employees' dependents

5666 during the duration of the subcontract; and

5667 (ii) obtain from a subcontractor that is subject to the requirements of this section a  
5668 written statement that:

5669 (A) the subcontractor offers qualified health ~~[insurance]~~ coverage that complies with  
5670 Section [26-40-115](#);

5671 (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, ~~[or]~~  
5672 an underwriter who is responsible for developing the employer group's premium rates, or if the  
5673 subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or  
5674 underwriter selected by an administrator; and

5675 (C) was created within one year before the day on which the contractor obtains the  
5676 statement.

5677 ~~[(e)]~~ (d) (i) (A) A contractor that fails to maintain an offer of qualified health  
5678 ~~[insurance]~~ coverage described in Subsection (5)(a) during the duration of the contract is  
5679 subject to penalties in accordance with administrative rules adopted by the division under  
5680 Subsection (6).

5681 (B) A contractor is not subject to penalties for the failure of a subcontractor to obtain  
5682 and maintain an offer of qualified health ~~[insurance]~~ coverage described in Subsection  
5683 (5)~~(b)~~(c)(i).

5684 (ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health  
5685 ~~[insurance]~~ coverage described in Subsection (5)~~(b)~~(c)(i) during the duration of the  
5686 subcontract is subject to penalties in accordance with administrative rules adopted by the  
5687 division under Subsection (6).

5688 (B) A subcontractor is not subject to penalties for the failure of a contractor to maintain  
5689 an offer of qualified health ~~[insurance]~~ coverage described in Subsection (5)(a).

5690 (6) The division shall adopt administrative rules:

5691 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

5692 (b) in coordination with:

5693 (i) the Department of Environmental Quality in accordance with Section [19-1-206](#);

5694 (ii) the Department of Natural Resources in accordance with Section [79-2-404](#);

5695 (iii) a public transit district in accordance with Section [17B-2a-818.5](#);

5696 (iv) the State Capitol Preservation Board in accordance with Section [63C-9-403](#);



5697 (v) the Department of Transportation in accordance with Section [72-6-107.5](#); and  
5698 (vi) the Legislature's Administrative Rules Review Committee; and  
5699 (c) that establish:  
5700 (i) the requirements and procedures a contractor and a subcontractor shall follow to  
5701 demonstrate compliance with this section, including:  
5702 (A) that a contractor or subcontractor's compliance with this section is subject to an  
5703 audit by the division or the Office of the Legislative Auditor General;  
5704 (B) that a contractor that is subject to the requirements of this section shall obtain a  
5705 written statement described in Subsection (5)(a); and  
5706 (C) that a subcontractor that is subject to the requirements of this section shall obtain a  
5707 written statement described in Subsection (5)~~(b)~~(c)(ii);  
5708 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally  
5709 violates the provisions of this section, which may include:  
5710 (A) a three-month suspension of the contractor or subcontractor from entering into  
5711 future contracts with the state upon the first violation;  
5712 (B) a six-month suspension of the contractor or subcontractor from entering into future  
5713 contracts with the state upon the second violation;  
5714 (C) an action for debarment of the contractor or subcontractor in accordance with  
5715 Section [63G-6a-904](#) upon the third or subsequent violation; and  
5716 (D) monetary penalties which may not exceed 50% of the amount necessary to  
5717 purchase qualified health ~~[insurance]~~ coverage for employees and dependents of employees of  
5718 the contractor or subcontractor who were not offered qualified health ~~[insurance]~~ coverage  
5719 during the duration of the contract; and  
5720 (iii) a website on which the department shall post the commercially equivalent  
5721 benchmark for the qualified health ~~[insurance]~~ coverage that is provided by the Department of  
5722 Health in accordance with Subsection [26-40-115\(2\)](#).  
5723 (7) (a) During the duration of a contract, the division may perform an audit to verify a  
5724 contractor or subcontractor's compliance with this section.  
5725 (b) Upon the division's request, a contractor or subcontractor shall provide the division:  
5726 (i) a signed actuarial certification that the coverage the contractor or subcontractor  
5727 offers is qualified health ~~[insurance]~~ coverage; or

5728 (ii) all relevant documents and information necessary for the division to determine  
5729 compliance with this section.

5730 (c) If a contractor or subcontractor provides the documents and information described  
5731 in Subsection (7)(b)(ii), the Insurance Department shall assist the division in determining if the  
5732 coverage the contractor or subcontractor offers is qualified health [insurance] coverage.

