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₵ 03-01-20 11:07 AM ₵

H.B. 37
2nd Sub. (Gray)

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;

- permits the insurance commissioner to exempt a health maintenance organization from certain deposit requirements without a hearing;
- amends the date before which a health insurer shall submit a written report regarding coverage for opioids;
- amends provisions regarding credit allowed a domestic ceding insurer against reserves for reinsurance, including:
  - establishing eligibility for credit;
  - requiring the insurance commissioner to create and publish a list of reciprocal jurisdictions;
  - requiring the insurance commissioner to create and publish a list of qualified assuming insurers;
  - requiring rulemaking;
  - establishing conditions for suspension of an assuming insurer's eligibility; and
  - addressing the reduction or elimination of credit;
- amends requirements for the loss and loss adjustment expense factors included in rates filed in relation to workers' compensation;
- amends certain filing requirements to reflect current practice;
- amends the forms that the insurance commissioner may prohibit;
- amends limitations of actions for an accident and health insurance policy;
- amends uninsured motorist coverage regarding arbitration awards;
- enacts provisions regarding the Restatement of the Law of Liability Insurance;
- outlines requirements for a notice of assignment related to a debt;
- amends requirements related to the shared common purposes of association groups;
- amends provisions regarding dependent coverage for accident and health insurance;
- enacts the Limited Long-Term Care Insurance Act, which:
  - defines terms;
  - establishes disclosure and performance standards for limited long-term care insurance;
  - establishes parameters of a limited long-term care insurance policy offering a nonforfeiture benefit; and
  - requires the insurance commissioner to make rules;

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

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

17B-2a-818.5, as last amended by Laws of Utah 2018, Chapter 319

19-1-206, as last amended by Laws of Utah 2018, Chapter 319

26-40-115, as last amended by Laws of Utah 2019, Chapter 393

31A-1-103, as last amended by Laws of Utah 2017, Chapter 27

31A-1-301, as last amended by Laws of Utah 2019, Chapter 193

31A-2-104, as last amended by Laws of Utah 2014, Chapters 290 and 300

31A-2-110, as last amended by Laws of Utah 1986, Chapter 204

31A-2-212, as last amended by Laws of Utah 2016, Chapter 138

31A-2-218, as last amended by Laws of Utah 2015, Chapter 283

31A-2-309, as last amended by Laws of Utah 2016, Chapter 138

31A-2-403, as last amended by Laws of Utah 2019, Chapter 193

31A-6a-101, as last amended by Laws of Utah 2018, Chapter 319

31A-6a-103, as last amended by Laws of Utah 2015, Chapter 244

31A-6a-104, as last amended by Laws of Utah 2018, Chapter 319

31A-8-211, as last amended by Laws of Utah 2002, Chapter 308

31A-17-404, as last amended by Laws of Utah 2017, Chapter 168
31A-17-404.3, as last amended by Laws of Utah 2016, Chapter 138
31A-17-601, as last amended by Laws of Utah 2001, Chapter 116
31A-19a-404, as renumbered and amended by Laws of Utah 1999, Chapter 130
31A-19a-405, as renumbered and amended by Laws of Utah 1999, Chapter 130
31A-19a-406, as renumbered and amended by Laws of Utah 1999, Chapter 130
31A-21-201, as last amended by Laws of Utah 2019, Chapter 193
31A-21-301, as last amended by Laws of Utah 2010, Chapter 10
31A-21-313, as last amended by Laws of Utah 2015, Chapter 244
31A-22-305, as last amended by Laws of Utah 2019, Chapter 131
31A-22-412, as last amended by Laws of Utah 1986, Chapter 204
31A-22-413, as last amended by Laws of Utah 2013, Chapter 264
31A-22-505, as last amended by Laws of Utah 2017, Chapter 168
31A-22-610.5, as last amended by Laws of Utah 2018, Chapter 443
31A-22-615.5, as enacted by Laws of Utah 2017, Chapter 53
31A-23a-111, as last amended by Laws of Utah 2019, Chapter 193
31A-23a-205, as renumbered and amended by Laws of Utah 2003, Chapter 298
31A-23a-415, as last amended by Laws of Utah 2019, Chapter 193
31A-23b-401, as last amended by Laws of Utah 2019, Chapter 193
31A-25-208, as last amended by Laws of Utah 2019, Chapter 193
31A-26-206, as last amended by Laws of Utah 2014, Chapters 290 and 300
31A-26-213, as last amended by Laws of Utah 2019, Chapter 193
31A-26-301.6, as last amended by Laws of Utah 2009, Chapter 11
31A-27a-105, as enacted by Laws of Utah 2007, Chapter 309
31A-27a-501, as enacted by Laws of Utah 2007, Chapter 309
31A-30-117, as last amended by Laws of Utah 2015, Chapter 283
31A-30-118, as last amended by Laws of Utah 2019, Chapter 193
31A-35-402, as last amended by Laws of Utah 2016, Chapter 234
31A-37-303, as last amended by Laws of Utah 2017, Chapter 168
31A-37-701, as enacted by Laws of Utah 2019, Chapter 193
34A-2-202, as last amended by Laws of Utah 2009, Chapter 212

36-29-106, as enacted by Laws of Utah 2019, Chapter 193
63A-5-205.5, as enacted by Laws of Utah 2018, Chapter 319
63C-9-403, as last amended by Laws of Utah 2018, Chapter 319
72-6-107.5, as last amended by Laws of Utah 2018, Chapter 319
79-2-404, as last amended by Laws of Utah 2018, Chapter 319
ENACTS:
31A-22-205, Utah Code Annotated 1953
31A-22-430, Utah Code Annotated 1953
31A-22-2001, Utah Code Annotated 1953
31A-22-2002, Utah Code Annotated 1953
31A-22-2003, Utah Code Annotated 1953
31A-22-2004, Utah Code Annotated 1953
31A-22-2005, Utah Code Annotated 1953
31A-22-2006, Utah Code Annotated 1953

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

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

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

(1) As used in this section:

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

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

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

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

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

(d) "Health benefit plan" means:

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

(ii) an employee welfare benefit plan:

(A) established under the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001 et seq.;

(B) for an employer with 100 or more employees; and

(C) in which the employer establishes a self-funded or partially self-funded group health plan to provide medical care for the employer's employees and dependents of the employees.

(e) "Qualified health [~~insurance~~] coverage" means the same as that term is defined in Section 26-40-115.

(f) "Subcontractor" means the same as that term is defined in Section 63A-5-208.

(g) "Third party administrator" or "administrator" means the same as that term is defined in Section 31A-1-301.

(2) Except as provided in Subsection (3), the requirements of this section apply to:

(a) a contractor of a design or construction contract entered into by the public transit district on or after July 1, 2009, if the prime contract is in an aggregate amount equal to or greater than $2,000,000; and

(b) a subcontractor of a contractor of a design or construction contract entered into by the public transit district on or after July 1, 2009, if the subcontract is in an aggregate amount equal to or greater than $1,000,000.

(3) The requirements of this section do not apply to a contractor or subcontractor described in Subsection (2) if:

(a) the application of this section jeopardizes the receipt of federal funds;

(b) the contract is a sole source contract; or

(c) the contract is an emergency procurement.

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

(5) (a) A contractor subject to the requirements of this section shall demonstrate to the public transit district that the contractor has and will maintain an offer of qualified health [~~insurance~~] coverage for the contractor's employees and the employee's dependents during the duration of the contract by submitting to the public transit district a written statement that:

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

Section 26-40-115;

(ii) is from:

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

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

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

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

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

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

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

(B) the public transit district.

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

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

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

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

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

underwriter selected by an administrator; and

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

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

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

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

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

(6) The public transit district shall adopt ordinances:

(a) in coordination with:

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

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

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

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

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

(b) that establish:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

coverage as required by this section:

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

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

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

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

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

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

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

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

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

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

(1) As used in this section:

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

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

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

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

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

(d) "Health benefit plan" means:

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

(ii) an employee welfare benefit plan:

(A) established under the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001 et seq.;

(B) for an employer with 100 or more employees; and

(C) in which the employer establishes a self-funded or partially self-funded group health plan to provide medical care for the employer's employees and dependents of the employees.

(e) "Qualified health [~~insurance~~] coverage" means the same as that term is defined in Section 26-40-115.

(f) "Subcontractor" means the same as that term is defined in Section 63A-5-208.

(g) "Third party administrator" or "administrator" means the same as that term is defined in Section 31A-1-301.

(2) Except as provided in Subsection (3), the requirements of this section apply to:

(a) a contractor of a design or construction contract entered into by, or delegated to, the department, or a division or board of the department, on or after July 1, 2009, if the prime contract is in an aggregate amount equal to or greater than $2,000,000; and

(b) a subcontractor of a contractor of a design or construction contract entered into by, or delegated to, the department, or a division or board of the department, on or after July 1, 2009, if the subcontract is in an aggregate amount equal to or greater than $1,000,000.

(3) This section does not apply to contracts entered into by the department or a division or board of the department if:

(a) the application of this section jeopardizes the receipt of federal funds;

(b) the contract or agreement is between:

(i) the department or a division or board of the department; and

(ii) (A) another agency of the state;

(B) the federal government;

(C) another state;

(D) an interstate agency;

(E) a political subdivision of this state; or

(F) a political subdivision of another state;

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

(d) the contract is:

(i) a sole source contract; or

(ii) an emergency procurement.

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

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

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

(ii) is from:

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

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

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

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

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

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

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

(B) the department.

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

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

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

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

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

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

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

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

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

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

(6) The department shall adopt administrative rules:

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

(b) in coordination with:

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

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

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

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

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

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

(c) that establish:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) the benchmark plan determined by the program under Subsection 26-40-106(1)(a)[~~,~~]; and

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

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

(i) has a deductible that is:

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

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

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

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

(2) The department shall:

(a) on or before July 1, 2016:

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

(1)(a); and

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

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

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

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

(1) This title does not apply to:

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

(i) with an individual client; and

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

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

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

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

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

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

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

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

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

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

(II) for a designated period of time; and

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

(B) the time since the service under Subsection (1)(f)(iii)(A) was completed is no more than 18 months; or

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

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

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

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

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

(b) ocean marine insurance;

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

(i) has as [~~its~~] the organization's principal purpose to achieve charitable, educational, social, or religious objectives rather than to provide death, accident, health, or disability benefits;

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

(iii) does not create reasonable expectations of receiving a specified amount on the part of an insured person;

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

(i) the transaction of the business in this state does not require regulation for the protection of the interests of the residents of this state; or

(ii) it would be impracticable to require compliance with this title;

(e) except as provided in Subsection (4), a transaction independently procured through negotiations under Section 31A-15-104;

(f) self-insurance;

(g) reinsurance;

(h) subject to Subsection (5), employee and labor union group or blanket insurance covering risks in this state if:

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

(ii) the policyholder:

(A) is not a resident of this state;

(B) is not a domestic corporation; or

(C) does not have [~~its~~] the policyholder's principal office in this state;

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

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

(v) (A) the insurer agrees to pay premium taxes on the Utah portion of [~~its~~] the insurer's business, as if [~~it~~] the insurer were authorized to do business in this state; and

(B) the insurer provides the commissioner with the security the commissioner considers necessary for the payment of premium taxes under Title 59, Chapter 9, Taxation of Admitted Insurers;

(i) to the extent provided in Subsection (6):

(i) a manufacturer's or seller's warranty; and

(ii) a manufacturer's or seller's service contract;

(j) except to the extent provided in Subsection (7), a public agency insurance mutual; or

(k) except as provided in Chapter 6b, Guaranteed Asset Protection Waiver Act, a guaranteed asset protection waiver.

(4) A transaction described in Subsection (3)(e) is subject to taxation under Section 31A-3-301.

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

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

(i) the insurer to be authorized to do business in this state; or

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

(c) Subsection (3)(h) does not apply to blanket accident and health insurance.

(6) (a) As used in Subsection (3)(i) and this Subsection (6):

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

(A) made available by:

(I) a manufacturer of a product;

(II) a seller of a product; or

(III) an affiliate of a manufacturer or seller of a product;

(B) made available:

(I) on one or more specific products; or

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

(C) under which the person described in Subsection (6)(a)(i)(A) is liable for services to be provided under the service contract including, if the manufacturer's or seller's service contract designates, providing parts and labor;

(ii) "manufacturer's or seller's warranty" means the guaranty of:

(A) (I) the manufacturer of a product;

(II) a seller of a product; or

(III) an affiliate of a manufacturer or seller of a product;

(B) (I) on one or more specific products; or

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

(C) under which the person described in Subsection (6)(a)(ii)(A) is liable for services to be provided under the warranty, including, if the manufacturer's or seller's warranty designates, providing parts and labor; and

(iii) "service contract" means the same as that term is defined in Section 31A-6a-101.

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

(i) a warranty;

(ii) a guaranty; or

(iii) a term similar to a term described in Subsection (6)(b)(i) or (ii).

(c) This title does not apply to:

(i) a manufacturer's or seller's warranty;

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

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

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

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

(C) the [~~cost~~] purchase price of the product is [~~equal to an amount determined in accordance with Subsection (6)(e); and~~] $3,700 or less;

(D) the product is not a motor vehicle[~~.~~]; and

(E) the product is not the subject of a home warranty service contract.

(d) This title does not apply to a manufacturer's or seller's warranty or service contract paid for with consideration that is in addition to the consideration paid for the product itself regardless of whether the manufacturer's or seller's warranty or service contract is sold:

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

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

[~~(e) (i) For fiscal year 2001-02, the amount described in Subsection (6)(c)(iii)(C) shall be equal to $3,700 or less.~~]

[~~(ii) For each fiscal year after fiscal year 2001-02, the commissioner shall annually determine whether the amount described in Subsection (6)(c)(iii)(C) should be adjusted in accordance with changes in the Consumer Price Index published by the United States Bureau of Labor Statistics selected by the commissioner by rule, between:~~]

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

[~~(B) the Consumer Price Index for February 2001.~~]

[~~(iii) If under Subsection (6)(e)(ii) the commissioner determines that an adjustment should be made, the commissioner shall make the adjustment by rule.~~]

(7) (a) For purposes of this Subsection (7), "public agency insurance mutual" means an entity formed by two or more political subdivisions or public agencies of the state:

(i) under Title 11, Chapter 13, Interlocal Cooperation Act; and

(ii) for the purpose of providing for the political subdivisions or public agencies:

(A) subject to Subsection (7)(b), insurance coverage; or

(B) risk management.

(b) Notwithstanding Subsection (7)(a)(ii)(A), a public agency insurance mutual may not provide health insurance unless the public agency insurance mutual provides the health

insurance using:

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

(ii) an admitted insurer; or

(iii) a program authorized by Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act.

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

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

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

31A-1-301. Definitions.

As used in this title, unless otherwise specified:

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

(i) a medical condition including:

(A) a medical care expense; or

(B) the risk of disability;

(ii) accident; or

(iii) sickness.

(b) "Accident and health insurance":

(i) includes a contract with disability contingencies including:

(A) an income replacement contract;

(B) a health care contract;

(C) an expense reimbursement contract;

(D) a credit accident and health contract;

(E) a continuing care contract; and

(F) a long-term care contract; and

(ii) may provide:

(A) hospital coverage;

(B) surgical coverage;

(C) medical coverage;

(D) loss of income coverage;

(E) prescription drug coverage;

(F) dental coverage; or

(G) vision coverage.

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

(d) For purposes of a national licensing registry, "accident and health insurance" is the same as "accident and health or sickness insurance."

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

(3) "Administrator" means the same as that term is defined in Subsection [~~(178)~~] (179).

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

(5) "Affiliate" means a person who controls, is controlled by, or is under common control with, another person. A corporation is an affiliate of another corporation, regardless of ownership, if substantially the same group of individuals manage the corporations.

(6) "Agency" means:

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

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

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

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

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

(10) "Application" means a document:

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

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

whether to:

(A) insure the risk under:

(I) the coverage as originally offered; or

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

(B) decline to insure the risk; or

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

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

(a) the original articles;

(b) a special law;

(c) a charter;

(d) an amendment;

(e) restated articles;

(f) articles of merger or consolidation;

(g) a trust instrument;

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

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

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

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

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

(a) without individual underwriting or application; and

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

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

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

(a) that is open to the public;

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

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

(17) "Business entity" means:

(a) a corporation;

(b) an association;

(c) a partnership;

(d) a limited liability company;

(e) a limited liability partnership; or

(f) another legal entity.

(18) "Business of insurance" means the same as that term is defined in Subsection (94).

(19) "Business plan" means the information required to be supplied to the commissioner under Subsections 31A-5-204(2)(i) and (j), including the information required when these subsections apply by reference under:

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

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

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

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

(21) "Captive insurance company" means:

(a) an insurer:

(i) owned by another organization; and

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

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

(i) owned by the insureds; and

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

(A) a member organization;

(B) a group member; or

(C) an affiliate of:

(I) a member organization; or

(II) a group member.

(22) "Casualty insurance" means liability insurance.

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

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

(b) a third party.

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

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

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

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

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

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

(i) provides board and lodging;

(ii) provides one or more of the following:

(A) a personal service;

(B) a nursing service;

(C) a medical service; or

(D) any other health-related service; and

(iii) provides the coverage described in this Subsection (28)(a) under an agreement effective:

(A) for the life of the insured; or

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

(b) Insurance is continuing care insurance regardless of whether or not the board and lodging are provided at the same location as a service described in Subsection (28)(a)(ii).

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

(i) by contract;

(ii) by common management;

(iii) through the ownership of voting securities; or

(iv) by a means other than those described in Subsections (29)(a)(i) through (iii).

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

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

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

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

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

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

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

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

(i) a corporation doing business:

(A) as:

(I) an insurance producer;

(II) a surplus lines producer;

(III) a limited line producer;

(IV) a consultant;

(V) a managing general agent;

(VI) a reinsurance intermediary;

(VII) a third party administrator; or

(VIII) an adjuster; and

(B) under:

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

(II) Chapter 25, Third Party Administrators; or

(III) Chapter 26, Insurance Adjusters; or

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

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

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

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

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

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

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

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

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

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

(b) "Credit insurance" includes:

(i) credit accident and health insurance;

(ii) credit life insurance;

(iii) credit property insurance;

(iv) credit unemployment insurance;

(v) guaranteed automobile protection insurance;

(vi) involuntary unemployment insurance;

(vii) mortgage accident and health insurance;

(viii) mortgage guaranty insurance; and

(ix) mortgage life insurance.

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

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

(a) matured;

(b) unmatured;

(c) liquidated;

(d) unliquidated;

(e) secured;

(f) unsecured;

(g) absolute;

(h) fixed; or

(i) contingent.

(40) "Credit property insurance" means insurance:

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

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

(41) "Credit unemployment insurance" means insurance:

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

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

(i) specific loan; or

(ii) credit transaction.

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

(i) provided by the private insurance market; or

(ii) subsidized by the Federal Crop Insurance Corporation.

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

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

(i) for the customer service representative's:

(A) producer;

(B) surplus lines producer; or

(C) consultant employer; and

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

(A) customer;

(B) client; or

(C) organization.

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

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

(a) imposed by:

(i) statute;

(ii) rule; or

(iii) order; and

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

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

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

(47) "Department" means the Insurance Department.

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

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

(a) perform the duties of:

(i) that individual's occupation; or

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

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

(i) eating;

(ii) toileting;

(iii) transferring;

(iv) bathing; or

(v) dressing.

(50) "Disability income insurance" means the same as that term is defined in Subsection (85).

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

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

(a) is incorporated;

(b) is organized; or

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

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

(i) an employee who:

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

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

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

(b) "Eligible employee" includes:

(i) an owner who:

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

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

(C) employs at least one common employee; and

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

(A) a sole proprietor;

(B) a partner in a partnership; or

(C) an independent contractor.

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

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

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

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

(54) "Employee" means:

(a) an individual employed by an employer; and

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

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

(a) an employee; or

(b) a dependent of an employee.

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

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

(A) one or more employers;

(B) one or more labor organizations; or

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

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

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

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

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

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

(58) (a) "Enrollee" means:

(i) a policyholder;

(ii) a certificate holder;

(iii) a subscriber; or

(iv) a covered individual:

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

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

(b) "Enrollee" includes an insured.

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

(a) the first day of coverage; or

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

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

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

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

(61) (a) "Escrow" means:

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

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

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

(ii) a settlement or closing involving:

(A) a mobile home;

(B) a grazing right;

(C) a water right; or

(D) other personal property authorized by the commissioner.

(b) "Escrow" does not include:

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

(A) an acknowledgment;

(B) a copy certification;

(C) jurat; and

(D) an oath or affirmation;

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

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

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

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

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

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

(a) a specific physical condition;

(b) a specific medical procedure;

(c) a specific disease or disorder; or

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

(65) "Expense reimbursement insurance" means insurance:

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

(b) written:

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

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

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

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

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

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

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

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

(B) rule.