5733 (8) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor  
5734 or subcontractor that intentionally violates the provisions of this section is liable to the  
5735 employee for health care costs that would have been covered by qualified health [insurance]  
5736 coverage.

5737 (ii) An employer has an affirmative defense to a cause of action under Subsection  
5738 (8)(a) if:

5739 (A) the employer relied in good faith on a written statement described in Subsection  
5740 (5)(a) or (5)(~~b~~)(c)(ii); or

5741 (B) the department determines that compliance with this section is not required under  
5742 the provisions of Subsection (3).

5743 (b) An employee has a private right of action only against the employee's employer to  
5744 enforce the provisions of this Subsection (8).

5745 (9) Any penalties imposed and collected under this section shall be deposited into the  
5746 Medicaid Restricted Account created by Section 26-18-402.

5747 (10) The failure of a contractor or subcontractor to provide qualified health [insurance]  
5748 coverage as required by this section:

5749 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,  
5750 or contractor under:

5751 (i) Section 63G-6a-1602; or

5752 (ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

5753 (b) may not be used by the procurement entity or a prospective bidder, offeror, or  
5754 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design  
5755 or construction.

5756 (11) An administrator, including an administrator's actuary or underwriter, who  
5757 provides a written statement under Subsection (5)(a) or (c) regarding the qualified health  
5758 coverage of a contractor or subcontractor who provides a health benefit plan described in

5759 Subsection (1)(d)(ii):

5760 (a) subject to Subsection (11)(b), is not liable for an error in the written statement,  
5761 unless the administrator commits gross negligence in preparing the written statement;

5762 (b) is not liable for any error in the written statement if the administrator relied in good  
5763 faith on information from the contractor or subcontractor; and

5764 (c) may require as a condition of providing the written statement that a contractor or  
5765 subcontractor hold the administrator harmless for an action arising under this section.

5766 Section 57. Section **63C-9-403** is amended to read:

5767 **63C-9-403. Contracting power of executive director -- Health insurance coverage.**

5768 (1) As used in this section:

5769 (a) "Aggregate" means the sum of all contracts, change orders, and modifications  
5770 related to a single project.

5771 (b) "Change order" means the same as that term is defined in Section [63G-6a-103](#).

5772 (c) "Employee" means, as defined in Section [34A-2-104](#), an "employee," "worker," or  
5773 "operative" who:

5774 (i) works at least 30 hours per calendar week; and

5775 (ii) meets employer eligibility waiting requirements for health care insurance, which  
5776 may not exceed the first of the calendar month following 60 days after the day on which the  
5777 individual is hired.

5778 (d) "Health benefit plan" means:

5779 (i) the same as that term is defined in Section [31A-1-301](#)~~[-]~~; or

5780 (ii) an employee welfare benefit plan:

5781 (A) established under the Employee Retirement Income Security Act of 1974, 29  
5782 U.S.C. Sec. 1001 et seq.;

5783 (B) for an employer with 100 or more employees; and

5784 (C) in which the employer establishes a self-funded or partially self-funded group  
5785 health plan to provide medical care for the employer's employees and dependents of the  
5786 employees.

5787 (e) "Qualified health [~~insurance~~] coverage" means the same as that term is defined in  
5788 Section [26-40-115](#).

5789 (f) "Subcontractor" means the same as that term is defined in Section [63A-5-208](#).

5790 (g) "Third party administrator" or "administrator" means the same as that term is  
5791 defined in Section 31A-1-301.

5792 (2) Except as provided in Subsection (3), the requirements of this section apply to:

5793 (a) a contractor of a design or construction contract entered into by the board, or on  
5794 behalf of the board, on or after July 1, 2009, if the prime contract is in an aggregate amount  
5795 equal to or greater than \$2,000,000; and

5796 (b) a subcontractor of a contractor of a design or construction contract entered into by  
5797 the board, or on behalf of the board, on or after July 1, 2009, if the subcontract is in an  
5798 aggregate amount equal to or greater than \$1,000,000.

5799 (3) The requirements of this section do not apply to a contractor or subcontractor  
5800 described in Subsection (2) if:

5801 (a) the application of this section jeopardizes the receipt of federal funds;

5802 (b) the contract is a sole source contract; or

5803 (c) the contract is an emergency procurement.

5804 (4) A person that intentionally uses change orders, contract modifications, or multiple  
5805 contracts to circumvent the requirements of this section is guilty of an infraction.

5806 (5) (a) A contractor subject to the requirements of this section shall demonstrate to the  
5807 executive director that the contractor has and will maintain an offer of qualified health  
5808 [~~insurance~~] coverage for the contractor's employees and the employees' dependents during the  
5809 duration of the contract by submitting to the executive director a written statement that:

5810 (i) the contractor offers qualified health [~~insurance~~] coverage that complies with  
5811 Section 26-40-115;

5812 (ii) is from:

5813 (A) an actuary selected by the contractor or the contractor's insurer; [~~or~~]

5814 (B) an underwriter who is responsible for developing the employer group's premium  
5815 rates; [~~and~~] or

5816 (C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii),  
5817 an actuary or underwriter selected by a third party administrator; and

5818 (iii) was created within one year before the day on which the statement is submitted.

5819 (b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii)  
5820 shall provide the actuary or underwriter selected by the administrator, as described in

5821 Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's  
5822 contribution to the health benefit plan and the health benefit plan's actuarial value meets the  
5823 requirements of qualified health coverage.

5824 (ii) A contractor may not make a change to the contractor's contribution to the health  
5825 benefit plan, unless the contractor provides notice to:

5826 (A) the actuary or underwriter selected by the administrator, as described in Subsection  
5827 (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in  
5828 Subsection (5)(a) in compliance with this section; and

5829 (B) the executive director.

5830 ~~(b)~~ (c) A contractor that is subject to the requirements of this section shall:

5831 (i) place a requirement in each of the contractor's subcontracts that a subcontractor that  
5832 is subject to the requirements of this section shall obtain and maintain an offer of qualified  
5833 health ~~[insurance]~~ coverage for the subcontractor's employees and the employees' dependents  
5834 during the duration of the subcontract; and

5835 (ii) obtain from a subcontractor that is subject to the requirements of this section a  
5836 written statement that:

5837 (A) the subcontractor offers qualified health ~~[insurance]~~ coverage that complies with  
5838 Section [26-40-115](#);

5839 (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, ~~[or]~~  
5840 an underwriter who is responsible for developing the employer group's premium rates, or if the  
5841 subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or  
5842 underwriter selected by an administrator; and

5843 (C) was created within one year before the day on which the contractor obtains the  
5844 statement.

5845 ~~(c)~~ (d) (i) (A) A contractor that fails to maintain an offer of qualified health  
5846 ~~[insurance]~~ coverage as described in Subsection (5)(a) during the duration of the contract is  
5847 subject to penalties in accordance with administrative rules adopted by the division under  
5848 Subsection (6).

5849 (B) A contractor is not subject to penalties for the failure of a subcontractor to obtain  
5850 and maintain an offer of qualified health ~~[insurance]~~ coverage described in Subsection  
5851 (5)~~(b)~~(c)(i).

5852 (ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health  
5853 [~~insurance~~] coverage described in Subsection (5)[~~(b)~~](c)(i) during the duration of the  
5854 subcontract is subject to penalties in accordance with administrative rules adopted by the  
5855 department under Subsection (6).

5856 (B) A subcontractor is not subject to penalties for the failure of a contractor to maintain  
5857 an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a).

5858 (6) The department shall adopt administrative rules:

5859 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

5860 (b) in coordination with:

5861 (i) the Department of Environmental Quality in accordance with Section 19-1-206;

5862 (ii) the Department of Natural Resources in accordance with Section 79-2-404;

5863 (iii) the State Building Board in accordance with Section 63A-5-205.5;

5864 (iv) a public transit district in accordance with Section 17B-2a-818.5;

5865 (v) the Department of Transportation in accordance with Section 72-6-107.5; and

5866 (vi) the Legislature's Administrative Rules Review Committee; and

5867 (c) that establish:

5868 (i) the requirements and procedures a contractor and a subcontractor shall follow to  
5869 demonstrate compliance with this section, including:

5870 (A) that a contractor or subcontractor's compliance with this section is subject to an  
5871 audit by the department or the Office of the Legislative Auditor General;

5872 (B) that a contractor that is subject to the requirements of this section shall obtain a  
5873 written statement described in Subsection (5)(a); and

5874 (C) that a subcontractor that is subject to the requirements of this section shall obtain a  
5875 written statement described in Subsection (5)[~~(b)~~](c)(ii);

5876 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally  
5877 violates the provisions of this section, which may include:

5878 (A) a three-month suspension of the contractor or subcontractor from entering into  
5879 future contracts with the state upon the first violation;