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

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

(a) a policy;

(b) a rate;

(c) a form;

(d) a document;

(e) a plan;

(f) a manual;

(g) an application;

(h) a report;

(i) a certificate;

(j) an endorsement;

(k) an actuarial certification;

(l) a licensee annual statement;

(m) a licensee renewal application;

(n) an advertisement;

(o) a binder; or

(p) an outline of coverage.

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

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

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

(i) a policy;

(ii) a certificate;

(iii) an application;

(iv) an outline of coverage; or

(v) an endorsement.

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

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

(73) "General lines of authority" include:

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

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

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

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

(iii) title marketing representative only;

(c) surplus lines;

(d) workers' compensation; and

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

(74) "General lines of insurance" include:

(a) accident and health;

(b) casualty;

(c) life;

(d) personal lines;

(e) property; and

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

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

(a) (i) to an employee; or

(ii) to a dependent of an employee; and

(b) (i) directly;

(ii) through insurance reimbursement; or

(iii) through another method.

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

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

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

(A) the policy; or

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

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

dependent.

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

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

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

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

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

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

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

(iv) workers' compensation or similar insurance;

(v) automobile medical payment insurance;

(vi) credit-only insurance;

(vii) coverage for on-site medical clinics;

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

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

(A) limited scope dental or vision benefits;

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) a professional service;

(b) a personal service;

(c) a facility;

(d) equipment;

(e) a device;

(f) supplies; or

(g) medicine.

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

(i) a health care benefit; or

(ii) payment of an incurred health care expense.

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

(i) replacement of income;

(ii) short-term accident;

(iii) fixed indemnity;

(iv) credit accident and health;

(v) supplements to liability;

(vi) workers' compensation;

(vii) automobile medical payment;

(viii) no-fault automobile;

(ix) equivalent self-insurance; or

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

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

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

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

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

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

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

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

(89) "Individual" means a natural person.

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

(a) property in transit on or over land;

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

(c) bailee liability;

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

(e) personal and commercial property floaters.

(91) "Insolvency" or "insolvent" means that:

(a) an insurer is unable to pay the insurer's obligations as the obligations are due;

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

(c) an insurer's admitted assets are less than the insurer's liabilities.

(92) (a) "Insurance" means:

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

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

(b) "Insurance" includes:

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

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

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

(93) "Insurance adjuster" means a person who directs or conducts the investigation, negotiation, or settlement of a claim under an insurance policy other than life insurance or an annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.

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

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

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

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

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

(c) providing an annuity:

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

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

and (3);

(d) providing the characteristic services of a motor club as outlined in Subsection (125);

(e) providing another person with insurance;

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

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

(i) solicitation;

(ii) negotiation preliminary to execution;

(iii) execution of a contract of title insurance;

(iv) insuring; and

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

(h) transacting or proposing a life settlement; and

(i) doing, or proposing to do, any business in substance equivalent to Subsections (94)(a) through (h) in a manner designed to evade this title.

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

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

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

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

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

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

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

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

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

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

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

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

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

(99) (a) "Insured" means a person to whom or for whose benefit an insurer makes a promise in an insurance policy and includes:

(i) a policyholder;

(ii) a subscriber;

(iii) a member; and

(iv) a beneficiary.

(b) The definition in Subsection (99)(a):

(i) applies only to this title;

(ii) does not define the meaning of "insured" as used in an insurance policy or certificate; and

(iii) includes an enrollee.

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

(i) a fraternal benefit society;

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

(iii) a motor club;

(iv) an employee welfare plan;

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

(vi) a health maintenance organization.

(b) "Insurer" does not include a governmental entity.

(101) "Interinsurance exchange" means the same as that term is defined in Subsection (160).

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

(a) that includes an insurer registered under Section 31A-16-105;

(b) that has premiums written in at least three countries;

(c) whose percentage of gross premiums written outside the United States is at least 10% of its total gross written premiums; and

(d) that, based on a three-year rolling average, has:

(i) total assets of at least $50,000,000,000; or

(ii) total gross written premiums of at least $10,000,000,000.

(103) "Involuntary unemployment insurance" means insurance:

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

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

(i) specific loan; or

(ii) credit transaction.

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

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

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

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

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

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

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

(b) through special enrollment.

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

specified legal expense.

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

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

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

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

(A) medical malpractice insurance;

(B) professional liability insurance; and

(C) workers' compensation insurance;

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

(A) medical malpractice insurance;

(B) professional liability insurance; and

(C) workers' compensation insurance;

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

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

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

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

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

(b) "Liability insurance" includes:

(i) vehicle liability insurance;

(ii) residential dwelling liability insurance; and

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

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

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

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

(i) insurance on a human life; and

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

(b) The business of life insurance includes:

(i) granting a death benefit;

(ii) granting an annuity benefit;

(iii) granting an endowment benefit;

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

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

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

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

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

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

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

(a) credit life;

(b) credit accident and health;

(c) credit property;

(d) credit unemployment;

(e) involuntary unemployment;

(f) mortgage life;

(g) mortgage guaranty;

(h) mortgage accident and health;

(i) guaranteed automobile protection; and

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

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

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

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

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

(114) "Limited line insurance" includes:

(a) bail bond;

(b) limited line credit insurance;

(c) legal expense insurance;

(d) motor club insurance;

(e) car rental related insurance;

(f) travel insurance;

(g) crop insurance;

(h) self-service storage insurance;

(i) guaranteed asset protection waiver;

(j) portable electronics insurance; and

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

(115) "Limited lines authority" includes the lines of insurance listed in Subsection (114).

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

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

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

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

(A) expenses incurred;

(B) indemnity;

(C) prepayment; or

(D) another method;

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

(A) diagnostic;

(B) preventative;

(C) therapeutic;

(D) rehabilitative;

(E) maintenance; or

(F) personal care; and

(iv) that may be issued by:

(A) an insurer;

(B) a fraternal benefit society;

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

(II) a medical service corporation;

(D) a prepaid health plan;

(E) a health maintenance organization; or

(F) an entity similar to the entities described in Subsections (117)(a)(iv)(A) through (E) to the extent that the entity is otherwise authorized to issue life or health care insurance.

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

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

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

(B) a life insurance policy or rider;

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

(A) cognitive impairment; or

(B) functional capacity; or

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

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

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

(ii) basic hospital expense coverage;

(iii) basic medical/surgical expense coverage;

(iv) hospital confinement indemnity coverage;

(v) major medical expense coverage;

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

(vii) accident only coverage;

(viii) coverage for a specified:

(A) disease; or

(B) accident;

(ix) limited benefit health coverage; or

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

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

(I) benefits; or

(II) eligibility; and

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

(I) terminal illness;

(II) medical conditions requiring extraordinary medical intervention; or

(III) permanent institutional confinement.

(118) "Managed care organization" means a person:

(a) licensed as a health maintenance organization under Chapter 8, Health Maintenance Organizations and Limited Health Plans; or

(b) (i) licensed under:

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

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

(C) Chapter 14, Foreign Insurers; and

(ii) that requires an enrollee to use, or offers incentives, including financial incentives, for an enrollee to use, network providers.

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

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

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

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

(123) "Mortgage guaranty insurance" means surety insurance under which a mortgagee or other creditor is indemnified against losses caused by the default of a debtor.

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

(125) "Motor club" means a person:

(a) licensed under:

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

(ii) Chapter 11, Motor Clubs; or

(iii) Chapter 14, Foreign Insurers; and

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

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

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

(iii) (A) trip reimbursement;

(B) towing services;

(C) emergency road services;

(D) stolen automobile services;

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

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

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

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

(a) that is issued by an insurer; and

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

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

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

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

(a) ships or hulls of ships;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) receives:

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

(ii) another government health benefit.

(138) "Person" includes:

(a) an individual;

(b) a partnership;

(c) a corporation;

(d) an incorporated or unincorporated association;

(e) a joint stock company;

(f) a trust;

(g) a limited liability company;

(h) a reciprocal;

(i) a syndicate; or

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

(139) "Personal lines insurance" means property and casualty insurance coverage sold for primarily noncommercial purposes to:

(a) an individual; or

(b) a family.

(140) "Plan sponsor" means the same as that term is defined in 29 U.S.C. Sec. 1002(16)(B).

(141) "Plan year" means:

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

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

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

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

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

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

(iii) the employer's taxable year if:

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

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

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

(c) in a case not described in Subsection (141)(a) or (b), the calendar year.

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

(i) purports to be an enforceable contract; and

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

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

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

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

(iii) a corporation licensed under:

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

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

(c) "Policy" does not include:

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

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

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

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

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

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

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

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

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

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

(b) "Premium" includes, however designated:

(i) an assessment;

(ii) a membership fee;

(iii) a required contribution; or

(iv) monetary consideration.

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

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

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

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

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

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

(i) from all hazards or causes; and

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

(b) "Property insurance" does not include:

(i) inland marine insurance; and

(ii) ocean marine insurance.

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

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

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

(i) (A) by rider; or

(B) as a part of the contract; and

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

(154) "Qualified United States financial institution" means an institution that:

(a) is:

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

(ii) in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or any state;

(b) is regulated, supervised, and examined by a United States federal or state authority having regulatory authority over a bank or trust company; and

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

(i) the commissioner by rule; or

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

(155) (a) "Rate" means:

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

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

(A) a single number; or

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

(I) expenses;

(II) profit; and

(III) individual insurer variation in loss experience.

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

(156) (a) Except as provided in Subsection (156)(b), "rate service organization" means a person who assists an insurer in rate making or filing by:

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

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

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

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

(i) an employee of an insurer;

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

(iii) a joint underwriting group; or

(iv) an individual serving as an actuarial or legal consultant.

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

(a) a manual of rates;

(b) a classification;

(c) a rate-related underwriting rule; and

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

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

(i) a refund of premium or portion of premium;

(ii) a refund of commission or portion of commission;

(iii) a refund of all or a portion of a consultant fee; or

(iv) providing services or other benefits not specified in an insurance or annuity contract.

(b) "Rebate" does not include:

(i) a refund due to termination or changes in coverage;

(ii) a refund due to overcharges made in error by the licensee; or

(iii) savings or wellness benefits as provided in the contract by the licensee.

(159) "Received by the department" means:

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

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

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

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

(i) facsimile;

(ii) email; or

(iii) another electronic method; or

(e) a date specified in:

(i) a statute;

(ii) a rule; or

(iii) an order.

(160) "Reciprocal" or "interinsurance exchange" means an unincorporated association of persons:

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

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

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

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

(b) the insurer assuming the risk as the:

(i) "assuming insurer"; or

(ii) "assuming reinsurer."

(162) "Reinsurer" means a person licensed in this state as an insurer with the authority to assume reinsurance.

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

(164) (a) "Retrocession" means reinsurance with another insurer of a liability assumed under a reinsurance contract.

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

(165) "Rider" means an endorsement to:

(a) an insurance policy; or

(b) an insurance certificate.

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

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

(i) note;

(ii) stock;

(iii) bond;

(iv) debenture;

(v) evidence of indebtedness;

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

(vii) collateral-trust certificate;

(viii) preorganization certificate or subscription;

(ix) transferable share;

(x) investment contract;

(xi) voting trust certificate;

(xii) certificate of deposit for a security;

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

(xiv) commodity contract or commodity option;

(xv) certificate of interest or participation in, temporary or interim certificate for, receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed in Subsections (167)(a)(i) through (xiv); or

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

(b) "Security" does not include:

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

(A) insurance;

(B) an endowment policy; or

(C) an annuity contract; or

(ii) a burial certificate or burial contract.

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

(a) common stock;

(b) preferred stock;

(c) debt obligations; and

(d) any other security convertible into or evidencing the right of any of the items listed in this Subsection (168).

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

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

(c) "Self-insurance" includes:

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

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

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

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

(a) by any means;

(b) for money or its equivalent; and

(c) on behalf of an insurance company.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) bail bond insurance; and

(c) fidelity insurance.

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

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

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

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

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

(c) "Excess surplus" means:

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

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

(I) 2.5; and

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

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

(I) 3.0; and

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

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

(A) 1.5; and

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

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

(a) a union on behalf of its members;

(b) a person administering a:

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

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

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

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

more of the subsidiary or affiliated corporations of the employer;

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

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

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

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

(iv) Chapter 9, Insurance Fraternals; or

(v) Chapter 14, Foreign Insurers;

(e) a person:

(i) licensed or exempt from licensing under:

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

(B) Chapter 26, Insurance Adjusters; and

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

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

(i) that is:

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

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

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

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

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

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

filed under Section 31A-4-113; and

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

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

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

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

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

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

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

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

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

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

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

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

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

(188) "Workers' compensation insurance" means:

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

(i) a compensable accidental injury; and

(ii) occupational disease disability;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

31A-2-212. Miscellaneous duties.

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

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

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

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

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

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

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

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

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

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

(i) an authorized insurer doing a surety business:

(A) files a petition for receivership; or

(B) is in receivership; or

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

(A) is in financial difficulty; or

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

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

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

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

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

(i) lifetime and annual limits;

(ii) prohibition of rescissions;

(iii) coverage of preventive health services;

(iv) coverage for a child or dependent;

(v) pre-existing condition limitations;

(vi) insurer transparency of consumer information including plan disclosures, uniform coverage documents, and standard definitions;

(vii) premium rate reviews;

(viii) essential health benefits;

(ix) provider choice;

(x) waiting periods;

(xi) appeals processes;

(xii) rating restrictions;

(xiii) uniform applications and notice provisions;

(xiv) certification and regulation of qualified health plans; and

(xv) network adequacy standards.

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

(i) the health insurance market in the state;

(ii) qualified health plans offered in the state; and

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

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

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

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

~~approval by the governor.~~]

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

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

The commissioner and the department shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

connection with this state;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

consent of the Senate as follows:

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

(ii) two members shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Section 63A-3-106;

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

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

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

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

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

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

subcommittee meeting, or emergency meeting by electronic means in accordance with Section 52-4-207.

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

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

(c) The commissioner may call additional meetings:

(i) at the commissioner's discretion;

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

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

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

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

(7) The commissioner shall staff the commission.

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

31A-6a-101. Definitions.

As used in this chapter:

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

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

(b) for a predetermined fee; and

(c) if:

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

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

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

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

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

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

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

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

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

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

(b) "Service contract" does not include:

(i) mechanical breakdown insurance; or

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

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

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

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

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

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

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

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

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

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

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

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

(ii) designed to:

(A) prevent the theft of the vehicle; or

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

(b) "Vehicle protection product" includes:

(i) a vehicle protection product warranty;

(ii) an alarm system;

(iii) a body part marking product;

(iv) a steering lock;

(v) a window etch product;

(vi) a pedal and ignition lock;

(vii) a fuel and ignition kill switch; and

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

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

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

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

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

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

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

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

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

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

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

(a) an insurer authorized to do business in this state; or

(b) a recognized surplus lines carrier.

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

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

(i) an application for registration;

(ii) a fee established in accordance with Section 31A-3-103;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Chapter 9, Insurance Fraternals;

(e) Chapter 10, Annuities;

(f) Chapter 11, Motor Clubs;

(g) Chapter 12, State Risk Management Fund;

(h) Chapter 14, Foreign Insurers;

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

(j) Chapter 25, Third Party Administrators; and

(k) Chapter 28, Guaranty Associations.

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

31A-6a-104. Required disclosures.

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

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

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

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

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

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

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

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

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

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

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

(iii) as applicable:

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

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

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

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

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

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

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

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

service contract or warranty is to be paid;

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

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

[~~(f)~~] (vi) state a term, restriction, or condition governing the transferability of the service contract or warranty; and

[~~(g)~~] (vii) state a term, restriction, or condition that governs cancellation of the service contract as provided in Sections 31A-21-303 through 31A-21-305 by either the contract holder or service contract provider.

(b) Beginning January 1, 2021, a service contract shall contain a conspicuous statement in substantially the following form: "Purchase of this product is optional and is not required in order to finance, lease, or purchase a motor vehicle."

(4) If prior approval of repair work is required[~~, a service~~] under a home protection service contract or a vehicle service contract, the contract shall conspicuously state the procedure for obtaining prior approval and for making a claim, including:

(a) a toll free telephone number for claim service; and

(b) a procedure for obtaining reimbursement for emergency repairs performed outside of normal business hours.

(5) A preexisting condition clause in a service contract shall specifically state which preexisting condition is excluded from coverage.

(6) (a) Except as provided in Subsection (6)(c), a service contract shall state the conditions upon which the use of a nonmanufacturers' part is allowed.

(b) A condition described in Subsection (6)(a) shall comply with applicable state and federal laws.

(c) This Subsection (6) does not apply to:

(i) a home warranty service contract[~~.~~]; or

(ii) a service contract that does not impose an obligation to provide parts.

(7) This section applies to a vehicle protection product warranty, except for the requirements of Subsections (3)(d) and (g), (4), (5), and (6). The department may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement the application of this section to a vehicle protection product warranty.

(8) (a) As used in this Subsection (8), "conspicuous statement" means a disclosure that:

(i) appears in all-caps, bold, and 14-point font; and

(ii) provides a space to be initialed by the consumer:

(A) immediately below the printed disclosure; and

(B) at or before the time the consumer purchases the vehicle protection product.

(b) A vehicle protection product warranty shall contain a conspicuous statement in substantially the following form: "Purchase of this product is optional and is not required in order to finance, lease, or purchase a motor vehicle."

(9) If a vehicle protection product warranty states that the warrantor will reimburse the warranty holder for incidental costs, the vehicle protection product warranty shall state how incidental costs paid under the warranty are calculated.

(10) If a vehicle protection product warranty states that the warrantor will reimburse the warranty holder in a fixed amount, the vehicle protection product warranty shall state the fixed amount.

Section 15. Section **31A-8-211** is amended to read:

31A-8-211. Deposit.

(1) Except as provided in Subsection (2), each health maintenance organization authorized in this state shall maintain a deposit with the commissioner under Section 31A-2-206 in an amount equal to the sum of:

(a) $100,000; and

(b) 50% of the greater of:

(i) $900,000;

(ii) 2% of the annual premium revenues as reported on the most recent annual financial statement filed with the commissioner; or

(iii) an amount equal to the sum of three months uncovered health care expenditures as reported on the most recent financial statement filed with the commissioner.

(2) (a) [~~After a hearing the~~] The commissioner may exempt a health maintenance organization from the deposit requirement of Subsection (1) if:

(i) the commissioner determines that the enrollees' interests are adequately protected;

(ii) the health maintenance organization has been continuously authorized to do business in this state for at least five years; and

(iii) the health maintenance organization has $5,000,000 surplus in excess of the health maintenance organization's company action level RBC as defined in Subsection 31A-17-601(8)(b).

(b) The commissioner may rescind an exemption given under Subsection (2)(a).

(3) (a) Each limited health plan authorized in this state shall maintain a deposit with the commissioner under Section 31A-2-206 in an amount equal to the minimum capital or permanent surplus plus 50% of the greater of:

(i) .5 times minimum required capital or minimum permanent surplus; or

(ii) (A) during the first year of operation, 10% of the limited health plan's projected uncovered expenditures for the first year of operation;

(B) during the second year of operation, 12% of the limited health plan's projected uncovered expenditures for the second year of operation;

(C) during the third year of operation, 14% of the limited health plan's projected uncovered expenditures for the third year of operation;

(D) during the fourth year of operation, 18% of the limited health plan's projected uncovered expenditures during the fourth year of operation; or

(E) during the fifth year of operation, and during all subsequent years, 20% of the limited health plan's projected uncovered expenditures for the previous 12 months.

(b) Projections of future uncovered expenditures shall be established in a manner that is approved by the commissioner.

(4) A deposit required by this section may be counted toward the minimum capital or minimum permanent surplus required under Section 31A-8-209.

Section 16. Section **31A-17-404** is amended to read:

31A-17-404. Credit allowed a domestic ceding insurer against reserves for reinsurance.

(1) A domestic ceding insurer is allowed credit for reinsurance as either an asset or a reduction from liability for reinsurance ceded only if the reinsurer meets the requirements of Subsection (3), (4), (5), (6), (7), [~~or~~] (8), or (9) subject to the following:

(a) Credit is allowed under Subsection (3), (4), or (5) only with respect to a cession of a kind or class of business that the assuming insurer is licensed or otherwise permitted to write or assume:

(i) in its state of domicile; or

(ii) in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance.

(b) Credit is allowed under Subsection (5) or (6) only if the applicable requirements of Subsection [~~(9)~~] (11) are met.

(2) A domestic ceding insurer is allowed credit for reinsurance ceded:

(a) only if the reinsurance is payable in a manner consistent with Section 31A-22-1201;

(b) only to the extent that the accounting:

(i) is consistent with the terms of the reinsurance contract; and

(ii) clearly reflects:

(A) the amount and nature of risk transferred; and

(B) liability, including contingent liability, of the ceding insurer;

(c) only to the extent the reinsurance contract shifts insurance policy risk from the ceding insurer to the assuming reinsurer in fact and not merely in form; and

(d) only if the reinsurance contract contains a provision placing on the reinsurer the credit risk of all dealings with intermediaries regarding the reinsurance contract.