5880 (B) a six-month suspension of the contractor or subcontractor from entering into future  
5881 contracts with the state upon the second violation;

5882 (C) an action for debarment of the contractor or subcontractor in accordance with

5883 Section 63G-6a-904 upon the third or subsequent violation; and

5884 (D) monetary penalties which may not exceed 50% of the amount necessary to  
5885 purchase qualified health [insurance] coverage for employees and dependents of employees of  
5886 the contractor or subcontractor who were not offered qualified health [insurance] coverage  
5887 during the duration of the contract; and

5888 (iii) a website on which the department shall post the commercially equivalent  
5889 benchmark, for the qualified health [insurance] coverage identified in Subsection (1)(e), that is  
5890 provided by the Department of Health, in accordance with Subsection 26-40-115(2).

5891 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor  
5892 or subcontractor who intentionally violates the provisions of this section is liable to the  
5893 employee for health care costs that would have been covered by qualified health [insurance]  
5894 coverage.

5895 (ii) An employer has an affirmative defense to a cause of action under Subsection  
5896 (7)(a)(i) if:

5897 (A) the employer relied in good faith on a written statement described in Subsection  
5898 (5)(a) or (5)(~~b~~)(c)(ii); or

5899 (B) the department determines that compliance with this section is not required under  
5900 the provisions of Subsection (3).

5901 (b) An employee has a private right of action only against the employee's employer to  
5902 enforce the provisions of this Subsection (7).

5903 (8) Any penalties imposed and collected under this section shall be deposited into the  
5904 Medicaid Restricted Account created in Section 26-18-402.

5905 (9) The failure of a contractor or subcontractor to provide qualified health [insurance]  
5906 coverage as required by this section:

5907 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,  
5908 or contractor under:

5909 (i) Section 63G-6a-1602; or

5910 (ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

5911 (b) may not be used by the procurement entity or a prospective bidder, offeror, or  
5912 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design  
5913 or construction.

5914 (10) An administrator, including the administrator's actuary or underwriter, who  
5915 provides a written statement under Subsection (5)(a) or (c) regarding the qualified health  
5916 coverage of a contractor or subcontractor who provides a health benefit plan described in  
5917 Subsection (1)(d)(ii):

5918 (a) subject to Subsection (10)(b), is not liable for an error in the written statement,  
5919 unless the administrator commits gross negligence in preparing the written statement;

5920 (b) is not liable for any error in the written statement if the administrator relied in good  
5921 faith on information from the contractor or subcontractor; and

5922 (c) may require as a condition of providing the written statement that a contractor or  
5923 subcontractor hold the administrator harmless for an action arising under this section.

5924 Section 58. Section **72-6-107.5** is amended to read:

5925 **72-6-107.5. Construction of improvements of highway -- Contracts -- Health**  
5926 **insurance coverage.**

5927 (1) As used in this section:

5928 (a) "Aggregate" means the sum of all contracts, change orders, and modifications  
5929 related to a single project.

5930 (b) "Change order" means the same as that term is defined in Section [63G-6a-103](#).

5931 (c) "Employee" means, as defined in Section [34A-2-104](#), an "employee," "worker," or  
5932 "operative" who:

5933 (i) works at least 30 hours per calendar week; and

5934 (ii) meets employer eligibility waiting requirements for health care insurance, which  
5935 may not exceed the first day of the calendar month following 60 days after the day on which  
5936 the individual is hired.

5937 (d) "Health benefit plan" means:

5938 (i) the same as that term is defined in Section [31A-1-301](#)~~[-]~~; or

5939 (ii) an employee welfare benefit plan:

5940 (A) established under the Employee Retirement Income Security Act of 1974, 29  
5941 U.S.C. Sec. 1001 et seq.;

5942 (B) for an employer with 100 or more employees; and

5943 (C) in which the employer establishes a self-funded or partially self-funded group  
5944 health plan to provide medical care for the employer's employees and dependents of the



5945 employees.

5946 (e) "Qualified health [~~insurance~~] coverage" means the same as that term is defined in  
5947 Section [26-40-115](#).

5948 (f) "Subcontractor" means the same as that term is defined in Section [63A-5-208](#).

5949 (g) "Third party administrator" or "administrator" means the same as that term is  
5950 defined in Section [31A-1-301](#).

5951 (2) Except as provided in Subsection (3), the requirements of this section apply to:

5952 (a) a contractor of a design or construction contract entered into by the department on  
5953 or after July 1, 2009, if the prime contract is in an aggregate amount equal to or greater than  
5954 \$2,000,000; and

5955 (b) a subcontractor of a contractor of a design or construction contract entered into by  
5956 the department on or after July 1, 2009, if the subcontract is in an aggregate amount equal to or  
5957 greater than \$1,000,000.

5958 (3) The requirements of this section do not apply to a contractor or subcontractor  
5959 described in Subsection (2) if:

5960 (a) the application of this section jeopardizes the receipt of federal funds;

5961 (b) the contract is a sole source contract; or

5962 (c) the contract is an emergency procurement.

5963 (4) A person that intentionally uses change orders, contract modifications, or multiple  
5964 contracts to circumvent the requirements of this section is guilty of an infraction.

5965 (5) (a) A contractor subject to the requirements of this section shall demonstrate to the  
5966 department that the contractor has and will maintain an offer of qualified health [~~insurance~~]  
5967 coverage for the contractor's employees and the employees' dependents during the duration of  
5968 the contract by submitting to the department a written statement that:

5969 (i) the contractor offers qualified health [~~insurance~~] coverage that complies with  
5970 Section [26-40-115](#);

5971 (ii) is from:

5972 (A) an actuary selected by the contractor or the contractor's insurer; [~~or~~]

5973 (B) an underwriter who is responsible for developing the employer group's premium  
5974 rates; [~~and~~] or

5975 (C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii),

5976 an actuary or underwriter selected by a third party administrator; and

5977 (iii) was created within one year before the day on which the statement is submitted.

5978 (b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii)

5979 shall provide the actuary or underwriter selected by an administrator, as described in

5980 Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's

5981 contribution to the health benefit plan and the actuarial value of the health benefit plan meet the

5982 requirements of qualified health coverage.

5983 (ii) A contractor may not make a change to the contractor's contribution to the health

5984 benefit plan, unless the contractor provides notice to:

5985 (A) the actuary or underwriter selected by an administrator, as described in Subsection

5986 (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in

5987 Subsection (5)(a) in compliance with this section; and

5988 (B) the department.

5989 ~~(b)~~ (c) A contractor that is subject to the requirements of this section shall:

5990 (i) place a requirement in each of the contractor's subcontracts that a subcontractor that

5991 is subject to the requirements of this section shall obtain and maintain an offer of qualified

5992 health ~~[insurance]~~ coverage for the subcontractor's employees and the employees' dependents

5993 during the duration of the subcontract; and

5994 (ii) obtain from a subcontractor that is subject to the requirements of this section a

5995 written statement that:

5996 (A) the subcontractor offers qualified health ~~[insurance]~~ coverage that complies with

5997 Section 26-40-115;

5998 (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, ~~[or]~~

5999 an underwriter who is responsible for developing the employer group's premium rates, or if the

6000 subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or

6001 underwriter selected by an administrator; and

6002 (C) was created within one year before the day on which the contractor obtains the

6003 statement.

6004 ~~(c)~~ (d) (i) (A) A contractor that fails to maintain an offer of qualified health

6005 ~~[insurance]~~ coverage described in Subsection (5)(a) during the duration of the contract is

6006 subject to penalties in accordance with administrative rules adopted by the department under

6007 Subsection (6).

6008 (B) A contractor is not subject to penalties for the failure of a subcontractor to obtain  
6009 and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection  
6010 (5)(~~(b)~~)(c)(i).

6011 (ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health  
6012 [~~insurance~~] coverage described in Subsection (5)(~~(b)~~)(c) during the duration of the subcontract  
6013 is subject to penalties in accordance with administrative rules adopted by the department under  
6014 Subsection (6).

6015 (B) A subcontractor is not subject to penalties for the failure of a contractor to maintain  
6016 an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a).

6017 (6) The department shall adopt administrative rules:

6018 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

6019 (b) in coordination with:

6020 (i) the Department of Environmental Quality in accordance with Section 19-1-206;

6021 (ii) the Department of Natural Resources in accordance with Section 79-2-404;

6022 (iii) the State Building Board in accordance with Section 63A-5-205.5;

6023 (iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;

6024 (v) a public transit district in accordance with Section 17B-2a-818.5; and

6025 (vi) the Legislature's Administrative Rules Review Committee; and

6026 (c) that establish:

6027 (i) the requirements and procedures a contractor and a subcontractor shall follow to  
6028 demonstrate compliance with this section, including:

6029 (A) that a contractor or subcontractor's compliance with this section is subject to an  
6030 audit by the department or the Office of the Legislative Auditor General;