(3) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this state.

(4) (a) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an assuming insurer that is accredited by the commissioner as a reinsurer in this state.

(b) An insurer is accredited as a reinsurer if the insurer:

(i) files with the commissioner evidence of the insurer's submission to this state's jurisdiction;

(ii) submits to the commissioner's authority to examine the insurer's books and records;

(iii) (A) is licensed to transact insurance or reinsurance in at least one state; or

(B) in the case of a United States branch of an alien assuming insurer, is entered through and licensed to transact insurance or reinsurance in at least one state;

(iv) files annually with the commissioner a copy of the insurer's:

(A) annual statement filed with the insurance department of its state of domicile; and

(B) most recent audited financial statement; and

(v) (A) (I) has not had its accreditation denied by the commissioner within 90 days [~~of~~]

after the day on which the insurer submits the information required by this Subsection (4); and

(II) maintains a surplus with regard to policyholders in an amount not less than $20,000,000; or

(B) (I) has its accreditation approved by the commissioner; and

(II) maintains a surplus with regard to policyholders in an amount less than $20,000,000.

(c) Credit may not be allowed a domestic ceding insurer if the assuming insurer's accreditation is revoked by the commissioner after a notice and hearing.

(5) (a) A domestic ceding insurer is allowed a credit if:

(i) the reinsurance is ceded to an assuming insurer that is:

(A) domiciled in a state meeting the requirements of Subsection (5)(a)(ii); or

(B) in the case of a United States branch of an alien assuming insurer, is entered through a state meeting the requirements of Subsection (5)(a)(ii);

(ii) the state described in Subsection (5)(a)(i) employs standards regarding credit for reinsurance substantially similar to those applicable under this section; and

(iii) the assuming insurer or United States branch of an alien assuming insurer:

(A) maintains a surplus with regard to policyholders in an amount not less than $20,000,000; and

(B) submits to the authority of the commissioner to examine its books and records.

(b) The requirements of Subsections (5)(a)(i) and (ii) do not apply to reinsurance ceded and assumed pursuant to a pooling arrangement among insurers in the same holding company system.

(6) (a) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an assuming insurer that maintains a trust fund:

(i) created in accordance with rules made by the commissioner pursuant to Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and

(ii) in a qualified United States financial institution for the payment of a valid claim of:

(A) a United States ceding insurer of the assuming insurer;

(B) an assign of the United States ceding insurer; and

(C) a successor in interest to the United States ceding insurer.

(b) To enable the commissioner to determine the sufficiency of the trust fund described

in Subsection (6)(a), the assuming insurer shall:

(i) report annually to the commissioner information substantially the same as that required to be reported on the National Association of Insurance Commissioners Annual Statement form by a licensed insurer; and

(ii) (A) submit to examination of its books and records by the commissioner; and

(B) pay the cost of an examination.

(c) (i) Credit for reinsurance may not be granted under this Subsection (6) unless the form of the trust and any amendment to the trust is approved by:

(A) the commissioner of the state where the trust is domiciled; or

(B) the commissioner of another state who, pursuant to the terms of the trust instrument, accepts principal regulatory oversight of the trust.

(ii) The form of the trust and an amendment to the trust shall be filed with the commissioner of every state in which a ceding insurer beneficiary of the trust is domiciled.

(iii) The trust instrument shall provide that a contested claim is valid and enforceable upon the final order of a court of competent jurisdiction in the United States.

(iv) The trust shall vest legal title to its assets in its one or more trustees for the benefit of:

(A) a United States ceding insurer of the assuming insurer;

(B) an assign of the United States ceding insurer; or

(C) a successor in interest to the United States ceding insurer.

(v) The trust and the assuming insurer are subject to examination as determined by the commissioner.

(vi) The trust shall remain in effect for as long as the assuming insurer has an outstanding obligation due under a reinsurance agreement subject to the trust.

(vii) No later than February 28 of each year, the trustee of the trust shall:

(A) report to the commissioner in writing the balance of the trust;

(B) list the trust's investments at the end of the preceding calendar year; and

(C) (I) certify the date of termination of the trust, if so planned; or

(II) certify that the trust will not expire [~~prior to~~] before the following December 31.

(d) The following requirements apply to the following categories of assuming insurer:

(i) For a single assuming insurer:

(A) the trust fund shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers; and

(B) the assuming insurer shall maintain a trusteed surplus of not less than $20,000,000, except as provided in Subsection (6)(d)(ii).

(ii) (A) At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three full years, the commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders, and claimants in light of reasonably foreseeable adverse loss development.

(B) The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors, including, when applicable, the lines of business involved, the stability of the incurred loss estimates, and the effect of the surplus requirements on the assuming insurer's liquidity or solvency.

(C) The minimum required trusteed surplus may not be reduced to an amount less than 30% of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust.

(iii) For a group acting as assuming insurer, including incorporated and individual unincorporated underwriters:

(A) for reinsurance ceded under a reinsurance agreement with an inception, amendment, or renewal date on or after August 1, 1995, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several liabilities attributable to business ceded by the one or more United States domiciled ceding insurers to an underwriter of the group;

(B) for reinsurance ceded under a reinsurance agreement with an inception date on or before July 31, 1995, and not amended or renewed after July 31, 1995, notwithstanding the other provisions of this chapter, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the United States;

(C) in addition to a trust described in Subsection (6)(d)(iii)(A) or (B), the group shall maintain in trust a trusteed surplus of which $100,000,000 is held jointly for the benefit of the

one or more United States domiciled ceding insurers of a member of the group for all years of account;

(D) the incorporated members of the group:

(I) may not be engaged in a business other than underwriting as a member of the group; and

(II) are subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members; and

(E) within 90 days after the day on which the group's financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the commissioner:

(I) an annual certification by the group's domiciliary regulator of the solvency of each underwriter member; or

(II) if a certification is unavailable, a financial statement, prepared by an independent public accountant, of each underwriter member of the group.

(iv) For a group of incorporated underwriters under common administration, the group shall:

(A) have continuously transacted an insurance business outside the United States for at least three years immediately preceding the day on which the group makes application for accreditation;

(B) maintain aggregate policyholders' surplus of at least $10,000,000,000;

(C) maintain a trust fund in an amount not less than the group's several liabilities attributable to business ceded by the one or more United States domiciled ceding insurers to a member of the group pursuant to a reinsurance contract issued in the name of the group;

(D) in addition to complying with the other provisions of this Subsection (6)(d)(iv), maintain a joint trusteed surplus of which $100,000,000 is held jointly for the benefit of the one or more United States domiciled ceding insurers of a member of the group as additional security for these liabilities; and

(E) within 90 days after the day on which the group's financial statements are due to be filed with the group's domiciliary regulator, make available to the commissioner:

(I) an annual certification of each underwriter member's solvency by the member's domiciliary regulator; and

(II) a financial statement of each underwriter member of the group prepared by an

independent public accountant.

[~~(7) If reinsurance is ceded to an assuming insurer not meeting the requirements of Subsection (3), (4), (5), or (6), a domestic ceding insurer is allowed credit only as to the insurance of a risk located in a jurisdiction where the reinsurance is required by applicable law or regulation of that jurisdiction.~~]

[~~(8)~~] (7) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an assuming insurer that secures its obligations in accordance with this Subsection [~~(8)~~] (7):

(a) The insurer shall be certified by the commissioner as a reinsurer in this state.

(b) To be eligible for certification, the assuming insurer shall:

(i) be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the commissioner pursuant to Subsection [~~(8)~~] (7)(d);

(ii) maintain minimum capital and surplus, or its equivalent, in an amount to be determined by the commissioner pursuant to rules made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(iii) maintain financial strength ratings from two or more rating agencies considered acceptable by the commissioner pursuant to rules made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and

(iv) agree to:

(A) submit to the jurisdiction of this state;

(B) appoint the commissioner as its agent for service of process in this state;

(C) provide security for 100% of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if it resists enforcement of a final United States judgment;

(D) agree to meet applicable information filing requirements as determined by the commissioner including an application for certification, a renewal and on an ongoing basis; and

(E) any other requirements for certification considered relevant by the commissioner.

(c) An association, including incorporated and individual unincorporated underwriters, may be a certified reinsurer. To be eligible for certification, in addition to satisfying requirements of Subsections [~~(8)~~] (7)(a) and (b), the association:

(i) shall satisfy its minimum capital and surplus requirements through the capital and surplus equivalents, net of liabilities, of the association and its members, which shall include a

joint central fund that may be applied to any unsatisfied obligation of the association or any of its members in an amount determined by the commissioner to provide adequate protection;

(ii) may not have incorporated members of the association engaged in any business other than underwriting as a member of the association;

(iii) shall be subject to the same level of regulation and solvency control of the incorporated members of the association by the association's domiciliary regulator as are the unincorporated members; and

(iv) within 90 days after its financial statements are due to be filed with the association's domiciliary regulator provide:

(A) to the commissioner an annual certification by the association's domiciliary regulator of the solvency of each underwriter member; or

(B) if a certification is unavailable, financial statements prepared by independent public accountants, of each underwriter member of the association.

(d) The commissioner shall create and publish a list of qualified jurisdictions under which an assuming insurer licensed and domiciled in the jurisdiction is eligible to be considered for certification by the commissioner as a certified reinsurer.

(i) To determine whether the domiciliary jurisdiction of a non-United States assuming insurer is eligible to be recognized as a qualified jurisdiction, the commissioner:

(A) shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis;

(B) shall consider the rights, the benefits, and the extent of reciprocal recognition afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the United States;

(C) shall require the qualified jurisdiction to share information and cooperate with the commissioner with respect to all certified reinsurers domiciled within that jurisdiction; and

(D) may not recognize a jurisdiction as a qualified jurisdiction if the commissioner has determined that the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards.

(ii) The commissioner may consider additional factors in determining a qualified jurisdiction.

(iii) A list of qualified jurisdictions shall be published through the National

Association of Insurance Commissioners' Committee Process and the commissioner shall:

(A) consider this list in determining qualified jurisdictions; and

(B) if the commissioner approves a jurisdiction as qualified that does not appear on the National Association of Insurance Commissioner's list of qualified jurisdictions, provide thoroughly documented justification in accordance with criteria to be developed by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(iv) United States jurisdictions that meet the requirement for accreditation under the National Association of Insurance Commissioners' financial standards and accreditation program shall be recognized as qualified jurisdictions.

(v) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the commissioner may suspend the reinsurer's certification indefinitely, in lieu of revocation.

(e) The commissioner shall:

(i) assign a rating to each certified reinsurer, giving due consideration to the financial strength ratings that have been assigned by rating agencies considered acceptable to the commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and

(ii) publish a list of all certified reinsurers and their ratings.

(f) A certified reinsurer shall secure obligations assumed from United States ceding insurers under this Subsection [~~(8)~~] (7) at a level consistent with its rating, as specified in rules made by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(i) For a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a form acceptable to the commissioner and consistent with Section 31A-17-404.1, or in a multibeneficiary trust in accordance with Subsections (5), (6), and [~~(7)~~] (9), except as otherwise provided in this Subsection [~~(8)~~] (7).

(ii) If a certified reinsurer maintains a trust to fully secure its obligations subject to Subsections (5), (6), and [~~(7)~~] (9), and chooses to secure its obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by this Subsection [~~(8)~~] (7) or comparable

laws of other United States jurisdictions and for its obligations subject to Subsections (5), (6), and [~~(7)~~] (9).

(iii) It shall be a condition to the grant of certification under this Subsection [~~(8)~~] (7) that the certified reinsurer shall have bound itself:

(A) by the language of the trust and agreement with the commissioner with principal regulatory oversight of the trust account; and

(B) upon termination of the trust account, to fund, out of the remaining surplus of the trust, any deficiency of any other trust account.

(iv) The minimum trusteed surplus requirements provided in Subsections (5), (6), and [~~(7)~~] (9) are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this Subsection [~~(8)~~] (7), except that the trust shall maintain a minimum trusteed surplus of $10,000,000.

(v) With respect to obligations incurred by a certified reinsurer under this Subsection [~~(8)~~] (7), if the security is insufficient, the commissioner:

(A) shall reduce the allowable credit by an amount proportionate to the deficiency; and

(B) may impose further reductions in allowable credit upon finding that there is a material risk that the certified reinsurer's obligations will not be paid in full when due.

(vi) For purposes of this Subsection [~~(8)~~] (7), a certified reinsurer whose certification has been terminated for any reason shall be treated as a certified reinsurer required to secure 100% of its obligations.

(A) As used in this Subsection [~~(8)~~] (7), the term "terminated" refers to revocation, suspension, voluntary surrender, and inactive status.

(B) If the commissioner continues to assign a higher rating as permitted by other provisions of this section, the requirement under this Subsection [~~(8)~~] (7)(f)(vi) does not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.

(g) If an applicant for certification has been certified as a reinsurer in a National Association of Insurance Commissioners' accredited jurisdiction, the commissioner may:

(i) defer to that jurisdiction's certification;

(ii) defer to the rating assigned by that jurisdiction; and

(iii) consider such reinsurer to be a certified reinsurer in this state.

(h) (i) A certified reinsurer that ceases to assume new business in this state may request to maintain its certification in inactive status in order to continue to qualify for a reduction in security for its in-force business.

(ii) An inactive certified reinsurer shall continue to comply with all applicable requirements of this Subsection [~~(8)~~] (7).

(iii) The commissioner shall assign a rating to a reinsurer that qualifies under this Subsection [~~(8)~~] (7)(h), that takes into account, if relevant, the reasons why the reinsurer is not assuming new business.

(8) (a) As used in this Subsection (8):

(i) "Covered agreement" means an agreement entered into pursuant to Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. Sections 313 and 314, that is currently in effect or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance.

(ii) "Reciprocal jurisdiction" means a jurisdiction that is:

(A) a non-United States jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and European Union, is a member state of the European Union;

(B) a United States jurisdiction that meets the requirements for accreditation under the National Association of Insurance Commissioners' financial standards and accreditation program; or

(C) a qualified jurisdiction, as determined by the commissioner in accordance with Subsection (7)(d), that is not otherwise described in this Subsection (8)(a)(ii) and meets certain additional requirements, consistent with the terms and conditions of in-force covered agreements, as specified by the commissioner in rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(b) (i) Credit shall be allowed when the reinsurance is ceded to an assuming insurer meeting each of the conditions set forth in this Subsection (8)(b).

(ii) The assuming insurer must have its head office or be domiciled in, as applicable, and be licensed in a reciprocal jurisdiction.

(iii) (A) The assuming insurer must have and maintain, on an ongoing basis, minimum capital and surplus, or its equivalent, calculated according to the methodology of its domiciliary jurisdiction, in an amount to be set forth in regulation.

(B) If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it must have and maintain, on an ongoing basis, minimum capital and surplus equivalents (net of liabilities), calculated according to the methodology applicable in its domiciliary jurisdiction, and a central fund containing a balance in amounts to be set forth in regulation.

(iv) (A) The assuming insurer must have and maintain, on an ongoing basis, a minimum solvency or capital ration, as applicable, which will be set forth in regulation.

(B) If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it must have and maintain, on an ongoing basis, a minimum solvency or capital ratio in the reciprocal jurisdiction where the assuming insurer has its head office or is domiciled, as applicable, and is also licensed.

(v) The assuming insurer must agree and provide adequate assurance to the commissioner, in a form specified by the commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as follows:

(A) the assuming insurer must provide prompt written notice and explanation to the commissioner if it falls below the minimum requirements set forth in Subsections (8)(c) or (d), or if any regulatory action is taken against it for serious noncompliance with applicable law;

(B) the assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the commissioner as agent for service of process, however the commissioner may require that consent for service of process be provided to the commissioner and included in each reinsurance agreement and nothing in this provision shall limit, or in any way alter, the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws;

(C) the assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or its legal successor, that have been declared enforceable in the jurisdiction where the judgment was obtained;

(D) each reinsurance agreement must include a provision requiring the assuming

insurer to provide security in an amount equal to 100% of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its resolution estate; and

(E) the assuming insurer must confirm that it is not presently participating in any solvent scheme of arrangement which involved this state's ceding insurers, and agree to notify the ceding insurer and the commissioner and to provide security:

(I) in an amount equal to 100% of the assuming insurer's liabilities to the ceding insurer, should the assuming insurer enter into such a solvent scheme of arrangement; and

(II) in a form consistent with the provisions of Subsections (7) and (10) and as specified by the commissioner in regulation.

(vi) The assuming insurer or its legal successor must provide, if requested by the commissioner, on behalf of itself and any legal predecessors, certain documentation to the commissioner, as specified by the commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(vii) The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements, pursuant to criteria set forth in rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(viii) The assuming insurer's supervisory authority must confirm to the commissioner on an annual basis, as of the preceding December 31 or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, that the assuming insurer complies with the requirements set forth in Subsections (8)(c) and (d).

(ix) Nothing in this provision precludes an assuming insurer from providing the commissioner with information on a voluntary basis.

(c) (i) The commissioner shall timely create and publish a list of reciprocal jurisdictions.

(ii) (A) A list of reciprocal jurisdictions is published through the National Association of Insurance Commissioners' Committee Process.

(B) The commissioner's list of reciprocal jurisdictions shall include any reciprocal jurisdiction as defined in this Subsection (8), and shall consider any other reciprocal

jurisdictions in accordance with the criteria developed under rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(iii) (A) The commissioner may remove a jurisdiction from the list of reciprocal jurisdictions upon a determination that the jurisdiction no longer meets the requirements of a reciprocal jurisdiction, in accordance with a process set forth in rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, except that the commissioner shall not remove from the list a reciprocal jurisdiction.

(B) Upon removal of a reciprocal jurisdiction from this list, credit for reinsurance ceded to an assuming insurer which has its home office or is domiciled in that jurisdiction shall be allowed, if otherwise allowed under this chapter.

(d) (i) The commissioner shall timely create and publish a list of assuming insurers that have satisfied the conditions set forth in this subsection and to which cessions shall be granted credit in accordance with this Subsection (8).

(ii) The commissioner may add an assuming insurer to such list if a National Association of Insurance Commissioners accredited jurisdiction has added such assuming insurer to a list of such assuming insurers or if, upon initial eligibility, the assuming insurer submits the information to the commissioner as required under this Subsection (8) and complies with any additional requirements that the commissioner may impose by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, except to the extent that they conflict with an applicable covered agreement.

(e) (i) If the commissioner determines that an assuming insurer no longer meets one or more of the requirements under this Subsection (8), the commissioner may revoke or suspend the eligibility of the assuming insurer for recognition under this Subsection (8) in accordance with procedures established in rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(ii) (A) While an assuming insurer's eligibility is suspended, no reinsurance agreement issued, amended, or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer's obligations under the contract are secured in accordance with Subsection (10).

(B) If an assuming insurer's eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements

entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the commissioner and consistent with the provisions of Subsection (10).

(f) If subject to a legal process of rehabilitation, liquidation, or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding ceded liabilities.

(g) Nothing in this Subsection (8) limits or in any way alters the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement, except as expressly prohibited by this chapter or other applicable law or regulation.

(h) (i) Credit may be taken under this Subsection (8) only for reinsurance agreements entered into, amended, or renewed on or after the effective date of the statute adding this Subsection (8), and only with respect to losses incurred and reserves reported on or after the later of:

(A) the date on which the assuming insurer has met all eligibility requirements pursuant to Subsection (8)(b); and

(B) the effective date of the new reinsurance agreement, amendment or renewal.

(ii) This Subsection (8) does not alter or impair a ceding insurer's right to take credit for reinsurance, to the extent that credit is not available under this Subsection (8), as long as the reinsurance qualifies for credit under any other applicable provision of this chapter.

(iii) Nothing in this Subsection (8) authorizes an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement except as permitted by the terms of the agreement.

(iv) Nothing in this Subsection (8) limits, or in any way alters, the capacity of parties to any reinsurance agreement to renegotiate the agreement.

(9) If reinsurance is ceded to an assuming insurer not meeting the requirements of Subsection (3), (4), (5), (6), (7), or (8), a domestic ceding insurer is allowed credit only as to the insurance of a risk located in a jurisdiction where the reinsurance is required by applicable law or regulation of that jurisdiction.

(10) (a) An asset or a reduction from liability for the reinsurance ceded by a domestic

insurer to an assuming insurer not meeting the requirements of Subsection (3), (4), (5), (6), (7), or (8) shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer.

(b) The commissioner may adopt by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, specific additional requirements relating to or setting forth:

(i) the valuation of assets or reserve credits;

(ii) the amount and forms of security supporting reinsurance arrangements; and

(iii) the circumstances pursuant to which credit will be reduced or eliminated.

(c) (i) The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder, if the security is:

(A) held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or

(B) in the case of a trust, held in a qualified United States financial institution.