6031 (B) that a contractor that is subject to the requirements of this section shall obtain a  
6032 written statement described in Subsection (5)(a); and

6033 (C) that a subcontractor that is subject to the requirements of this section shall obtain a  
6034 written statement described in Subsection (5)(~~(b)~~)(c)(ii);

6035 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally  
6036 violates the provisions of this section, which may include:

6037 (A) a three-month suspension of the contractor or subcontractor from entering into

6038 future contracts with the state upon the first violation;

6039 (B) a six-month suspension of the contractor or subcontractor from entering into future  
6040 contracts with the state upon the second violation;

6041 (C) an action for debarment of the contractor or subcontractor in accordance with  
6042 Section 63G-6a-904 upon the third or subsequent violation; and

6043 (D) monetary penalties which may not exceed 50% of the amount necessary to  
6044 purchase qualified health [insurance] coverage for an employee and a dependent of the  
6045 employee of the contractor or subcontractor who was not offered qualified health [insurance]  
6046 coverage during the duration of the contract; and

6047 (iii) a website on which the department shall post the commercially equivalent  
6048 benchmark, for the qualified health [insurance] coverage identified in Subsection (1)(e), that is  
6049 provided by the Department of Health, in accordance with Subsection 26-40-115(2).

6050 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor  
6051 or subcontractor who intentionally violates the provisions of this section is liable to the  
6052 employee for health care costs that would have been covered by qualified health [insurance]  
6053 coverage.

6054 (ii) An employer has an affirmative defense to a cause of action under Subsection  
6055 (7)(a)(i) if:

6056 (A) the employer relied in good faith on a written statement described in Subsection  
6057 (5)(a) or (5)(~~b~~)(c)(ii); or

6058 (B) the department determines that compliance with this section is not required under  
6059 the provisions of Subsection (3).

6060 (b) An employee has a private right of action only against the employee's employer to  
6061 enforce the provisions of this Subsection (7).

6062 (8) Any penalties imposed and collected under this section shall be deposited into the  
6063 Medicaid Restricted Account created in Section 26-18-402.

6064 (9) The failure of a contractor or subcontractor to provide qualified health [insurance]  
6065 coverage as required by this section:

6066 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,  
6067 or contractor under:

6068 (i) Section 63G-6a-1602; or

6069 (ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and  
6070 (b) may not be used by the procurement entity or a prospective bidder, offeror, or  
6071 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design  
6072 or construction.

6073 (10) An administrator, including an administrator's actuary or underwriter, who  
6074 provides a written statement under Subsection (5)(a) or (c) regarding the qualified health  
6075 coverage of a contractor or subcontractor who provides a health benefit plan described in  
6076 Subsection (1)(d)(ii):

6077 (a) subject to Subsection (10)(b), is not liable for an error in the written statement,  
6078 unless the administrator commits gross negligence in preparing the written statement;

6079 (b) is not liable for any error in the written statement if the administrator relied in good  
6080 faith on information from the contractor or subcontractor; and

6081 (c) may require as a condition of providing the written statement that a contractor or  
6082 subcontractor hold the administrator harmless for an action arising under this section.

6083 Section 59. Section **79-2-404** is amended to read:

6084 **79-2-404. Contracting powers of department -- Health insurance coverage.**

6085 (1) As used in this section:

6086 (a) "Aggregate" means the sum of all contracts, change orders, and modifications  
6087 related to a single project.

6088 (b) "Change order" means the same as that term is defined in Section [63G-6a-103](#).

6089 (c) "Employee" means, as defined in Section [34A-2-104](#), an "employee," "worker," or  
6090 "operative" who:

6091 (i) works at least 30 hours per calendar week; and

6092 (ii) meets employer eligibility waiting requirements for health care insurance, which  
6093 may not exceed the first day of the calendar month following 60 days after the day on which  
6094 the individual is hired.

6095 (d) "Health benefit plan" means:

6096 (i) the same as that term is defined in Section [31A-1-301](#)[-]; or

6097 (ii) an employee welfare benefit plan:

6098 (A) established under the Employee Retirement Income Security Act of 1974, 29

6099 U.S.C. Sec. 1001 et seq.;

6100 (B) for an employer with 100 or more employees; and

6101 (C) in which the employer establishes a self-funded or partially self-funded group  
6102 health plan to provide medical care for the employer's employees and dependents of the  
6103 employees.