(ii) The security described in this Subsection (10)(c) may be in the form of:

(A) cash;

(B) securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the Securities Valuation Office, and qualifying as admitted assets;

(C) clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution effective no later than December 31 of the year for which the filing is being made, and in the possession of, or in trust for, the ceding insurer on or before the filing date of its annual statement;

(D) letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs; or

(E) any other form of security acceptable to the commissioner.

[~~(9)~~] (11) Reinsurance credit may not be allowed a domestic ceding insurer unless the

assuming insurer under the reinsurance contract submits to the jurisdiction of Utah courts by:

(a) (i) being an admitted insurer; and

(ii) submitting to jurisdiction under Section 31A-2-309;

(b) having irrevocably appointed the commissioner as the domestic ceding insurer's agent for service of process in an action arising out of or in connection with the reinsurance, which appointment is made under Section 31A-2-309; or

(c) agreeing in the reinsurance contract:

(i) that if the assuming insurer fails to perform its obligations under the terms of the reinsurance contract, the assuming insurer, at the request of the ceding insurer, shall:

(A) submit to the jurisdiction of a court of competent jurisdiction in a state of the United States;

(B) comply with all requirements necessary to give the court jurisdiction; and

(C) abide by the final decision of the court or of an appellate court in the event of an appeal; and

(ii) to designate the commissioner or a specific attorney licensed to practice law in this state as its attorney upon whom may be served lawful process in an action, suit, or proceeding instituted by or on behalf of the ceding company.

[~~(10)~~] (12) Submitting to the jurisdiction of Utah courts under Subsection [~~(9)~~] (11) does not override a duty or right of a party under the reinsurance contract, including a requirement that the parties arbitrate their disputes.

[~~(11)~~] (13) If an assuming insurer does not meet the requirements of Subsection (3), (4), [~~or~~] (5), or (8), the credit permitted by Subsection (6) or [~~(8)~~] (7) may not be allowed unless the assuming insurer agrees in the trust instrument to the following conditions:

(a) (i) Notwithstanding any other provision in the trust instrument, if an event described in Subsection [~~(11)~~] (13)(a)(ii) occurs the trustee shall comply with:

(A) an order of the commissioner with regulatory oversight over the trust; or

(B) an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight all of the assets of the trust fund.

(ii) This Subsection [~~(11)~~] (13)(a) applies if:

(A) the trust fund is inadequate because the trust contains an amount less than the amount required by Subsection (6)(d); or

(B) the grantor of the trust is:

(I) declared insolvent; or

(II) placed into receivership, rehabilitation, liquidation, or similar proceeding under the laws of its state or country of domicile.

(b) The assets of a trust fund described in Subsection [~~(11)~~] (13)(a) shall be distributed by and a claim shall be filed with and valued by the commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of a domestic insurance company.

(c) If the commissioner with regulatory oversight determines that the assets of the trust fund, or any part of the assets, are not necessary to satisfy the claims of the one or more United States ceding insurers of the grantor of the trust, the assets, or a part of the assets, shall be returned by the commissioner with regulatory oversight to the trustee for distribution in accordance with the trust instrument.

(d) A grantor shall waive any right otherwise available to it under United States law that is inconsistent with this Subsection [~~(11)~~] (13).

[~~(12)~~] (14) If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the commissioner may suspend or revoke the reinsurer's accreditation or certification.

(a) The commissioner shall give the reinsurer notice and opportunity for hearing.

(b) The suspension or revocation may not take effect until after the commissioner's order after a hearing, unless:

(i) the reinsurer waives its right to hearing;

(ii) the commissioner's order is based on:

(A) regulatory action by the reinsurer's domiciliary jurisdiction; or

(B) the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or primary certifying state under Subsection [~~(8)~~] (7)(g); or

(iii) the commissioner's finding that an emergency requires immediate action and a court of competent jurisdiction has not stayed the commissioner's action.

(c) While a reinsurer's accreditation or certification is suspended, no reinsurance contract issued or renewed after the effective date of the suspension qualifies for credit except

to the extent that the reinsurer's obligations under the contract are secured in accordance with Section 31A-17-404.1.

(d) If a reinsurer's accreditation or certification is revoked, no credit for reinsurance may be granted after the effective date of the revocation except to the extent that the reinsurer's obligations under the contract are secured in accordance with Subsection [~~(8)~~] (7)(f) or Section 31A-17-404.1.

[~~(13)~~] (15) (a) A ceding insurer shall take steps to manage its reinsurance recoverables proportionate to its own book of business.

(b) (i) A domestic ceding insurer shall notify the commissioner within 30 days after reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers:

(A) exceeds 50% of the domestic ceding insurer's last reported surplus to policyholders; or

(B) after it is determined that reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed 50% of the domestic ceding insurer's last reported surplus to policyholders.

(ii) The notification required by Subsection [~~(13)~~] (15)(b)(i) shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

(c) A ceding insurer shall take steps to diversify its reinsurance program.

(d) (i) A domestic ceding insurer shall notify the commissioner within 30 days after ceding or being likely to cede more than 20% of the ceding insurer's gross written premium in the prior calendar year to any:

(A) single assuming insurer; or

(B) group of affiliated assuming insurers.

(ii) The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

Section 17. Section **31A-17-404.3** is amended to read:

31A-17-404.3. Rules.

(1) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and this chapter, the commissioner may make rules prescribing:

(a) the form of a letter of credit required under this chapter;

(b) the requirements for a trust or trust instrument required by this chapter;

(c) the procedures for licensing and accrediting;

(d) minimum capital and surplus requirements;

(e) additional requirements relating to calculation of credit allowed a domestic ceding insurer against reserves for reinsurance under Section 31A-17-404; and

(f) additional requirements relating to calculation of asset reduction from liability for reinsurance ceded by a domestic insurer to other ceding insurers under Section 31A-17-404.1.

(2) A rule made pursuant to Subsection (1)(e) or (f) may apply to reinsurance relating to:

(a) a life insurance policy with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits;

(b) a universal life insurance policy with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period;

(c) a variable annuity with guaranteed death or living benefits;

(d) a long-term care insurance policy; or

(e) such other life and health insurance or annuity product as to which the National Association of Insurance Commissioners adopts model regulatory requirements with respect for credit for reinsurance.

(3) A rule adopted pursuant to Subsection (1)(e) or (f) may apply to a treaty containing:

(a) a policy issued on or after January 1, 2015; and

(b) a policy issued before January 1, 2015, if risk pertaining to the policy is ceded in connection with the treaty, either in whole or in part, on or after January 1, 2015.

(4) A rule adopted pursuant to Subsection (1)(e) or (f) may require the ceding insurer, in calculating the amounts or forms of security required to be held under rules made under this section, to use the Valuation Manual adopted by the National Association of Insurance Commissioners under Section 11B(1) of the National Association of Insurance Commissioners Standard Valuation Law, including all amendments adopted by the National Association of Insurance Commissioners and in effect on the date as of which the calculation is made, to the extent applicable.

(5) A rule adopted pursuant to Subsection (1)(e) or (f) may not apply to cessions to an assuming insurer that:

(a) meets the conditions established in Subsection 31A-17-404(8);

[~~(a)~~] (b) is certified in this state [~~or, if this state has not adopted provisions substantially equivalent to Section 2E of the Credit for Reinsurance Model Law, certified in a minimum of five other states~~]; or

[~~(b)~~] (c) maintains at least $250,000,000 in capital and surplus when determined in accordance with the National Association of Insurance Commissioners Accounting Practices and Procedures Manual, including all amendments thereto adopted by the National Association of Insurance Commissioners, excluding the impact of any permitted or prescribed practices and is:

(i) licensed in at least 26 states; or

(ii) licensed in at least 10 states, and licensed or accredited in a total of at least 35 states.

(6) The authority to adopt rules pursuant to Subsection (1)(e) or (f) does not otherwise limit the commissioner's general authority to make rules pursuant to Subsection (1).

Section 18. Section **31A-17-601** is amended to read:

31A-17-601. Definitions.

As used in this part:

(1) "Adjusted RBC report" means an RBC report that has been adjusted by the commissioner in accordance with Subsection 31A-17-602(5).

(2) "Corrective order" means an order issued by the commissioner specifying corrective action that the commissioner determines is required.

(3) "Health organization" means:

(a) an entity that is authorized under Chapter 7, Nonprofit Health Service Insurance Corporations, or Chapter 8, Health Maintenance Organizations and Limited Health Plans; and

(b) that is:

(i) a health maintenance organization;

(ii) a limited health service organization;

(iii) a dental or vision plan;

(iv) a hospital, medical, and dental indemnity or service corporation; or

(v) other managed care organization.

(4) "Life or accident and health insurer" means:

(a) an insurance company licensed to write life insurance, disability insurance, or both; or

(b) a licensed property casualty insurer writing only disability insurance.

(5) "Property and casualty insurer" means any insurance company licensed to write lines of insurance other than life but does not include a monoline mortgage guaranty insurer, financial guaranty insurer, or title insurer.

(6) "RBC" means risk-based capital.

(7) "RBC instructions" means the RBC report including the National Association of Insurance Commissioner's risk-based capital instructions [~~adopted by the department by rule~~] that govern the year for which an RBC report is prepared.

(8) "RBC level" means an insurer's or health organization's authorized control level RBC, company action level RBC, mandatory control level RBC, or regulatory action level RBC.

(a) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;

(b) "Company action level RBC" means the product of 2.0 and its authorized control level RBC;

(c) "Mandatory control level RBC" means the product of .70 and the authorized control level RBC; and

(d) "Regulatory action level RBC" means the product of 1.5 and its authorized control level RBC.

(9) (a) "RBC plan" means a comprehensive financial plan containing the elements specified in Subsection 31A-17-603(2).

(b) Notwithstanding Subsection (9)(a), the plan is a "revised RBC plan" if:

(i) the commissioner rejects the RBC plan; and

(ii) the plan is revised by the insurer or health organization, with or without the commissioner's recommendation.

(10) "RBC report" means the report required in Section 31A-17-602.

Section 19. Section **31A-19a-404** is amended to read:

31A-19a-404. Designated rate service organization.

(1) For purposes of workers' compensation insurance, the commissioner shall designate

one rate service organization to:

(a) develop and administer the uniform statistical plan, uniform classification plan, and uniform experience rating plan filed with and approved by the commissioner;

(b) assist the commissioner in gathering, compiling, and reporting relevant statistical information on an aggregate basis;

(c) develop and file manual rules, subject to the approval of the commissioner, that are reasonably related to the recording and reporting of data pursuant to the uniform statistical plan, uniform experience rating plan, and the uniform classification plan; and

(d) develop and file the [~~prospective~~] advisory loss costs pursuant to Section 31A-19a-406.

(2) The uniform experience rating plan shall:

(a) contain reasonable eligibility standards;

(b) provide adequate incentives for loss prevention; and

(c) provide for sufficient premium differentials so as to encourage safety.

(3) Each workers' compensation insurer, directly or through its selected rate service organization, shall:

(a) record and report its workers' compensation experience to the designated rate service organization as set forth in the uniform statistical plan approved by the commissioner; and

(b) adhere to a uniform classification plan and uniform experience rating plan filed with the commissioner by the rate service organization designated by the commissioner[~~; and~~].

[~~(c) adhere to the prospective loss costs filed by the designated rate service organization.~~]

(4) The commissioner may adopt rules for:

(a) the development and administration by the designated rate service organization of the:

(i) uniform statistical plan;

(ii) uniform experience rating plan; and

(iii) uniform classification plan;

(b) the recording and reporting of statistical data and experience rating data by the various insurers writing workers' compensation insurance;

(c) the selection, retention, and termination of the designated rate service organization; and

(d) providing for the equitable sharing and recovery of the expense of the designated rate service organization to develop, maintain, and provide the plans, services, and filings that are used by the various insurers writing workers' compensation insurance.

(5) (a) Notwithstanding Subsection (3), an insurer may develop directly or through its selected rate service organization subclassifications of the uniform classification system upon which a rate may be made.

(b) A subclassification shall be filed with the commissioner 30 days before its use.

(c) The commissioner shall disapprove subclassifications if the insurer fails to demonstrate that the data produced by the subclassifications can be reported consistently with the uniform statistical plan and uniform classification plan.

(6) Notwithstanding Subsection (3), an insurer may, directly or though its selected rate service organization, develop its own experience modifications based on the uniform statistical plan, uniform classification plan, and uniform rating plan filed by the rate service organization designated by the commissioner under Subsection (1).

Section 20. Section **31A-19a-405** is amended to read:

31A-19a-405. Filing of rates and other rating information.

(1) (a) All workers' compensation rates, supplementary rate information, and supporting information shall be filed at least 30 days before the effective date of the rate or information.

(b) Notwithstanding Subsection (1)(a), on application by the filer, the commissioner may authorize an earlier effective date.

(2) The loss and loss adjustment expense factors included in the rates filed under Subsection (1) shall be:

(a) the [~~prospective~~] advisory loss costs filed by the designated rate service organization under Section 31A-19a-406[.]; or

(b) a percent modification of the advisory loss costs filed by the designated rate service organization under Section 31A-19a-406.

(3) A modification filed under Subsection (2)(b) shall be accompanied by adequate support as required by Part 2, General Rate Regulation.

Section 21. Section **31A-19a-406** is amended to read:

31A-19a-406. Filing requirements for designated rate service organization.

(1) The rate service organization designated under Section 31A-19a-404 shall file with the commissioner the following items proposed for use in this state at least 30 calendar days before the [~~date they~~] day on which the items are distributed to members, subscribers, or others:

(a) each [~~prospective~~] advisory loss cost with its supporting information;

(b) the uniform classification plan and rating manual;

(c) the uniform experience rating plan manual;

(d) the uniform statistical plan manual; and

(e) each change, amendment, or modification of any of the items listed in Subsections (1)(a) through (d).

(2) (a) If the commissioner believes that [~~prospective~~] advisory loss costs filed violate the excessive, inadequate, or unfair discriminatory standard in Section 31A-19a-201 or any other applicable requirement of this part, the commissioner may require that the rate service organization file additional supporting information.

(b) If, after reviewing the supporting information, the commissioner determines that the [~~prospective~~] advisory loss costs violate these requirements, the commissioner may:

(i) require that adjustments to the [~~prospective~~] advisory loss costs be made; or

(ii) call a hearing for any purpose regarding the filing.

Section 22. Section **31A-21-201** is amended to read:

31A-21-201. Filing of forms.

(1) (a) Except as exempted under Subsections 31A-21-101(2) through (6), a form may not be used, sold, or offered for sale until the form is filed with the commissioner.

(b) A form is considered filed with the commissioner when the commissioner receives:

(i) the form;

(ii) the applicable filing fee as prescribed under Section 31A-3-103; and

(iii) the applicable transmittal forms as required by the commissioner.

(2) In filing a form for use in this state the insurer is responsible for assuring that the form is in compliance with this title and rules adopted by the commissioner.

(3) (a) The commissioner may prohibit the use of a form at any time upon a finding that:

(i) the form:

(A) is inequitable;

(B) is unfairly discriminatory;

(C) is misleading;

(D) is deceptive;

(E) is obscure;

(F) is unfair;

(G) encourages misrepresentation; or

(H) is not in the public interest;

(ii) the form provides benefits or contains another provision that endangers the solidity of the insurer;

(iii) except for a life or accident and health insurance policy form, the form is an insurance policy or application for an insurance policy, that fails to conspicuously, as defined by rule, provide:

(A) the exact name of the insurer; and

(B) the state of domicile of the insurer filing the insurance policy or application for the insurance policy;

[~~(iii)~~] (iv) except an application required by Section 31A-22-635, [~~the form is an insurance policy or application for an insurance policy~~] the form is a life or accident and health insurance policy form that fails to conspicuously, as defined by rule, provide:

(A) the exact name of the insurer;

(B) the state of domicile of the insurer filing the insurance policy or application for the insurance policy; and

(C) for a life insurance [~~and annuity insurance~~] policy only, the address of the administrative office of the insurer filing the [~~insurance policy or application for the insurance policy~~] form;

[~~(iv)~~] (v) the form violates a statute or a rule adopted by the commissioner; or

[~~(v)~~] (vi) the form is otherwise contrary to law.

(b) (i) When the commissioner prohibits the use of a form under Subsection (3)(a), the commissioner may order that, on or before a date not less than 15 days after the order, the use of the form be discontinued.

(ii) Once use of a form is prohibited, the form may not be used until appropriate changes are filed with and reviewed by the commissioner.

(iii) When the commissioner prohibits the use of a form under Subsection (3)(a), the commissioner may require the insurer to disclose contract deficiencies to the existing policyholders.

(c) If the commissioner prohibits use of a form under this Subsection (3), the prohibition shall:

(i) be in writing;

(ii) constitute an order; and

(iii) state the reasons for the prohibition.

(4) (a) If, after a hearing, the commissioner determines that it is in the public interest, the commissioner may require by rule or order that a form be subject to the commissioner's approval before its use.

(b) The rule or order described in Subsection (4)(a) shall prescribe the filing procedures for a form if the procedures are different from the procedures stated in this section.

(c) The type of form that under Subsection (4)(a) the commissioner may require approval of before use includes:

(i) a form for a particular class of insurance;

(ii) a form for a specific line of insurance;

(iii) a specific type of form; or

(iv) a form for a specific market segment.

(5) (a) An insurer shall maintain a complete and accurate record of the following for the time period described in Subsection (5)(b):

(i) a form:

(A) filed under this section for use; or

(B) that is in use; and

(ii) a document filed under this section with a form described in Subsection (5)(a)(i).

(b) The insurer shall maintain a record required under Subsection (5)(a) for the balance of the current year, plus five years from:

(i) the last day on which the form is used; or

(ii) the last day an insurance policy that is issued using the form is in effect.

Section 23. Section **31A-21-301** is amended to read:

31A-21-301. Clauses required to be in a prominent position.

(1) The following portions of insurance policies shall appear conspicuously in the policy:

(a) as required by [~~Subsection~~] Subsections 31A-21-201(3)(a)(iii) and (iv):

(i) the exact name of the insurer;

(ii) the state of domicile of the insurer; and

(iii) for life insurance and annuity policies only, the address of the administrative office of the insurer;

(b) information that two or more insurers under Subsection (1)(a) undertake only several liability, as required by Section 31A-21-306;

(c) if a policy is assessable, a statement of that;

(d) a statement that benefits are variable, as required by Section 31A-22-411; however, the methods of calculation need not be in a prominent position;

(e) the right to return a life or accident and health insurance policy under Sections 31A-22-423 and 31A-22-606; and

(f) the beginning and ending dates of insurance protection.

(2) Each clause listed in Subsection (1) shall be displayed conspicuously and separately from any other clause.

Section 24. Section **31A-21-313** is amended to read:

31A-21-313. Limitation of actions.

(1) (a) An action on a written policy or contract of first party insurance shall be commenced within three years after the inception of the loss.

(b) The inception of the loss on a fidelity bond is the date the insurer first denies all or part of a claim made under the fidelity bond.

(2) Except as provided in Subsection (1) or elsewhere in this title, the law applicable to limitation of actions in Title 78B, Chapter 2, Statutes of Limitations, applies to actions on insurance policies.

(3) An insurance policy may not:

(a) limit the time for beginning an action on the policy to a time less than that authorized by statute;

(b) prescribe in what court an action may be brought on the policy; or

(c) provide that no action may be brought, subject to permissible arbitration provisions in contracts.

(4) (a) Unless by verified complaint it is alleged that prejudice to the complainant will arise from a delay in bringing suit against an insurer, which prejudice is other than the delay itself, no action may be brought against an insurer on an insurance policy to compel payment under the policy until the earlier of:

[~~(a)~~] (i) 60 days after proof of loss has been furnished as required under the policy;

[~~(b)~~] (ii) waiver by the insurer of proof of loss; or

[~~(c)~~] (iii) (A) the insurer's denial of full payment[~~.~~]; or

(B) for an accident and health insurance policy, the insurer's denial of payment.

(b) Under an accident and health insurance policy, an insurer may not require the completion of an appeals process that exceeds the provisions in 29 C.F.R. Sec. 2560.503-1 to bring suit under this Subsection (4).

(5) The period of limitation is tolled during the period in which the parties conduct an appraisal or arbitration procedure prescribed by the insurance policy, by law, or as agreed to by the parties.

Section 25. Section **31A-22-205** is enacted to read:

31A-22-205. Applicability of Restatement of the Law of Liability Insurance.

(1) As used in this section, "restatement" means the American Law Institute's Restatement of the Law of Liability Insurance.

(2) The restatement is not the law or public policy of this state if the restatement is inconsistent or in conflict with or otherwise not addressed by:

(a) the Constitution of the United States;

(b) the Utah Constitution;

(c) a state statute;

(d) state case law; or

(e) state-adopted common law.

(3) The restatement is not a source of Utah law.

Section 26. Section **31A-22-305** is amended to read:

31A-22-305. Uninsured motorist coverage.

(1) As used in this section, "covered persons" includes:

(a) the named insured;

(b) for a claim arising on or after May 13, 2014, the named insured's dependent minor children;

(c) persons related to the named insured by blood, marriage, adoption, or guardianship, who are residents of the named insured's household, including those who usually make their home in the same household but temporarily live elsewhere;

(d) any person occupying or using a motor vehicle:

(i) referred to in the policy; or

(ii) owned by a self-insured; and

(e) any person who is entitled to recover damages against the owner or operator of the uninsured or underinsured motor vehicle because of bodily injury to or death of persons under Subsection (1)(a), (b), (c), or (d).

(2) As used in this section, "uninsured motor vehicle" includes:

(a) (i) a motor vehicle, the operation, maintenance, or use of which is not covered under a liability policy at the time of an injury-causing occurrence; or

(ii) (A) a motor vehicle covered with lower liability limits than required by Section 31A-22-304; and

(B) the motor vehicle described in Subsection (2)(a)(ii)(A) is uninsured to the extent of the deficiency;

(b) an unidentified motor vehicle that left the scene of an accident proximately caused by the motor vehicle operator;

(c) a motor vehicle covered by a liability policy, but coverage for an accident is disputed by the liability insurer for more than 60 days or continues to be disputed for more than 60 days; or

(d) (i) an insured motor vehicle if, before or after the accident, the liability insurer of the motor vehicle is declared insolvent by a court of competent jurisdiction; and

(ii) the motor vehicle described in Subsection (2)(d)(i) is uninsured only to the extent that the claim against the insolvent insurer is not paid by a guaranty association or fund.

(3) Uninsured motorist coverage under Subsection 31A-22-302(1)(b) provides coverage for covered persons who are legally entitled to recover damages from owners or

operators of uninsured motor vehicles because of bodily injury, sickness, disease, or death.

(4) (a) For new policies written on or after January 1, 2001, the limits of uninsured motorist coverage shall be equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum uninsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy, unless a named insured rejects or purchases coverage in a lesser amount by signing an acknowledgment form that:

(i) is filed with the department;

(ii) is provided by the insurer;

(iii) waives the higher coverage;

(iv) need only state in this or similar language that uninsured motorist coverage provides benefits or protection to you and other covered persons for bodily injury resulting from an accident caused by the fault of another party where the other party has no liability insurance; and

(v) discloses the additional premiums required to purchase uninsured motorist coverage with limits equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum uninsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy.

(b) Any selection or rejection under this Subsection (4) continues for that issuer of the liability coverage until the insured requests, in writing, a change of uninsured motorist coverage from that liability insurer.

(c) (i) Subsections (4)(a) and (b) apply retroactively to any claim arising on or after January 1, 2001, for which, as of May 14, 2013, an insured has not made a written demand for arbitration or filed a complaint in a court of competent jurisdiction.

(ii) The Legislature finds that the retroactive application of Subsections (4)(a) and (b) clarifies legislative intent and does not enlarge, eliminate, or destroy vested rights.

(d) For purposes of this Subsection (4), "new policy" means:

(i) any policy that is issued which does not include a renewal or reinstatement of an existing policy; or

(ii) a change to an existing policy that results in:

(A) a named insured being added to or deleted from the policy; or

(B) a change in the limits of the named insured's motor vehicle liability coverage.

(e) (i) As used in this Subsection (4)(e), "additional motor vehicle" means a change that increases the total number of vehicles insured by the policy, and does not include replacement, substitute, or temporary vehicles.

(ii) The adding of an additional motor vehicle to an existing personal lines or commercial lines policy does not constitute a new policy for purposes of Subsection (4)(d).

(iii) If an additional motor vehicle is added to a personal lines policy where uninsured motorist coverage has been rejected, or where uninsured motorist limits are lower than the named insured's motor vehicle liability limits, the insurer shall provide a notice to a named insured within 30 days after the day on which the additional motor vehicle is added that:

(A) in the same manner as described in Subsection (4)(a)(iv), explains the purpose of uninsured motorist coverage; and

(B) encourages the named insured to contact the insurance company or insurance producer for quotes as to the additional premiums required to purchase uninsured motorist coverage with limits equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum uninsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy.

(f) A change in policy number resulting from any policy change not identified under Subsection (4)(d)(ii) does not constitute a new policy.

(g) (i) Subsection (4)(d) applies retroactively to any claim arising on or after January 1, 2001, for which, as of May 1, 2012, an insured has not made a written demand for arbitration or filed a complaint in a court of competent jurisdiction.

(ii) The Legislature finds that the retroactive application of Subsection (4):

(A) does not enlarge, eliminate, or destroy vested rights; and

(B) clarifies legislative intent.

(h) A self-insured, including a governmental entity, may elect to provide uninsured motorist coverage in an amount that is less than its maximum self-insured retention under Subsections (4)(a) and (5)(a) by issuing a declaratory memorandum or policy statement from the chief financial officer or chief risk officer that declares the:

(i) self-insured entity's coverage level; and

(ii) process for filing an uninsured motorist claim.

(i) Uninsured motorist coverage may not be sold with limits that are less than the

minimum bodily injury limits for motor vehicle liability policies under Section 31A-22-304.

(j) The acknowledgment under Subsection (4)(a) continues for that issuer of the uninsured motorist coverage until the named insured requests, in writing, different uninsured motorist coverage from the insurer.

(k) (i) In conjunction with the first two renewal notices sent after January 1, 2001, for policies existing on that date, the insurer shall disclose in the same medium as the premium renewal notice, an explanation of:

(A) the purpose of uninsured motorist coverage in the same manner as described in Subsection (4)(a)(iv); and

(B) a disclosure of the additional premiums required to purchase uninsured motorist coverage with limits equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum uninsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy.

(ii) The disclosure required under Subsection (4)(k)(i) shall be sent to all named insureds that carry uninsured motorist coverage limits in an amount less than the named insured's motor vehicle liability policy limits or the maximum uninsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy.

(l) For purposes of this Subsection (4), a notice or disclosure sent to a named insured in a household constitutes notice or disclosure to all insureds within the household.

(5) (a) (i) Except as provided in Subsection (5)(b), the named insured may reject uninsured motorist coverage by an express writing to the insurer that provides liability coverage under Subsection 31A-22-302(1)(a).

(ii) This rejection shall be on a form provided by the insurer that includes a reasonable explanation of the purpose of uninsured motorist coverage.

(iii) This rejection continues for that issuer of the liability coverage until the insured in writing requests uninsured motorist coverage from that liability insurer.

(b) (i) All persons, including governmental entities, that are engaged in the business of, or that accept payment for, transporting natural persons by motor vehicle, and all school districts that provide transportation services for their students, shall provide coverage for all motor vehicles used for that purpose, by purchase of a policy of insurance or by self-insurance, uninsured motorist coverage of at least $25,000 per person and $500,000 per accident.

(ii) This coverage is secondary to any other insurance covering an injured covered person.

(c) Uninsured motorist coverage:

(i) does not cover any benefit paid or payable under Title 34A, Chapter 2, Workers' Compensation Act, except that the covered person is credited an amount described in Subsection 34A-2-106(5);

(ii) may not be subrogated by the workers' compensation insurance carrier;

(iii) may not be reduced by any benefits provided by workers' compensation insurance;

(iv) may be reduced by health insurance subrogation only after the covered person has been made whole;

(v) may not be collected for bodily injury or death sustained by a person:

(A) while committing a violation of Section 41-1a-1314;

(B) who, as a passenger in a vehicle, has knowledge that the vehicle is being operated in violation of Section 41-1a-1314; or

(C) while committing a felony; and

(vi) notwithstanding Subsection (5)(c)(v), may be recovered:

(A) for a person under 18 years of age who is injured within the scope of Subsection (5)(c)(v) but limited to medical and funeral expenses; or

(B) by a law enforcement officer as defined in Section 53-13-103, who is injured within the course and scope of the law enforcement officer's duties.

(d) As used in this Subsection (5), "motor vehicle" has the same meaning as under Section 41-1a-102.

(6) When a covered person alleges that an uninsured motor vehicle under Subsection (2)(b) proximately caused an accident without touching the covered person or the motor vehicle occupied by the covered person, the covered person shall show the existence of the uninsured motor vehicle by clear and convincing evidence consisting of more than the covered person's testimony.

(7) (a) The limit of liability for uninsured motorist coverage for two or more motor vehicles may not be added together, combined, or stacked to determine the limit of insurance coverage available to an injured person for any one accident.

(b) (i) Subsection (7)(a) applies to all persons except a covered person as defined under

Subsection (8)(b)(ii).

(ii) A covered person as defined under Subsection (8)(b)(ii) is entitled to the highest limits of uninsured motorist coverage afforded for any one motor vehicle that the covered person is the named insured or an insured family member.

(iii) This coverage shall be in addition to the coverage on the motor vehicle the covered person is occupying.

(iv) Neither the primary nor the secondary coverage may be set off against the other.

(c) Coverage on a motor vehicle occupied at the time of an accident shall be primary coverage, and the coverage elected by a person described under Subsections (1)(a), (b), and (c) shall be secondary coverage.

(8) (a) (i) Uninsured motorist coverage under this section applies to bodily injury, sickness, disease, or death of covered persons while occupying or using a motor vehicle only if the motor vehicle is described in the policy under which a claim is made, or if the motor vehicle is a newly acquired or replacement motor vehicle covered under the terms of the policy.

(ii) Except as provided in Subsection (7) or this Subsection (8), a covered person injured in a motor vehicle described in a policy that includes uninsured motorist benefits may not elect to collect uninsured motorist coverage benefits from any other motor vehicle insurance policy under which the person is a covered person.

(b) Each of the following persons may also recover uninsured motorist benefits under any one other policy in which they are described as a "covered person" as defined in Subsection (1):

(i) a covered person injured as a pedestrian by an uninsured motor vehicle; and

(ii) except as provided in Subsection (8)(c), a covered person injured while occupying or using a motor vehicle that is not owned, leased, or furnished:

(A) to the covered person;

(B) to the covered person's spouse; or

(C) to the covered person's resident parent or resident sibling.

(c) (i) A covered person may recover benefits from no more than two additional policies, one additional policy from each parent's household if the covered person is:

(A) a dependent minor of parents who reside in separate households; and

(B) injured while occupying or using a motor vehicle that is not owned, leased, or

furnished:

(I) to the covered person;

(II) to the covered person's resident parent; or

(III) to the covered person's resident sibling.

(ii) Each parent's policy under this Subsection (8)(c) is liable only for the percentage of the damages that the limit of liability of each parent's policy of uninsured motorist coverage bears to the total of both parents' uninsured coverage applicable to the accident.

(d) A covered person's recovery under any available policies may not exceed the full amount of damages.

(e) A covered person in Subsection (8)(b) is not barred against making subsequent elections if recovery is unavailable under previous elections.

(f) (i) As used in this section, "interpolicy stacking" means recovering benefits for a single incident of loss under more than one insurance policy.

(ii) Except to the extent permitted by Subsection (7) and this Subsection (8), interpolicy stacking is prohibited for uninsured motorist coverage.

(9) (a) When a claim is brought by a named insured or a person described in Subsection (1) and is asserted against the covered person's uninsured motorist carrier, the claimant may elect to resolve the claim:

(i) by submitting the claim to binding arbitration; or

(ii) through litigation.

(b) Unless otherwise provided in the policy under which uninsured benefits are claimed, the election provided in Subsection (9)(a) is available to the claimant only, except that if the policy under which insured benefits are claimed provides that either an insured or the insurer may elect arbitration, the insured or the insurer may elect arbitration and that election to arbitrate shall stay the litigation of the claim under Subsection (9)(a)(ii).

(c) Once the claimant has elected to commence litigation under Subsection (9)(a)(ii), the claimant may not elect to resolve the claim through binding arbitration under this section without the written consent of the uninsured motorist carrier.

(d) For purposes of the statute of limitations applicable to a claim described in Subsection (9)(a), if the claimant does not elect to resolve the claim through litigation, the claim is considered filed when the claimant submits the claim to binding arbitration in

accordance with this Subsection (9).

(e) (i) Unless otherwise agreed to in writing by the parties, a claim that is submitted to binding arbitration under Subsection (9)(a)(i) shall be resolved by a single arbitrator.

(ii) All parties shall agree on the single arbitrator selected under Subsection (9)(e)(i).

(iii) If the parties are unable to agree on a single arbitrator as required under Subsection (9)(e)(ii), the parties shall select a panel of three arbitrators.

(f) If the parties select a panel of three arbitrators under Subsection (9)(e)(iii):

(i) each side shall select one arbitrator; and

(ii) the arbitrators appointed under Subsection (9)(f)(i) shall select one additional arbitrator to be included in the panel.

(g) Unless otherwise agreed to in writing:

(i) each party shall pay an equal share of the fees and costs of the arbitrator selected under Subsection (9)(e)(i); or

(ii) if an arbitration panel is selected under Subsection (9)(e)(iii):

(A) each party shall pay the fees and costs of the arbitrator selected by that party; and

(B) each party shall pay an equal share of the fees and costs of the arbitrator selected under Subsection (9)(f)(ii).

(h) Except as otherwise provided in this section or unless otherwise agreed to in writing by the parties, an arbitration proceeding conducted under this section shall be governed by Title 78B, Chapter 11, Utah Uniform Arbitration Act.

(i) (i) The arbitration shall be conducted in accordance with Rules 26(a)(4) through (f), 27 through 37, 54, and 68 of the Utah Rules of Civil Procedure, once the requirements of Subsections (10)(a) through (c) are satisfied.

(ii) The specified tier as defined by Rule 26(c)(3) of the Utah Rules of Civil Procedure shall be determined based on the claimant's specific monetary amount in the written demand for payment of uninsured motorist coverage benefits as required in Subsection (10)(a)(i)(A).

(iii) Rules 26.1 and 26.2 of the Utah Rules of Civil Procedure do not apply to arbitration claims under this part.

(j) All issues of discovery shall be resolved by the arbitrator or the arbitration panel.

(k) A written decision by a single arbitrator or by a majority of the arbitration panel shall constitute a final decision.

(l) (i) Except as provided in Subsection (10), the amount of an arbitration award may not exceed the uninsured motorist policy limits of all applicable uninsured motorist policies, including applicable uninsured motorist umbrella policies.

(ii) If the initial arbitration award exceeds the uninsured motorist policy limits of all applicable uninsured motorist policies, the arbitration award shall be reduced to an amount equal to the combined uninsured motorist policy limits of all applicable uninsured motorist policies.

(m) The arbitrator or arbitration panel may not decide the issues of coverage or extra-contractual damages, including:

(i) whether the claimant is a covered person;

(ii) whether the policy extends coverage to the loss; or

(iii) any allegations or claims asserting consequential damages or bad faith liability.

(n) The arbitrator or arbitration panel may not conduct arbitration on a class-wide or class-representative basis.

(o) If the arbitrator or arbitration panel finds that the action was not brought, pursued, or defended in good faith, the arbitrator or arbitration panel may award reasonable attorney fees and costs against the party that failed to bring, pursue, or defend the claim in good faith.

(p) An arbitration award issued under this section shall be the final resolution of all claims not excluded by Subsection (9)(m) between the parties unless:

(i) the award was procured by corruption, fraud, or other undue means; or

(ii) either party, within 20 days after [~~service of~~] the day on which the arbitration award is served:

(A) files a complaint requesting a trial de novo in the district court; and

(B) serves the nonmoving party with a copy of the complaint requesting a trial de novo under Subsection (9)(p)(ii)(A).

(q) (i) Upon filing a complaint for a trial de novo under Subsection (9)(p), the claim shall proceed through litigation pursuant to the Utah Rules of Civil Procedure and Utah Rules of Evidence in the district court.

(ii) In accordance with Rule 38, Utah Rules of Civil Procedure, either party may request a jury trial with a complaint requesting a trial de novo under Subsection (9)(p)(ii)(A).

(r) (i) If the claimant, as the moving party in a trial de novo requested under Subsection

(9)(p), does not obtain a verdict that is at least $5,000 and is at least 20% greater than the arbitration award, the claimant is responsible for all of the nonmoving party's costs.

(ii) If the uninsured motorist carrier, as the moving party in a trial de novo requested under Subsection (9)(p), does not obtain a verdict that is at least 20% less than the arbitration award, the uninsured motorist carrier is responsible for all of the nonmoving party's costs.

(iii) Except as provided in Subsection (9)(r)(iv), the costs under this Subsection (9)(r) shall include:

(A) any costs set forth in Rule 54(d), Utah Rules of Civil Procedure; and

(B) the costs of expert witnesses and depositions.

(iv) An award of costs under this Subsection (9)(r) may not exceed $2,500 unless Subsection (10)(h)(iii) applies.

(s) For purposes of determining whether a party's verdict is greater or less than the arbitration award under Subsection (9)(r), a court may not consider any recovery or other relief granted on a claim for damages if the claim for damages:

(i) was not fully disclosed in writing prior to the arbitration proceeding; or

(ii) was not disclosed in response to discovery contrary to the Utah Rules of Civil Procedure.

(t) If a district court determines, upon a motion of the nonmoving party, that the moving party's use of the trial de novo process was filed in bad faith in accordance with Section 78B-5-825, the district court may award reasonable attorney fees to the nonmoving party.

(u) Nothing in this section is intended to limit any claim under any other portion of an applicable insurance policy.

(v) If there are multiple uninsured motorist policies, as set forth in Subsection (8), the claimant may elect to arbitrate in one hearing the claims against all the uninsured motorist carriers.

(10) (a) Within 30 days after the day on which a covered person elects to submit a claim for uninsured motorist benefits to binding arbitration or files litigation, the covered person shall provide to the uninsured motorist carrier:

(i) a written demand for payment of uninsured motorist coverage benefits, setting forth:

(A) subject to Subsection (10)(l), the specific monetary amount of the demand,

including a computation of the covered person's claimed past medical expenses, claimed past lost wages, and the other claimed past economic damages; and

(B) the factual and legal basis and any supporting documentation for the demand;

(ii) a written statement under oath disclosing:

(A) (I) the names and last known addresses of all health care providers who have rendered health care services to the covered person that are material to the claims for which uninsured motorist benefits are sought for a period of five years preceding the date of the event giving rise to the claim for uninsured motorist benefits up to the time the election for arbitration or litigation has been exercised; and

(II) the names and last known addresses of the health care providers who have rendered health care services to the covered person, which the covered person claims are immaterial to the claims for which uninsured motorist benefits are sought, for a period of five years preceding the date of the event giving rise to the claim for uninsured motorist benefits up to the time the election for arbitration or litigation has been exercised that have not been disclosed under Subsection (10)(a)(ii)(A)(I);

(B) (I) the names and last known addresses of all health insurers or other entities to whom the covered person has submitted claims for health care services or benefits material to the claims for which uninsured motorist benefits are sought, for a period of five years preceding the date of the event giving rise to the claim for uninsured motorist benefits up to the time the election for arbitration or litigation has been exercised; and

(II) the names and last known addresses of the health insurers or other entities to whom the covered person has submitted claims for health care services or benefits, which the covered person claims are immaterial to the claims for which uninsured motorist benefits are sought, for a period of five years preceding the date of the event giving rise to the claim for uninsured motorist benefits up to the time the election for arbitration or litigation have not been disclosed;

(C) if lost wages, diminished earning capacity, or similar damages are claimed, all employers of the covered person for a period of five years preceding the date of the event giving rise to the claim for uninsured motorist benefits up to the time the election for arbitration or litigation has been exercised;

(D) other documents to reasonably support the claims being asserted; and

(E) all state and federal statutory lienholders including a statement as to whether the

covered person is a recipient of Medicare or Medicaid benefits or Utah Children's Health Insurance Program benefits under Title 26, Chapter 40, Utah Children's Health Insurance Act, or if the claim is subject to any other state or federal statutory liens; and

(iii) signed authorizations to allow the uninsured motorist carrier to only obtain records and billings from the individuals or entities disclosed under Subsections (10)(a)(ii)(A)(I), (B)(I), and (C).

(b) (i) If the uninsured motorist carrier determines that the disclosure of undisclosed health care providers or health care insurers under Subsection (10)(a)(ii) is reasonably necessary, the uninsured motorist carrier may:

(A) make a request for the disclosure of the identity of the health care providers or health care insurers; and

(B) make a request for authorizations to allow the uninsured motorist carrier to only obtain records and billings from the individuals or entities not disclosed.

(ii) If the covered person does not provide the requested information within 10 days:

(A) the covered person shall disclose, in writing, the legal or factual basis for the failure to disclose the health care providers or health care insurers; and

(B) either the covered person or the uninsured motorist carrier may request the arbitrator or arbitration panel to resolve the issue of whether the identities or records are to be provided if the covered person has elected arbitration.

(iii) The time periods imposed by Subsection (10)(c)(i) are tolled pending resolution of the dispute concerning the disclosure and production of records of the health care providers or health care insurers.