6104 (e) "Qualified health [~~insurance~~] coverage" means the same as that term is defined in  
6105 Section [26-40-115](#).

6106 (f) "Subcontractor" means the same as that term is defined in Section [63A-5-208](#).

6107 (g) "Third party administrator" or "administrator" means the same as that term is  
6108 defined in Section [31A-1-301](#).

6109 (2) Except as provided in Subsection (3), the requirements of this section apply to:

6110 (a) a contractor of a design or construction contract entered into by, or delegated to, the  
6111 department or a division, board, or council of the department on or after July 1, 2009, if the  
6112 prime contract is in an aggregate amount equal to or greater than \$2,000,000; and

6113 (b) a subcontractor of a contractor of a design or construction contract entered into by,  
6114 or delegated to, the department or a division, board, or council of the department on or after  
6115 July 1, 2009, if the subcontract is in an aggregate amount equal to or greater than \$1,000,000.

6116 (3) This section does not apply to contracts entered into by the department or a  
6117 division, board, or council of the department if:

6118 (a) the application of this section jeopardizes the receipt of federal funds;

6119 (b) the contract or agreement is between:

6120 (i) the department or a division, board, or council of the department; and

6121 (ii) (A) another agency of the state;

6122 (B) the federal government;

6123 (C) another state;

6124 (D) an interstate agency;

6125 (E) a political subdivision of this state; or

6126 (F) a political subdivision of another state; or

6127 (c) the contract or agreement is:

6128 (i) for the purpose of disbursing grants or loans authorized by statute;

6129 (ii) a sole source contract; or

6130 (iii) an emergency procurement.

6131 (4) A person that intentionally uses change orders, contract modifications, or multiple  
6132 contracts to circumvent the requirements of this section is guilty of an infraction.

6133 (5) (a) A contractor subject to the requirements of this section shall demonstrate to the  
6134 department that the contractor has and will maintain an offer of qualified health [insurance]  
6135 coverage for the contractor's employees and the employees' dependents during the duration of  
6136 the contract by submitting to the department a written statement that:

6137 (i) the contractor offers qualified health [insurance] coverage that complies with  
6138 Section 26-40-115;

6139 (ii) is from:

6140 (A) an actuary selected by the contractor or the contractor's insurer; [or]

6141 (B) an underwriter who is responsible for developing the employer group's premium  
6142 rates; [and] or

6143 (C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii),  
6144 an actuary or underwriter selected by a third party administrator; and

6145 (iii) was created within one year before the day on which the statement is submitted.

6146 (b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii)  
6147 shall provide the actuary or underwriter selected by an administrator, as described in  
6148 Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's  
6149 contribution to the health benefit plan and the actuarial value of the health benefit plan meet the  
6150 requirements of qualified health coverage.

6151 (ii) A contractor may not make a change to the contractor's contribution to the health  
6152 benefit plan, unless the contractor provides notice to:

6153 (A) the actuary or underwriter selected by an administrator, as described in Subsection  
6154 (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in  
6155 Subsection (5)(a) in compliance with this section; and

6156 (B) the department.

6157 [~~b~~] (c) A contractor that is subject to the requirements of this section shall:

6158 (i) place a requirement in each of the contractor's subcontracts that a subcontractor that  
6159 is subject to the requirements of this section shall obtain and maintain an offer of qualified  
6160 health [insurance] coverage for the subcontractor's employees and the employees' dependents  
6161 during the duration of the subcontract; and

6162 (ii) obtain from a subcontractor that is subject to the requirements of this section a  
6163 written statement that:

6164 (A) the subcontractor offers qualified health [~~insurance~~] coverage that complies with  
6165 Section [26-40-115](#);

6166 (B) is from an actuary selected by the subcontractor or the subcontractor's insurer, [~~or~~]  
6167 an underwriter who is responsible for developing the employer group's premium rates, or if the  
6168 subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or  
6169 underwriter selected by an administrator; and

6170 (C) was created within one year before the day on which the contractor obtains the  
6171 statement.

6172 [~~(e)~~] (d) (i) (A) A contractor that fails to maintain an offer of qualified health  
6173 [~~insurance~~] coverage described in Subsection (5)(a) during the duration of the contract is  
6174 subject to penalties in accordance with administrative rules adopted by the department under  
6175 Subsection (6).

6176 (B) A contractor is not subject to penalties for the failure of a subcontractor to obtain  
6177 and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection  
6178 (5)[~~(b)~~](c)(i).