(c) (i) An uninsured motorist carrier that receives an election for arbitration or a notice of filing litigation and the demand for payment of uninsured motorist benefits under Subsection (10)(a)(i) shall have a reasonable time, not to exceed 60 days from the date of the demand and receipt of the items specified in Subsections (10)(a)(i) through (iii), to:

(A) provide a written response to the written demand for payment provided for in Subsection (10)(a)(i);

(B) except as provided in Subsection (10)(c)(i)(C), tender the amount, if any, of the uninsured motorist carrier's determination of the amount owed to the covered person; and

(C) if the covered person is a recipient of Medicare or Medicaid benefits or Utah

Children's Health Insurance Program benefits under Title 26, Chapter 40, Utah Children's Health Insurance Act, or if the claim is subject to any other state or federal statutory liens, tender the amount, if any, of the uninsured motorist carrier's determination of the amount owed to the covered person less:

(I) if the amount of the state or federal statutory lien is established, the amount of the lien; or

(II) if the amount of the state or federal statutory lien is not established, two times the amount of the medical expenses subject to the state or federal statutory lien until such time as the amount of the state or federal statutory lien is established.

(ii) If the amount tendered by the uninsured motorist carrier under Subsection (10)(c)(i) is the total amount of the uninsured motorist policy limits, the tendered amount shall be accepted by the covered person.

(d) A covered person who receives a written response from an uninsured motorist carrier as provided for in Subsection (10)(c)(i), may:

(i) elect to accept the amount tendered in Subsection (10)(c)(i) as payment in full of all uninsured motorist claims; or

(ii) elect to:

(A) accept the amount tendered in Subsection (10)(c)(i) as partial payment of all uninsured motorist claims; and

(B) continue to litigate or arbitrate the remaining claim in accordance with the election made under Subsections (9)(a), (b), and (c).

(e) If a covered person elects to accept the amount tendered under Subsection (10)(c)(i) as partial payment of all uninsured motorist claims, the final award obtained through arbitration, litigation, or later settlement shall be reduced by any payment made by the uninsured motorist carrier under Subsection (10)(c)(i).

(f) In an arbitration proceeding on the remaining uninsured claims:

(i) the parties may not disclose to the arbitrator or arbitration panel the amount paid under Subsection (10)(c)(i) until after the arbitration award has been rendered; and

(ii) the parties may not disclose the amount of the limits of uninsured motorist benefits provided by the policy.

(g) If the final award obtained through arbitration or litigation is greater than the

average of the covered person's initial written demand for payment provided for in Subsection (10)(a)(i) and the uninsured motorist carrier's initial written response provided for in Subsection (10)(c)(i), the uninsured motorist carrier shall pay:

(i) the final award obtained through arbitration or litigation, except that if the award exceeds the policy limits of the subject uninsured motorist policy by more than $15,000, the amount shall be reduced to an amount equal to the policy limits plus $15,000; and

(ii) any of the following applicable costs:

(A) any costs as set forth in Rule 54(d), Utah Rules of Civil Procedure;

(B) the arbitrator or arbitration panel's fee; and

(C) the reasonable costs of expert witnesses and depositions used in the presentation of evidence during arbitration or litigation.

(h) (i) The covered person shall provide an affidavit of costs within five days of an arbitration award.

(ii) (A) Objection to the affidavit of costs shall specify with particularity the costs to which the uninsured motorist carrier objects.

(B) The objection shall be resolved by the arbitrator or arbitration panel.

(iii) The award of costs by the arbitrator or arbitration panel under Subsection (10)(g)(ii) may not exceed $5,000.

(i) (i) A covered person shall disclose all material information, other than rebuttal evidence, within 30 days after a covered person elects to submit a claim for uninsured motorist coverage benefits to binding arbitration or files litigation as specified in Subsection (10)(a).

(ii) If the information under Subsection (10)(i)(i) is not disclosed, the covered person may not recover costs or any amounts in excess of the policy under Subsection (10)(g).

(j) This Subsection (10) does not limit any other cause of action that arose or may arise against the uninsured motorist carrier from the same dispute.

(k) The provisions of this Subsection (10) only apply to motor vehicle accidents that occur on or after March 30, 2010.

(l) (i) The written demand requirement in Subsection (10)(a)(i)(A) does not affect the covered person's requirement to provide a computation of any other economic damages claimed, and the one or more respondents shall have a reasonable time after the receipt of the computation of any other economic damages claimed to conduct fact and expert discovery as to

any additional damages claimed. The changes made by Laws of Utah 2014, Chapter 290, Section 10, and Chapter 300, Section 10, to this Subsection (10)(l) and Subsection (10)(a)(i)(A) apply to a claim submitted to binding arbitration or through litigation on or after May 13, 2014.

(ii) The changes made by Laws of Utah 2014, Chapter 290, Section 10, and Chapter 300, Section 10, to Subsections (10)(a)(ii)(A)(II) and (B)(II) apply to any claim submitted to binding arbitration or through litigation on or after May 13, 2014.

(11) (a) Notwithstanding Section 31A-21-313, an action on a written policy or contract for uninsured motorist coverage shall be commenced within four years after the inception of loss.

(b) Subsection (11)(a) shall apply to all claims that have not been time barred by Subsection 31A-21-313(1)(a) as of May 14, 2019.

Section 27. Section **31A-22-412** is amended to read:

31A-22-412. Assignment of life insurance rights.

(1) As used in this section, "final termination of a policy" means the day after which an insurer will not reinstate a policy without requiring:

(a) evidence of insurability; or

(b) written application.

[~~(1)~~] (2) (a) Except as provided under Subsection [~~(3)~~] (4), the owner of any rights in a life insurance policy or annuity contract may assign any of those rights, including any right to designate a beneficiary and the rights secured under Sections 31A-22-517 through 31A-22-521 and any other provision of this title.

(b) An assignment, valid under general contract law, vests the assigned rights in the assignee, subject, so far as reasonably necessary for the protection of the insurer, to any provisions in the insurance policy or annuity contract inserted to protect the insurer against double payment or obligation.

[~~(2)~~] (3) The rights of a beneficiary under a life insurance policy or annuity contract are subordinate to those of an assignee, unless the beneficiary was designated as an irrevocable beneficiary prior to the assignment.

[~~(3)~~] (4) Assignment of insurance rights may be expressly prohibited by an annuity contract which provides annuities as retirement benefits related to employment contracts.

[~~(4)~~] (5) (a) [~~When~~] After July 1, 1986, when a life insurance policy or annuity is[~~, after July 1, 1986,~~] assigned in writing as security for an indebtedness, the insurer shall[~~, in any case in which it has received written notice of the assignment, the name and address of the assignee, and a request for cancellation notice by the assignee,~~] mail to the assignee a copy of any cancellation notice sent with respect to the policy[~~.~~], if the insurer has received:

(i) written notice of the assignment;

(ii) the name and address of the assignee; and

(iii) a request for assignment notice from the assignee.

(b) An insurer shall mail the cancellation notice described in Subsection (5)(a):

(i) [~~This notice shall be sent, postage~~] prepaid, and addressed to the assignee's address filed with the insured[~~. The notice shall be mailed~~];

(ii) not less than 10 days [~~prior to~~] before the final termination of the policy; and

(iii) each time the insured [~~has failed or refused~~] fails or refuses to transmit a premium payment to the insurer before the commencement of the policy's grace period.

(c) The insurer may charge the insured directly or charge against the policy the reasonable cost of complying with this section, but in no event to exceed $5 for each notice.

[~~As used in this section, "final termination of the policy" means the date after which the policy will not be reinstated by the insurer without requiring evidence of insurability or written application.~~]

[~~(5)~~] (6) In lieu of providing notices to assignees of final termination of the policy under Subsection [~~(4)~~] (5), an insurer may provide an assignee with an identical copy of all notices sent to the owner of the life insurance policy, provided these notices comply with the other requirements of this title.

Section 28. Section **31A-22-413** is amended to read:

31A-22-413. Designation of beneficiary.

(1) Subject to Subsection 31A-22-412[~~(2)~~](3), no life insurance policy or annuity contract may restrict the right of a policyholder or certificate holder:

(a) to make an irrevocable designation of beneficiary effective immediately or at some subsequent time; or

(b) if the designation of beneficiary is not explicitly irrevocable, to change the beneficiary without the consent of the previously designated beneficiary. Subsection

75-6-201(1)(c) applies to designations by will or by separate writing.

(2) (a) An insurer may prescribe formalities to be complied with for the change of beneficiaries, but those formalities may only be designed for the protection of the insurer. Notwithstanding Section 75-2-804, the insurer discharges its obligation under the insurance policy or certificate of insurance if it pays the properly designated beneficiary unless it has actual notice of either an assignment or a change in beneficiary designation made pursuant to Subsection (1)(b).

(b) The insurer has actual notice if the formalities prescribed by the policy are complied with, or if the change in beneficiary has been requested in the form prescribed by the insurer and delivered to an agent representing the insurer at least three days prior to payment to the earlier properly designated beneficiary.

Section 29. Section **31A-22-430** is enacted to read:

31A-22-430. Policy notification.

(1) (a) An insurer that delivers or issues for delivery an individual life insurance policy in this state shall notify the applicant for the policy, in writing at the time of application for the policy, of an applicant's right to designate a third party to receive notice of lapse or cancellation of the policy based on nonpayment of premium.

(b) An applicant may make a designation described in Subsection (1)(a) at the time of application for the policy, or at any time the policy is in force, by submitting a written notice to the insurer containing the name and address of the third-party designee.

(2) An insurer shall transmit a copy of a notice of lapse or cancellation of the policy based on nonpayment of premium to a third party designated in accordance with this section in addition to the transmission of the notice of lapse or cancellation of the policy to the policyholder.

(3) The designation of a third party under this section does not constitute acceptance of any liability on the part of the third party or insurer for a service provided to the policyholder.

Section 30. Section **31A-22-505** is amended to read:

31A-22-505. Association groups.

(1) A policy is subject to the requirements of this section if the policy is issued as policyholder to an association or to the trustees of a fund established, created, or maintained for the benefit of members of one or more associations:

(a) with a minimum membership of 100 persons;

(b) with a constitution and bylaws;

(c) having a shared [~~or common purpose that is not primarily a business or customer relationship; and~~] substantial common purpose that:

(i) is the same profession, trade, occupation, or similar; or

(ii) is by some common economic or representation of interest or genuine organizational relationship unrelated to the provision of benefits; and

(d) that has been in active existence for at least two years.

(2) The policy may insure members and employees of the association, employees of the members, one or more of the preceding entities, or all of any classes of these named entities for the benefit of persons other than the employees' employer, or any officials, representatives, trustees, or agents of the employer or association.

(3) (a) The premiums shall be paid by:

(i) the policyholder from funds contributed by the associations[~~, by~~];

(ii) employer members, from funds contributed by the covered persons[~~,~~]; or

(iii) from any combination of [~~these~~] Subsections (3)(a)(i) and (ii).

(b) Except as provided under Section 31A-22-512, a policy on which no part of the premium is contributed by the covered persons, specifically for their insurance, is required to insure all eligible persons.

Section 31. Section **31A-22-610.5** is amended to read:

31A-22-610.5. Dependent coverage.

(1) As used in this section, "child" has the same meaning as defined in Section 78B-12-102.

(2) (a) Any individual or group accident and health insurance policy or managed care organization contract that provides coverage for a policyholder's or certificate holder's dependent:

(i) may not terminate coverage of an unmarried dependent by reason of the dependent's age before the dependent's 26th birthday; and

(ii) shall, upon application, provide coverage for all unmarried dependents up to age 26.

(b) The cost of coverage for unmarried dependents 19 to 26 years of age shall be

included in the premium on the same basis as other dependent coverage.

(c) This section does not prohibit the employer from requiring the employee to pay all or part of the cost of coverage for unmarried dependents.

(d) An individual or group health insurance policy or managed care organization shall continue in force coverage for a dependent through the last day of the month in which the dependent ceases to be a dependent:

(i) if premiums are paid; and

(ii) notwithstanding Sections 31A-22-618.6 and 31A-22-618.7.

(3) (a) When a parent is required by a court or administrative order to provide health insurance coverage for a child, an accident and health insurer may not deny enrollment of a child under the accident and health insurance plan of the child's parent on the grounds the child:

(i) was born out of wedlock and is entitled to coverage under Subsection (4);

(ii) was born out of wedlock and the custodial parent seeks enrollment for the child under the custodial parent's policy;

(iii) is not claimed as a dependent on the parent's federal tax return; [~~or~~]

(iv) does not reside with the parent; or

(v) does not reside in the insurer's service area.

(b) A child enrolled as required under Subsection (3)(a)(iv) is subject to the terms of the accident and health insurance plan contract pertaining to services received outside of an insurer's service area.

(4) When a child has accident and health coverage through an insurer of a noncustodial parent, and when requested by the noncustodial or custodial parent, the insurer shall:

(a) provide information to the custodial parent as necessary for the child to obtain benefits through that coverage, but the insurer or employer, or the agents or employees of either of them, are not civilly or criminally liable for providing information in compliance with this Subsection (4)(a), whether the information is provided pursuant to a verbal or written request;

(b) permit the custodial parent or the service provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and

(c) make payments on claims submitted in accordance with Subsection (4)(b) directly

to the custodial parent, the child who obtained benefits, the provider, or the state Medicaid agency.

(5) When a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family health coverage, the insurer shall:

(a) permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to an enrollment season restrictions;

(b) if the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under family coverage upon application of the child's other parent, the state agency administering the Medicaid program, or the state agency administering 42 U.S.C. Sec. 651 through 669, the child support enforcement program; and

(c) (i) when the child is covered by an individual policy, not disenroll or eliminate coverage of the child unless the insurer is provided satisfactory written evidence that:

(A) the court or administrative order is no longer in effect; or

(B) the child is or will be enrolled in comparable accident and health coverage through another insurer which will take effect not later than the effective date of disenrollment; or

(ii) when the child is covered by a group policy, not disenroll or eliminate coverage of the child unless the employer is provided with satisfactory written evidence, which evidence is also provided to the insurer, that Subsection (8)(c)(i), (ii), or (iii) has happened.

(6) An insurer may not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered for accident and health benefits from the insurer that are different from requirements applicable to an agent or assignee of any other individual so covered.

(7) Insurers may not reduce their coverage of pediatric vaccines below the benefit level in effect on May 1, 1993.

(8) When a parent is required by a court or administrative order to provide health coverage, which is available through an employer doing business in this state, the employer shall:

(a) permit the parent to enroll under family coverage any child who is otherwise eligible for coverage without regard to any enrollment season restrictions;

(b) if the parent is enrolled but fails to make application to obtain coverage of the child, enroll the child under family coverage upon application by the child's other parent, by the state

agency administering the Medicaid program, or the state agency administering 42 U.S.C. Sec. 651 through 669, the child support enforcement program;

(c) not disenroll or eliminate coverage of the child unless the employer is provided satisfactory written evidence that:

(i) the court order is no longer in effect;

(ii) the child is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment; or

(iii) the employer has eliminated family health coverage for all of its employees; and

(d) withhold from the employee's compensation the employee's share, if any, of premiums for health coverage and to pay this amount to the insurer.

(9) An order issued under Section 62A-11-326.1 may be considered a "qualified medical support order" for the purpose of enrolling a dependent child in a group accident and health insurance plan as defined in Section 609(a), Federal Employee Retirement Income Security Act of 1974.

(10) This section does not affect any insurer's ability to require as a precondition of any child being covered under any policy of insurance that:

(a) the parent continues to be eligible for coverage;

(b) the child shall be identified to the insurer with adequate information to comply with this section; and

(c) the premium shall be paid when due.

(11) This section applies to employee welfare benefit plans as defined in Section 26-19-102.

(12) (a) A policy that provides coverage to a child of a group member may not deny eligibility for coverage to a child solely because:

(i) the child does not reside with the insured; or

(ii) the child is solely dependent on a former spouse of the insured rather than on the insured.

(b) A child who does not reside with the insured may be excluded on the same basis as a child who resides with the insured.

Section 32. Section **31A-22-615.5** is amended to read:

31A-22-615.5. Insurance coverage for opioids -- Policies -- Reports.

(1) For purposes of this section:

(a) "Health care provider" means an individual, other than a veterinarian, who:

(i) is licensed to prescribe a controlled substance under Title 58, Chapter 37, Utah Controlled Substances Act; and

(ii) possesses the authority, in accordance with the individual's scope of practice, to prescribe Schedule II controlled substances and Schedule III controlled substances that are applicable to opioids and benzodiazapines.

(b) "Health insurer" means:

(i) an insurer who offers health care insurance as that term is defined in Section 31A-1-301;

(ii) health benefits offered to state employees under Section 49-20-202; and

(iii) a workers' compensation insurer:

(A) authorized to provide workers' compensation insurance in the state; or

(B) that is a self-insured employer as [~~defined~~] described in Section 34A-2-201.

(c) "Opioid" has the same meaning as "opiate," as that term is defined in Section 58-37-2.

(d) "Prescribing policy" means a policy developed by a health insurer that includes evidence based guidelines for prescribing opioids, and may include the 2016 Center for Disease Control Guidelines for Prescribing Opioids for Chronic Pain, or the Utah Clinical Guidelines on Prescribing Opioids for the treatment of pain.

(2) A health insurer that provides prescription drug coverage may enact a policy to minimize the risk of opioid addiction and overdose from:

(a) chronic co-prescription of opioids with benzodiazapines and other sedating substances;

(b) prescription of very high dose opioids in the primary care setting; and

(c) the inadvertent transition of short-term opioids for an acute injury into long-term opioid dependence.

(3) A health insurer that provides prescription drug coverage may enact policies to facilitate:

(a) non-narcotic treatment alternatives for patients who have chronic pain; and

(b) medication-assisted treatment for patients who have opioid dependence disorder.

(4) The requirements of this section apply to insurance plans entered into or renewed on or after July 1, 2017.

(5) (a) A health insurer subject to this section shall on or before [~~September 1, 2017~~] July 15, 2020, and before each [~~September 1~~] July 15 thereafter, submit a written report to the Utah Insurance Department regarding whether the insurer has adopted a policy and a general description of the policy.

(b) The Utah Insurance Department shall, on or before October 1, 2017, and before each October 1 thereafter, submit a written summary of the information under Subsection (5)(a) to the Health and Human Services Interim Committee.

(6) A health insurer subject to this section may share the policies developed under this section with other health insurers and the public.

(7) This section sunsets in accordance with Section 63I-1-231.

Section 33. Section **31A-22-2001** is enacted to read:

Part 20. Limited Long-Term Care Insurance Act

31A-22-2001. Title.

This part is known as the "Limited Long-Term Care Insurance Act."

Section 34. Section **31A-22-2002** is enacted to read:

31A-22-2002. Definitions.

As used in this part:

(1) "Applicant" means:

(a) when referring to an individual limited long-term care insurance policy, the person who seeks to contract for benefits; and

(b) when referring to a group limited long-term care insurance policy, the proposed certificate holder.

(2) "Elimination period" means the length of time between meeting the eligibility for benefit payment and receiving benefit payments from an insurer.

(3) "Group limited long-term care insurance" means a limited long-term care insurance policy that is delivered or issued for delivery:

(a) in this state; and

(b) to an eligible group, as described under Subsection 31A-22-701(2).

(4) (a) "Limited long-term care insurance" means an insurance:

(i) policy, endorsement, or rider that is advertised, marketed, offered, or designed to provide coverage:

(A) for less than 12 consecutive months for each covered person;

(B) on an expense-incurred, indemnity, prepaid or other basis; and

(C) for one or more necessary or medically necessary diagnostic, preventative, therapeutic, rehabilitative, maintenance, or personal care services that is provided in a setting other than an acute care unit of a hospital; or

(ii) policy or rider that provides for payment of benefits based on cognitive impairment or the loss of functional capacity.

(b) "Limited long-term care insurance" does not include an insurance policy that is offered primarily to provide:

(i) basic Medicare supplement coverage;

(ii) basic hospital expense coverage;

(iii) basic medical-surgical expense coverage;

(iv) hospital confinement indemnity coverage;

(v) major medical expense coverage;

(vi) disability income or related asset-protection coverage;

(vii) accidental only coverage;

(viii) specified disease or specified accident coverage; or

(ix) limited benefit health coverage.

(5) "Preexisting condition" means a condition for which medical advice or treatment is recommended:

(a) by, or received from, a provider of health care services; and

(b) within six months before the day on which the coverage of an insured person becomes effective.

(6) "Waiting period" means the time an insured waits before some or all of the insured's coverage becomes effective.

Section 35. Section **31A-22-2003** is enacted to read:

31A-22-2003. Scope.

(1) The requirements of this part apply to limited long-term care insurance policies and certificates marketed, delivered, or issued for delivery in this state on or after July 1, 2020.

(2) Laws and regulations designed or intended to apply to Medicare supplement insurance policies may not be applied to limited long-term care insurance.

Section 36. Section **31A-22-2004** is enacted to read:

31A-22-2004. Disclosure and performance standards for limited long-term care insurance.

(1) A limited long-term care insurance policy may not:

(a) be cancelled, nonrenewed, or otherwise terminated because of the age, gender, or the deterioration of the mental or physical health of the insured individual or certificate holder;

(b) contain a provision establishing a new waiting period if existing coverage is converted to or replaced by a new or other form within the same insurer, or the insurer's affiliates, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(c) provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

(2) (a) A limited long-term care insurance policy or certificate may not:

(i) use a definition of "preexisting condition" that is more restrictive than the definition under this part; or

(ii) exclude coverage for a loss or confinement that is the result of a preexisting condition, unless the loss or confinement begins within six months after the day on which the coverage of the insured person becomes effective.

(b) A preexisting condition does not prohibit an insurer from:

(i) using an application form designed to elicit the complete health history of an applicant; or

(ii) on the basis of the answers on the application described in Subsection (2)(c)(i), underwriting in accordance with the insurer's established underwriting standards.

(c) (i) Unless otherwise provided in the policy or certificate, an insurer may exclude coverage of a preexisting condition:

(A) for a time period of six months, beginning the day on which the coverage of the insured person becomes effective; and

(B) regardless of whether the preexisting condition is disclosed on the application.

(ii) A limited long-term care insurance policy or certificate may not exclude or use

waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions for more than a time period of six months, beginning the day on which the coverage of the insured person becomes effective.

(3) (a) An insurer may not deliver or issue for delivery a limited long-term care insurance policy that conditions eligibility for any benefits:

(i) on a prior hospitalization requirement;

(ii) provided in an institutional care setting, on the receipt of a higher level of institutional care; or

(iii) other than waiver of premium, post-confinement, post-acute care, or recuperative benefits, on a prior institutionalization requirement.

(b) A limited long-term care insurance policy or rider may not condition eligibility for noninstitutional benefits on the prior or continuing receipt of skilled care services.

(4) (a) If, after examination of a policy, certificate, or rider, a limited long-term care insurance applicant is not satisfied for any reason, the applicant has the right to:

(i) within 30 days after the day on which the applicant receives the policy, certificate, endorsement, or rider, return the policy, certificate, endorsement, or rider to the company or a producer of the company; and

(ii) have the premium refunded.

(b) (i) Each limited long-term care insurance policy, certificate, endorsement, and rider shall:

(A) have a notice prominently printed on the first page or attached thereto detailing specific instructions to accomplish a return; and

(B) include the following free-look statement or language substantially similar: "You have 30 days from the day on which you receive this policy certificate, endorsement, or rider to review it and return it to the company if you decide not to keep it. You do not have to tell the company why you are returning it. If you decide not to keep it, simply return it to the company at its administrative office. Or you may return it to the producer that you bought it from. You must return it within 30 days of the day you first received it. The company will refund the full amount of any premium paid within 30 days after it receives the returned policy, certificate, or rider. The premium refund will be sent directly to the person who paid it. The policy certificate or rider will be void as if it had never been issued."

(ii) The requirements described in Subsection (4)(b)(i) do not apply to a certificate issued to an employee under an employer group limited long-term care insurance policy.

(5) (a) (i) An insurer shall deliver an outline of coverage to a prospective applicant for limited long-term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and the document's purpose.

(ii) In the case of an agent solicitation, the agent shall deliver the outline of coverage before the presentation of an application or enrollment form.

(iii) In the case of a direct response solicitation, the outline of coverage shall be presented in conjunction with any application or enrollment form.

(iv) (A) In the case of a policy issued to a group, the outline of coverage is not required to be delivered if the information described in Subsections (5)(b)(i) through (iii) is contained in other materials relating to enrollment, including the certificate.

(B) Upon request, an insurer shall make the other materials described in this Subsection (5)(a)(iv) available to the commissioner.

(b) An outline of coverage shall include:

(i) a description of the principal benefits and coverage provided in the policy;

(ii) a description of the eligibility triggers for benefits and how the eligibility triggers are met;

(iii) a statement of the principal exclusions, reductions, and limitations contained in the policy;

(iv) a statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium.

(v) a specific description of each continuation or conversion provision of group coverage;

(vi) a statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(vii) a description of the terms under which a person may return the policy or certificate and have the premium refunded;

(viii) a brief description of the relationship of cost of care and benefits; and

(ix) a statement that discloses to the policyholder or certificate holder that the policy is

not long-term care insurance.

(6) A certificate pursuant to a group limited long-term care insurance policy that is delivered or issued for delivery in this state shall include:

(a) a description of the principal benefits and coverage provided in the policy;

(b) a statement of the principal exclusions, reductions, and limitations contained in the policy; and

(c) a statement that the group master policy determines governing contractual provisions.

(7) If an application for a limited long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later that 30 days after the day on which the application is approved.

Section 37. Section **31A-22-2005** is enacted to read:

31A-22-2005. Nonforfeiture benefits.

(1) (a) A limited long-term care insurance policy may offer the option of purchasing a policy or certificate including a nonforfeiture benefit.

(b) The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy.

(c) In the event the policy holder or certificate holder does not purchase a nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates.

(2) If an insurer issues a group limited long-term care insurance policy, the insurer shall:

(a) make any offer of a nonforfeiture benefit to the group policyholder; and

(b) make any offer to each proposed certificate holder.

Section 38. Section **31A-22-2006** is enacted to read:

31A-22-2006. Rulemaking.

In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner:

(1) shall makes rules:

(a) in the event of a substantial rate increase, promoting premium adequacy and protecting the policy holder;

(b) establishing minimum standards for limited long-term care insurance marketing practices, producer compensation, producer testing, independent review of benefit determinations, penalties, and reporting practices;

(c) prescribing a standard format, including style, arrangement, and overall appearance of an outline of coverage;

(d) prescribing the content of an outline of coverage, in accordance with the requirements described in Subsection 31A-22-2004(5)(b);

(e) specifying the type of nonforfeiture benefits offered as part of a limited long-term care insurance policy or certificate;

(f) establishing the standards of nonforfeiture benefits; and

(g) establishing the rules regarding contingent benefits upon lapse, including:

(i) a determination of the specified period of time during which a contingent benefit upon lapse will be available; and

(ii) the substantial premium rate increase that triggers a contingent benefit upon lapse as described in Subsection 31A-22-2005(1); and

(2) may make rules establishing loss-ratio standards for limited long-term care insurance policies.

Section 39. Section **31A-23a-111** is amended to read:

31A-23a-111. Revoking, suspending, surrendering, lapsing, limiting, or otherwise terminating a license -- Forfeiture -- Rulemaking for renewal or reinstatement.

(1) A license type issued under this chapter remains in force until:

(a) revoked or suspended under Subsection (5);

(b) surrendered to the commissioner and accepted by the commissioner in lieu of administrative action;

(c) the licensee dies or is adjudicated incompetent as defined under:

(i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

(ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and Minors;

(d) lapsed under Section 31A-23a-113; or

(e) voluntarily surrendered.

(2) The following may be reinstated within one year after the day on which the license

is no longer in force:

(a) a lapsed license; or

(b) a voluntarily surrendered license, except that a voluntarily surrendered license may not be reinstated after the license period in which the license is voluntarily surrendered.

(3) Unless otherwise stated in a written agreement for the voluntary surrender of a license, submission and acceptance of a voluntary surrender of a license does not prevent the department from pursuing additional disciplinary or other action authorized under:

(a) this title; or

(b) rules made under this title in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(4) A line of authority issued under this chapter remains in force until:

(a) the qualifications pertaining to a line of authority are no longer met by the licensee; or

(b) the supporting license type:

(i) is revoked or suspended under Subsection (5);

(ii) is surrendered to the commissioner and accepted by the commissioner in lieu of administrative action;

(iii) lapses under Section 31A-23a-113; or

(iv) is voluntarily surrendered; or

(c) the licensee dies or is adjudicated incompetent as defined under:

(i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

(ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and Minors.

(5) (a) If the commissioner makes a finding under Subsection (5)(b), as part of an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the commissioner may:

(i) revoke:

(A) a license; or

(B) a line of authority;

(ii) suspend for a specified period of 12 months or less:

(A) a license; or

(B) a line of authority;

(iii) limit in whole or in part:

(A) a license; or

(B) a line of authority;

(iv) deny a license application;

(v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or

(vi) take a combination of actions under Subsections (5)(a)(i) through (iv) and Subsection (5)(a)(v).

(b) The commissioner may take an action described in Subsection (5)(a) if the commissioner finds that the licensee or license applicant:

(i) is unqualified for a license or line of authority under Section 31A-23a-104, 31A-23a-105, or 31A-23a-107;

(ii) violates:

(A) an insurance statute;

(B) a rule that is valid under Subsection 31A-2-201(3); or

(C) an order that is valid under Subsection 31A-2-201(4);

(iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other delinquency proceedings in any state;

(iv) fails to pay a final judgment rendered against the person in this state within 60 days after the day on which the judgment became final;

(v) fails to meet the same good faith obligations in claims settlement that is required of admitted insurers;

(vi) is affiliated with and under the same general management or interlocking directorate or ownership as another insurance producer that transacts business in this state without a license;

(vii) refuses:

(A) to be examined; or

(B) to produce its accounts, records, and files for examination;

(viii) has an officer who refuses to:

(A) give information with respect to the insurance producer's affairs; or

(B) perform any other legal obligation as to an examination;

(ix) provides information in the license application that is:

(A) incorrect;

(B) misleading;

(C) incomplete; or

(D) materially untrue;

(x) violates an insurance law, valid rule, or valid order of another regulatory agency in any jurisdiction;

(xi) obtains or attempts to obtain a license through misrepresentation or fraud;

(xii) improperly withholds, misappropriates, or converts money or properties received in the course of doing insurance business;

(xiii) intentionally misrepresents the terms of an actual or proposed:

(A) insurance contract;

(B) application for insurance; or

(C) life settlement;

(xiv) has been convicted of:

(A) a felony; or

(B) a misdemeanor involving fraud, misrepresentation, theft, or dishonesty;

(xv) admits or is found to have committed an insurance unfair trade practice or fraud;

(xvi) in the conduct of business in this state or elsewhere:

(A) uses fraudulent, coercive, or dishonest practices; or

(B) demonstrates incompetence, untrustworthiness, or financial irresponsibility;

(xvii) has had an insurance license or other professional or occupational license, or an equivalent to an insurance license or registration, or other professional or occupational license or registration:

(A) denied;

(B) suspended;

(C) revoked; or

(D) surrendered to resolve an administrative action;

(xviii) forges another's name to:

(A) an application for insurance; or

(B) a document related to an insurance transaction;

(xix) improperly uses notes or another reference material to complete an examination for an insurance license;

(xx) knowingly accepts insurance business from an individual who is not licensed;

(xxi) fails to comply with an administrative or court order imposing a child support obligation;

(xxii) fails to:

(A) pay state income tax; or

(B) comply with an administrative or court order directing payment of state income tax;

(xxiii) has been convicted of violating the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and has not obtained written consent to engage in the business of insurance or participate in such business as required by 18 U.S.C. Sec. 1033;

(xxiv) engages in a method or practice in the conduct of business that endangers the legitimate interests of customers and the public; or

(xxv) has been convicted of any criminal felony involving dishonesty or breach of trust and has not obtained written consent to engage in the business of insurance or participate in such business as required by 18 U.S.C. Sec. 1033.

(c) For purposes of this section, if a license is held by an agency, both the agency itself and any individual designated under the license are considered to be the holders of the license.

(d) If an individual designated under the agency license commits an act or fails to perform a duty that is a ground for suspending, revoking, or limiting the individual's license, the commissioner may suspend, revoke, or limit the license of:

(i) the individual;

(ii) the agency, if the agency:

(A) is reckless or negligent in its supervision of the individual; or

(B) knowingly participates in the act or failure to act that is the ground for suspending, revoking, or limiting the license; or

(iii) (A) the individual; and

(B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).

(6) A licensee under this chapter is subject to the penalties for acting as a licensee without a license if:

(a) the licensee's license is:

(i) revoked;

(ii) suspended;

(iii) limited;

(iv) surrendered in lieu of administrative action;

(v) lapsed; or

(vi) voluntarily surrendered; and

(b) the licensee:

(i) continues to act as a licensee; or

(ii) violates the terms of the license limitation.

(7) A licensee under this chapter shall immediately report to the commissioner:

(a) a revocation, suspension, or limitation of the person's license in another state, the District of Columbia, or a territory of the United States;

(b) the imposition of a disciplinary sanction imposed on that person by another state, the District of Columbia, or a territory of the United States; or

(c) a judgment or injunction entered against that person on the basis of conduct involving:

(i) fraud;

(ii) deceit;

(iii) misrepresentation; or

(iv) a violation of an insurance law or rule.

(8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a license in lieu of administrative action may specify a time, not to exceed five years, within which the former licensee may not apply for a new license.

(b) If no time is specified in an order or agreement described in Subsection (8)(a), the former licensee may not apply for a new license for five years from the day on which the order or agreement is made without the express approval by the commissioner.

(9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of a license issued under this part if so ordered by a court.

(10) The commissioner shall by rule prescribe the license renewal and reinstatement procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

Section 40. Section **31A-23a-205** is amended to read:

31A-23a-205. Special requirements for bail bond producers and bail bond enforcement agents.

(1) As used in this section, "bail bond producer" and "bail enforcement agent" have the same definitions as in Section 31A-35-102.

(2) A bail bond producer may not operate in this state without an appointment from one or more authorized bail bond surety insurers or licensed bail bond [~~surety~~] companies.

(3) A bail bond enforcement agent may not operate in this state without an appointment from one or more licensed bail bond producers.

Section 41. Section **31A-23a-415** is amended to read:

31A-23a-415. Assessment on agency title insurance producers or title insurers -- Account created.

(1) For purposes of this section:

(a) "Premium" is as [~~defined~~] described in Subsection 59-9-101(3).

(b) "Title insurer" means a person:

(i) making any contract or policy of title insurance as:

(A) insurer;

(B) guarantor; or

(C) surety;

(ii) proposing to make any contract or policy of title insurance as:

(A) insurer;

(B) guarantor; or

(C) surety; or

(iii) transacting or proposing to transact any phase of title insurance, including:

(A) soliciting;

(B) negotiating preliminary to execution;

(C) executing of a contract of title insurance;

(D) insuring; and

(E) transacting matters subsequent to the execution of the contract and arising out of the contract.

(c) "Utah risks" means insuring, guaranteeing, or indemnifying with regard to real or

personal property located in Utah, an owner of real or personal property, the holders of liens or encumbrances on that property, or others interested in the property against loss or damage suffered by reason of:

(i) liens or encumbrances upon, defects in, or the unmarketability of the title to the property; or

(ii) invalidity or unenforceability of any liens or encumbrances on the property.

(2) (a) The commissioner may assess each title insurer, each individual title insurance producer who is not an employee of a title insurer or who is not designated by an agency title insurance producer, and each agency title insurance producer an annual assessment:

(i) determined by the Title and Escrow Commission:

(A) after consultation with the commissioner; and

(B) in accordance with this Subsection (2); and

(ii) to be used for the purposes described in Subsection (3).

(b) An agency title insurance producer and individual title insurance producer who is not an employee of a title insurer or who is not designated by an agency title insurance producer shall be assessed up to:

(i) $250 for the first office in each county in which the agency title insurance producer or individual title insurance producer maintains an office; and

(ii) $150 for each additional office the agency title insurance producer or individual title insurance producer maintains in the county described in Subsection (2)(b)(i).

(c) A title insurer shall be assessed up to:

(i) $250 for the first office in each county in which the title insurer maintains an office;

(ii) $150 for each additional office the title insurer maintains in the county described in Subsection (2)(c)(i); and

(iii) an amount calculated by:

(A) aggregating the assessments imposed on:

(I) agency title insurance producers and individual title insurance producers under Subsection (2)(b); and

(II) title insurers under Subsections (2)(c)(i) and (2)(c)(ii);

(B) subtracting the amount determined under Subsection (2)(c)(iii)(A) from the total costs and expenses determined under Subsection (2)(d); and

(C) multiplying:

(I) the amount calculated under Subsection (2)(c)(iii)(B); and

(II) the percentage of total premiums for title insurance on Utah risk that are premiums of the title insurer.

(d) Notwithstanding Section 31A-3-103 and subject to Section 31A-2-404, the Title and Escrow Commission by rule shall establish the amount of costs and expenses described under Subsection (3) that will be covered by the assessment, except the costs or expenses to be covered by the assessment may not exceed [~~$100,000 annually~~] the cost of one full-time equivalent position.

(e) (i) An individual licensed to practice law in Utah is exempt from the requirements of this Subsection (2) if that person issues 12 or less policies during a 12-month period.

(ii) In determining the number of policies issued by an individual licensed to practice law in Utah for purposes of Subsection (2)(e)(i), if the individual issues a policy to more than one party to the same closing, the individual is considered to have issued only one policy.

(3) (a) Money received by the state under this section shall be deposited into the Title Licensee Enforcement Restricted Account.

(b) There is created in the General Fund a restricted account known as the "Title Licensee Enforcement Restricted Account."

(c) The Title Licensee Enforcement Restricted Account shall consist of the money received by the state under this section.

(d) The commissioner shall administer the Title Licensee Enforcement Restricted Account. Subject to appropriations by the Legislature, the commissioner shall use the money deposited into the Title Licensee Enforcement Restricted Account only to pay for a cost or expense incurred by the department in the administration, investigation, and enforcement of laws governing individual title insurance producers, agency title insurance producers, or title insurers.

(e) An appropriation from the Title Licensee Enforcement Restricted Account is nonlapsing.

(4) The assessment imposed by this section shall be in addition to any premium assessment imposed under Subsection 59-9-101(3).

Section 42. Section **31A-23b-401** is amended to read:

31A-23b-401. Revoking, suspending, surrendering, lapsing, limiting, or otherwise terminating a license -- Rulemaking for renewal or reinstatement.

(1) A license as a navigator under this chapter remains in force until:

(a) revoked or suspended under Subsection (4);

(b) surrendered to the commissioner and accepted by the commissioner in lieu of administrative action;

(c) the licensee dies or is adjudicated incompetent as defined under:

(i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

(ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and Minors;

(d) lapsed under this section; or

(e) voluntarily surrendered.

(2) The following may be reinstated within one year after the day on which the license is no longer in force:

(a) a lapsed license; or

(b) a voluntarily surrendered license, except that a voluntarily surrendered license may not be reinstated after the license period in which the license is voluntarily surrendered.

(3) Unless otherwise stated in a written agreement for the voluntary surrender of a license, submission and acceptance of a voluntary surrender of a license does not prevent the department from pursuing additional disciplinary or other action authorized under:

(a) this title; or

(b) rules made under this title in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(4) (a) If the commissioner makes a finding under Subsection (4)(b), as part of an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the commissioner may:

(i) revoke a license;

(ii) suspend a license for a specified period of 12 months or less;

(iii) limit a license in whole or in part;

(iv) deny a license application;

(v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or

(vi) take a combination of actions under Subsections (4)(a)(i) through (iv) and Subsection (4)(a)(v).

(b) The commissioner may take an action described in Subsection (4)(a) if the commissioner finds that the licensee or license applicant:

(i) is unqualified for a license under Section 31A-23b-204, 31A-23b-205, or 31A-23b-206;

(ii) violated:

(A) an insurance statute;

(B) a rule that is valid under Subsection 31A-2-201(3); or

(C) an order that is valid under Subsection 31A-2-201(4);

(iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other delinquency proceedings in any state;

(iv) failed to pay a final judgment rendered against the person in this state within 60 days after the day on which the judgment became final;

(v) refused:

(A) to be examined; or

(B) to produce its accounts, records, and files for examination;

(vi) had an officer who refused to:

(A) give information with respect to the navigator's affairs; or

(B) perform any other legal obligation as to an examination;

(vii) provided information in the license application that is:

(A) incorrect;

(B) misleading;

(C) incomplete; or

(D) materially untrue;

(viii) violated an insurance law, valid rule, or valid order of another regulatory agency in any jurisdiction;

(ix) obtained or attempted to obtain a license through misrepresentation or fraud;

(x) improperly withheld, misappropriated, or converted money or properties received in the course of doing insurance business;

(xi) intentionally misrepresented the terms of an actual or proposed:

(A) insurance contract;

(B) application for insurance; or

(C) application for public program;

(xii) has been convicted of:

(A) a felony; or

(B) a misdemeanor involving fraud, misrepresentation, theft, or dishonesty;

(xiii) admitted or is found to have committed an insurance unfair trade practice or fraud;

(xiv) in the conduct of business in this state or elsewhere:

(A) used fraudulent, coercive, or dishonest practices; or

(B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;

(xv) has had an insurance license, navigator license, or other professional or occupational license or registration, or an equivalent of the same denied, suspended, revoked, or surrendered to resolve an administrative action;

(xvi) forged another's name to:

(A) an application for insurance;

(B) a document related to an insurance transaction;

(C) a document related to an application for a public program; or

(D) a document related to an application for premium subsidies;

(xvii) improperly used notes or another reference material to complete an examination for a license;

(xviii) knowingly accepted insurance business from an individual who is not licensed;

(xix) failed to comply with an administrative or court order imposing a child support obligation;

(xx) failed to:

(A) pay state income tax; or

(B) comply with an administrative or court order directing payment of state income tax;

(xxi) has been convicted of violating the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and has not obtained written consent to engage in the business of insurance or participate in such business as required by 18 U.S.C. Sec. 1033;

(xxii) engaged in a method or practice in the conduct of business that endangered the legitimate interests of customers and the public; or

(xxiii) has been convicted of any criminal felony involving dishonesty or breach of trust and has not obtained written consent to engage in the business of insurance or participate in such business as required by 18 U.S.C. Sec. 1033.