6179 (ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health  
6180 [~~insurance~~] coverage described in Subsection (5)[~~(b)~~](c) during the duration of the subcontract  
6181 is subject to penalties in accordance with administrative rules adopted by the department under  
6182 Subsection (6).

6183 (B) A subcontractor is not subject to penalties for the failure of a contractor to maintain  
6184 an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a).

6185 (6) The department shall adopt administrative rules:

6186 (a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

6187 (b) in coordination with:

6188 (i) the Department of Environmental Quality in accordance with Section [19-1-206](#);

6189 (ii) a public transit district in accordance with Section [17B-2a-818.5](#);

6190 (iii) the State Building Board in accordance with Section [63A-5-205.5](#);

6191 (iv) the State Capitol Preservation Board in accordance with Section [63C-9-403](#);

6192 (v) the Department of Transportation in accordance with Section [72-6-107.5](#); and



6193 (vi) the Legislature's Administrative Rules Review Committee; and  
6194 (c) that establish:  
6195 (i) the requirements and procedures a contractor and a subcontractor shall follow to  
6196 demonstrate compliance with this section, including:  
6197 (A) that a contractor or subcontractor's compliance with this section is subject to an  
6198 audit by the department or the Office of the Legislative Auditor General;  
6199 (B) that a contractor that is subject to the requirements of this section shall obtain a  
6200 written statement described in Subsection (5)(a); and  
6201 (C) that a subcontractor that is subject to the requirements of this section shall obtain a  
6202 written statement described in Subsection (5)(b)(c)(ii);  
6203 (ii) the penalties that may be imposed if a contractor or subcontractor intentionally  
6204 violates the provisions of this section, which may include:  
6205 (A) a three-month suspension of the contractor or subcontractor from entering into  
6206 future contracts with the state upon the first violation;  
6207 (B) a six-month suspension of the contractor or subcontractor from entering into future  
6208 contracts with the state upon the second violation;  
6209 (C) an action for debarment of the contractor or subcontractor in accordance with  
6210 Section 63G-6a-904 upon the third or subsequent violation; and  
6211 (D) monetary penalties which may not exceed 50% of the amount necessary to  
6212 purchase qualified health [insurance] coverage for an employee and a dependent of an  
6213 employee of the contractor or subcontractor who was not offered qualified health [insurance]  
6214 coverage during the duration of the contract; and  
6215 (iii) a website on which the department shall post the commercially equivalent  
6216 benchmark, for the qualified health [insurance] coverage identified in Subsection (1)(e),  
6217 provided by the Department of Health, in accordance with Subsection 26-40-115(2).  
6218 (7) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor  
6219 or subcontractor who intentionally violates the provisions of this section is liable to the  
6220 employee for health care costs that would have been covered by qualified health [insurance]  
6221 coverage.  
6222 (ii) An employer has an affirmative defense to a cause of action under Subsection  
6223 (7)(a)(i) if:

6224 (A) the employer relied in good faith on a written statement described in Subsection  
6225 (5)(a) or (5)~~(b)~~(c)(ii); or

6226 (B) the department determines that compliance with this section is not required under  
6227 the provisions of Subsection (3).

6228 (b) An employee has a private right of action only against the employee's employer to  
6229 enforce the provisions of this Subsection (7).

6230 (8) Any penalties imposed and collected under this section shall be deposited into the  
6231 Medicaid Restricted Account created in Section 26-18-402.

6232 (9) The failure of a contractor or subcontractor to provide qualified health [~~insurance~~]  
6233 coverage as required by this section:

6234 (a) may not be the basis for a protest or other action from a prospective bidder, offeror,  
6235 or contractor under:

6236 (i) Section 63G-6a-1602; or

6237 (ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

6238 (b) may not be used by the procurement entity or a prospective bidder, offeror, or  
6239 contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design  
6240 or construction.

6241 (10) An administrator, including an administrator's actuary or underwriter, who  
6242 provides a written statement under Subsection (5)(a) or (c) regarding the qualified health  
6243 coverage of a contractor or subcontractor who provides a health benefit plan described in  
6244 Subsection (1)(d)(ii):

6245 (a) subject to Subsection (10)(b), is not liable for an error in the written statement,  
6246 unless the administrator commits gross negligence in preparing the written statement;

6247 (b) is not liable for any error in the written statement if the administrator relied in good  
6248 faith on information from the contractor or subcontractor; and

6249 (c) may require as a condition of providing the written statement that a contractor or  
6250 subcontractor hold the administrator harmless for an action arising under this section.