(c) For purposes of this section, if a license is held by an agency, both the agency itself and any individual designated under the license are considered to be the holders of the license.

(d) If an individual designated under the agency license commits an act or fails to perform a duty that is a ground for suspending, revoking, or limiting the individual's license, the commissioner may suspend, revoke, or limit the license of:

(i) the individual;

(ii) the agency, if the agency:

(A) is reckless or negligent in its supervision of the individual; or

(B) knowingly participates in the act or failure to act that is the ground for suspending, revoking, or limiting the license; or

(iii) (A) the individual; and

(B) the agency if the agency meets the requirements of Subsection (4)(d)(ii).

(5) A licensee under this chapter is subject to the penalties for acting as a licensee without a license if:

(a) the licensee's license is:

(i) revoked;

(ii) suspended;

(iii) surrendered in lieu of administrative action;

(iv) lapsed; or

(v) voluntarily surrendered; and

(b) the licensee:

(i) continues to act as a licensee; or

(ii) violates the terms of the license limitation.

(6) A licensee under this chapter shall immediately report to the commissioner:

(a) a revocation, suspension, or limitation of the person's license in another state, the District of Columbia, or a territory of the United States;

(b) the imposition of a disciplinary sanction imposed on that person by another state, the District of Columbia, or a territory of the United States; or

(c) a judgment or injunction entered against that person on the basis of conduct involving:

(i) fraud;

(ii) deceit;

(iii) misrepresentation; or

(iv) a violation of an insurance law or rule.

(7) (a) An order revoking a license under Subsection (4) or an agreement to surrender a license in lieu of administrative action may specify a time, not to exceed five years, within which the former licensee may not apply for a new license.

(b) If no time is specified in an order or agreement described in Subsection (7)(a), the former licensee may not apply for a new license for five years from the day on which the order or agreement is made without the express approval of the commissioner.

(8) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of a license issued under this chapter if so ordered by a court.

(9) The commissioner shall by rule prescribe the license renewal and reinstatement procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

Section 43. Section **31A-25-208** is amended to read:

31A-25-208. Revoking, suspending, surrendering, lapsing, limiting, or otherwise terminating a license -- Rulemaking for renewal and reinstatement.

(1) A license type issued under this chapter remains in force until:

(a) revoked or suspended under Subsection (4);

(b) surrendered to the commissioner and accepted by the commissioner in lieu of administrative action;

(c) the licensee dies or is adjudicated incompetent as defined under:

(i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

(ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and Minors;

(d) lapsed under Section 31A-25-210; or

(e) voluntarily surrendered.

(2) The following may be reinstated within one year after the day on which the license is no longer in force:

(a) a lapsed license; or

(b) a voluntarily surrendered license, except that a voluntarily surrendered license may not be reinstated after the license period in which the license is voluntarily surrendered.

(3) Unless otherwise stated in a written agreement for the voluntary surrender of a license, submission and acceptance of a voluntary surrender of a license does not prevent the department from pursuing additional disciplinary or other action authorized under:

(a) this title; or

(b) rules made under this title in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(4) (a) If the commissioner makes a finding under Subsection (4)(b), as part of an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the commissioner may:

(i) revoke a license;

(ii) suspend a license for a specified period of 12 months or less;

(iii) limit a license in whole or in part; or

(iv) deny a license application.

(b) The commissioner may take an action described in Subsection (4)(a) if the commissioner finds that the licensee or license applicant:

(i) is unqualified for a license under Section 31A-25-202, 31A-25-203, or 31A-25-204;

(ii) has violated:

(A) an insurance statute;

(B) a rule that is valid under Subsection 31A-2-201(3); or

(C) an order that is valid under Subsection 31A-2-201(4);

(iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other delinquency proceedings in any state;

(iv) fails to pay a final judgment rendered against the person in this state within 60 days after the day on which the judgment became final;

(v) fails to meet the same good faith obligations in claims settlement that is required of admitted insurers;

(vi) is affiliated with and under the same general management or interlocking directorate or ownership as another third party administrator that transacts business in this state without a license;

(vii) refuses:

(A) to be examined; or

(B) to produce its accounts, records, and files for examination;

(viii) has an officer who refuses to:

(A) give information with respect to the third party administrator's affairs; or

(B) perform any other legal obligation as to an examination;

(ix) provides information in the license application that is:

(A) incorrect;

(B) misleading;

(C) incomplete; or

(D) materially untrue;

(x) has violated an insurance law, valid rule, or valid order of another regulatory agency in any jurisdiction;

(xi) has obtained or attempted to obtain a license through misrepresentation or fraud;

(xii) has improperly withheld, misappropriated, or converted money or properties received in the course of doing insurance business;

(xiii) has intentionally misrepresented the terms of an actual or proposed:

(A) insurance contract; or

(B) application for insurance;

(xiv) has been convicted of:

(A) a felony; or

(B) a misdemeanor involving fraud, misrepresentation, theft, or dishonesty;

(xv) has admitted or been found to have committed an insurance unfair trade practice or fraud;

(xvi) in the conduct of business in this state or elsewhere has:

(A) used fraudulent, coercive, or dishonest practices; or

(B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;

(xvii) has had an insurance license or other professional or occupational license or

registration, or an equivalent of the same, denied, suspended, revoked, or surrendered to resolve an administrative action;

(xviii) has forged another's name to:

(A) an application for insurance; or

(B) a document related to an insurance transaction;

(xix) has improperly used notes or any other reference material to complete an examination for an insurance license;

(xx) has knowingly accepted insurance business from an individual who is not licensed;

(xxi) has failed to comply with an administrative or court order imposing a child support obligation;

(xxii) has failed to:

(A) pay state income tax; or

(B) comply with an administrative or court order directing payment of state income tax;

(xxiii) [~~has violated or permitted others to violate~~] is convicted of violating the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and [~~therefore~~] has not obtained written consent to engage in the business of insurance or participate in such business as required under 18 U.S.C. Sec. 1033 [~~is prohibited from engaging in the business of insurance; or~~];

(xxiv) has engaged in methods and practices in the conduct of business that endanger the legitimate interests of customers and the public[~~.~~]; or

(xxv) has been convicted of a criminal felony involving dishonesty or breach of trust and has not obtained written consent to engage in the business of insurance or participate in such business as required under 18 U.S.C. Sec. 1033.

(c) For purposes of this section, if a license is held by an agency, both the agency itself and any individual designated under the license are considered to be the holders of the agency license.

(d) If an individual designated under the agency license commits an act or fails to perform a duty that is a ground for suspending, revoking, or limiting the individual's license, the commissioner may suspend, revoke, or limit the license of:

(i) the individual;

(ii) the agency if the agency:

(A) is reckless or negligent in its supervision of the individual; or

(B) knowingly participated in the act or failure to act that is the ground for suspending, revoking, or limiting the license; or

(iii) (A) the individual; and

(B) the agency if the agency meets the requirements of Subsection (4)(d)(ii).

(5) A licensee under this chapter is subject to the penalties for acting as a licensee without a license if:

(a) the licensee's license is:

(i) revoked;

(ii) suspended;

(iii) limited;

(iv) surrendered in lieu of administrative action;

(v) lapsed; or

(vi) voluntarily surrendered; and

(b) the licensee:

(i) continues to act as a licensee; or

(ii) violates the terms of the license limitation.

(6) A licensee under this chapter shall immediately report to the commissioner:

(a) a revocation, suspension, or limitation of the person's license in any other state, the District of Columbia, or a territory of the United States;

(b) the imposition of a disciplinary sanction imposed on that person by any other state, the District of Columbia, or a territory of the United States; or

(c) a judgment or injunction entered against the person on the basis of conduct involving:

(i) fraud;

(ii) deceit;

(iii) misrepresentation; or

(iv) a violation of an insurance law or rule.

(7) (a) An order revoking a license under Subsection (4) or an agreement to surrender a

license in lieu of administrative action may specify a time, not to exceed five years, within which the former licensee may not apply for a new license.

(b) If no time is specified in the order or agreement described in Subsection (7)(a), the former licensee may not apply for a new license for five years from the day on which the order or agreement is made without the express approval of the commissioner.

(8) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of a license issued under this part if so ordered by the court.

(9) The commissioner shall by rule prescribe the license renewal and reinstatement procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

Section 44. Section **31A-26-206** is amended to read:

31A-26-206. Continuing education requirements.

(1) Pursuant to this section, the commissioner shall by rule prescribe continuing education requirements for each class of license under Section 31A-26-204.

(2) (a) The commissioner shall impose continuing education requirements in accordance with a two-year licensing period in which the licensee meets the requirements of this Subsection (2).

(b) (i) Except as otherwise provided in this section, the continuing education requirements shall require:

(A) that a licensee complete 24 credit hours of continuing education for every two-year licensing period;

(B) that 3 of the 24 credit hours described in Subsection (2)(b)(i)(A) be ethics courses; and

(C) that the licensee complete at least half of the required hours through classroom hours of insurance-related instruction.

(ii) A continuing education hour completed in accordance with Subsection (2)(b)(i) may be obtained through:

(A) classroom attendance;

(B) home study;

(C) watching a video recording;

(D) experience credit; or

(E) other methods provided by rule.

(iii) Notwithstanding Subsections (2)(b)(i)(A) and (B), a title insurance adjuster is required to complete 12 credit hours of continuing education for every two-year licensing period, with 3 of the credit hours being ethics courses.

(c) A licensee may obtain continuing education hours at any time during the two-year licensing period.

(d) (i) A licensee is exempt from the continuing education requirements of this section if:

(A) the licensee was first licensed before December 31, 1982;

(B) the license does not have a continuous lapse for a period of more than one year, except for a license for which the licensee has had an exemption approved before May 11, 2011;

(C) the licensee requests an exemption from the department; and

(D) the department approves the exemption.

(ii) If the department approves the exemption under Subsection (2)(d)(i), the licensee is not required to apply again for the exemption.

(e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner shall by rule:

(i) publish a list of insurance professional designations whose continuing education requirements can be used to meet the requirements for continuing education under Subsection (2)(b); and

(ii) authorize a professional adjuster association to:

(A) offer a qualified program for a classification of license on a geographically accessible basis; and

(B) collect a reasonable fee for funding and administration of a qualified program, subject to the review and approval of the commissioner.

(f) (i) A fee permitted under Subsection (2)(e)(ii)(B) that is charged to fund and administer a qualified program shall reasonably relate to the cost of administering the qualified program.

(ii) Nothing in this section shall prohibit a provider of a continuing education program or course from charging a fee for attendance at a course offered for continuing education credit.

(iii) A fee permitted under Subsection (2)(e)(ii)(B) that is charged for attendance at an

association program may be less for an association member, on the basis of the member's affiliation expense, but shall preserve the right of a nonmember to attend without affiliation.

(3) The continuing education requirements of this section apply only to a licensee who is an individual.

(4) The continuing education requirements of this section do not apply to a member of the Utah State Bar.

(5) The commissioner shall designate a course that satisfies the requirements of this section, including a course presented by an insurer.

(6) A nonresident adjuster is considered to have satisfied this state's continuing education requirements if:

(a) the nonresident adjuster satisfies the nonresident [~~producer's~~] home state's continuing education requirements for a licensed insurance adjuster; and

(b) on the same basis the nonresident adjuster's home state considers satisfaction of Utah's continuing education requirements for [~~a producer~~] an adjuster as satisfying the continuing education requirements of the home state.

(7) A licensee subject to this section shall keep documentation of completing the continuing education requirements of this section for two years after the end of the two-year licensing period to which the continuing education requirement applies.

Section 45. Section **31A-26-213** is amended to read:

31A-26-213. Revoking, suspending, surrendering, lapsing, limiting, or otherwise terminating a license -- Forfeiture -- Rulemaking for renewal or reinstatement.

(1) A license type issued under this chapter remains in force until:

(a) revoked or suspended under Subsection (5);

(b) surrendered to the commissioner and accepted by the commissioner in lieu of administrative action;

(c) the licensee dies or is adjudicated incompetent as defined under:

(i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

(ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and Minors;

(d) lapsed under Section 31A-26-214.5; or

(e) voluntarily surrendered.

(2) The following may be reinstated within one year after the day on which the license is no longer in force:

(a) a lapsed license; or

(b) a voluntarily surrendered license, except that a voluntarily surrendered license may not be reinstated after the license period in which it is voluntarily surrendered.

(3) Unless otherwise stated in a written agreement for the voluntary surrender of a license, submission and acceptance of a voluntary surrender of a license does not prevent the department from pursuing additional disciplinary or other action authorized under:

(a) this title; or

(b) rules made under this title in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(4) A license classification issued under this chapter remains in force until:

(a) the qualifications pertaining to a license classification are no longer met by the licensee; or

(b) the supporting license type:

(i) is revoked or suspended under Subsection (5); or

(ii) is surrendered to the commissioner and accepted by the commissioner in lieu of administrative action.

(5) (a) If the commissioner makes a finding under Subsection (5)(b) as part of an adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the commissioner may:

(i) revoke:

(A) a license; or

(B) a license classification;

(ii) suspend for a specified period of 12 months or less:

(A) a license; or

(B) a license classification;

(iii) limit in whole or in part:

(A) a license; or

(B) a license classification;

(iv) deny a license application;

(v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or

(vi) take a combination of actions under Subsections (5)(a)(i) through (iv) and Subsection (5)(a)(v).

(b) The commissioner may take an action described in Subsection (5)(a) if the commissioner finds that the licensee or license applicant:

(i) is unqualified for a license or license classification under Section 31A-26-202, 31A-26-203, 31A-26-204, or 31A-26-205;

(ii) has violated:

(A) an insurance statute;

(B) a rule that is valid under Subsection 31A-2-201(3); or

(C) an order that is valid under Subsection 31A-2-201(4);

(iii) is insolvent, or the subject of receivership, conservatorship, rehabilitation, or other delinquency proceedings in any state;

(iv) fails to pay a final judgment rendered against the person in this state within 60 days after the judgment became final;

(v) fails to meet the same good faith obligations in claims settlement that is required of admitted insurers;

(vi) is affiliated with and under the same general management or interlocking directorate or ownership as another insurance adjuster that transacts business in this state without a license;

(vii) refuses:

(A) to be examined; or

(B) to produce its accounts, records, and files for examination;

(viii) has an officer who refuses to:

(A) give information with respect to the insurance adjuster's affairs; or

(B) perform any other legal obligation as to an examination;

(ix) provides information in the license application that is:

(A) incorrect;

(B) misleading;

(C) incomplete; or

(D) materially untrue;

(x) has violated an insurance law, valid rule, or valid order of another regulatory agency in any jurisdiction;

(xi) has obtained or attempted to obtain a license through misrepresentation or fraud;

(xii) has improperly withheld, misappropriated, or converted money or properties received in the course of doing insurance business;

(xiii) has intentionally misrepresented the terms of an actual or proposed:

(A) insurance contract; or

(B) application for insurance;

(xiv) has been convicted of:

(A) a felony; or

(B) a misdemeanor involving fraud, misrepresentation, theft, or dishonesty;

(xv) has admitted or been found to have committed an insurance unfair trade practice or fraud;

(xvi) in the conduct of business in this state or elsewhere has:

(A) used fraudulent, coercive, or dishonest practices; or

(B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;

(xvii) has had an insurance license or other professional or occupational license or registration, or equivalent, denied, suspended, revoked, or surrendered to resolve an administrative action;

(xviii) has forged another's name to:

(A) an application for insurance; or

(B) a document related to an insurance transaction;

(xix) has improperly used notes or any other reference material to complete an examination for an insurance license;

(xx) has knowingly accepted insurance business from an individual who is not licensed;

(xxi) has failed to comply with an administrative or court order imposing a child support obligation;

(xxii) has failed to:

(A) pay state income tax; or

(B) comply with an administrative or court order directing payment of state income

tax;

(xxiii) has been convicted of a violation of the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and has not obtained written consent in accordance with 18 U.S.C. Sec. 1033 to engage in the business of insurance or participate in such business;

(xxiv) has engaged in methods and practices in the conduct of business that endanger the legitimate interests of customers and the public; or

(xxv) has been convicted of any criminal felony involving dishonesty or breach of trust and has not obtained written consent in accordance with 18 U.S.C. Sec. 1033 to engage in the business of insurance or participate in such business.

(c) For purposes of this section, if a license is held by an agency, both the agency itself and any individual designated under the license are considered to be the holders of the license.

(d) If an individual designated under the agency license commits an act or fails to perform a duty that is a ground for suspending, revoking, or limiting the individual's license, the commissioner may suspend, revoke, or limit the license of:

(i) the individual;

(ii) the agency, if the agency:

(A) is reckless or negligent in its supervision of the individual; or

(B) knowingly participated in the act or failure to act that is the ground for suspending, revoking, or limiting the license; or

(iii) (A) the individual; and

(B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).

(6) A licensee under this chapter is subject to the penalties for conducting an insurance business without a license if:

(a) the licensee's license is:

(i) revoked;

(ii) suspended;

(iii) limited;

(iv) surrendered in lieu of administrative action;

(v) lapsed; or

(vi) voluntarily surrendered; and

(b) the licensee:

(i) continues to act as a licensee; or

(ii) violates the terms of the license limitation.

(7) A licensee under this chapter shall immediately report to the commissioner:

(a) a revocation, suspension, or limitation of the person's license in any other state, the District of Columbia, or a territory of the United States;

(b) the imposition of a disciplinary sanction imposed on that person by any other state, the District of Columbia, or a territory of the United States; or

(c) a judgment or injunction entered against that person on the basis of conduct involving:

(i) fraud;

(ii) deceit;

(iii) misrepresentation; or

(iv) a violation of an insurance law or rule.

(8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a license in lieu of administrative action may specify a time not to exceed five years within which the former licensee may not apply for a new license.

(b) If no time is specified in the order or agreement described in Subsection (8)(a), the former licensee may not apply for a new license for five years without the express approval of the commissioner.

(9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of a license issued under this part if so ordered by a court.

(10) The commissioner shall by rule prescribe the license renewal and reinstatement procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

Section 46. Section **31A-26-301.6** is amended to read:

31A-26-301.6. Health care claims practices.

(1) As used in this section:

[~~(a) "Articulable reason" may include a determination regarding:~~]

[~~(i) eligibility for coverage;~~]

[~~(ii) preexisting conditions;~~]

[~~(iii) applicability of other public or private insurance;~~]

[~~(iv) medical necessity; and~~]

[~~(v) any other reason that would justify an extension of the time to investigate a claim.~~]

(a) "Dentist" means an individual licensed under Title 58, Chapter 69, Dentist and Dental Hygienist Practice Act.

(b) "Health care provider" means a person licensed to provide health care under:

(i) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or

(ii) Title 58, Occupations and Professions.

(c) "Insurer" means an admitted or authorized insurer, as defined in Section 31A-1-301, and includes:

(i) a health maintenance organization; and

(ii) a third party administrator that is subject to this title, provided that nothing in this section may be construed as requiring a third party administrator to use its own funds to pay claims that have not been funded by the entity for which the third party administrator is paying claims.

(d) "Provider" means a health care provider to whom an insurer is obligated to pay directly in connection with a claim by virtue of:

(i) an agreement between the insurer and the provider;

(ii) a health insurance policy or contract of the insurer; or

(iii) state or federal law.

(2) An insurer shall timely pay every valid insurance claim submitted by a provider in accordance with this section.

(3) (a) Except as provided in Subsection (4), within 30 days of the day on which the insurer receives a written claim, an insurer shall:

(i) pay the claim; or

(ii) deny the claim and provide a written explanation for the denial.

(b) (i) Subject to Subsection (3)(b)(ii), the time period described in Subsection (3)(a) may be extended by 15 days if the insurer:

(A) determines that the extension is necessary due to matters beyond the control of the insurer; and

(B) before the end of the 30-day period described in Subsection (3)(a), notifies the provider and insured in writing of:

(I) the circumstances requiring the extension of time; and

(II) the date by which the insurer expects to pay the claim or deny the claim with a written explanation for the denial.

(ii) If an extension is necessary due to a failure of the provider or insured to submit the information necessary to decide the claim:

(A) the notice of extension required by this Subsection (3)(b) shall specifically describe the required information; and

(B) the insurer shall give the provider or insured at least 45 days from the day on which the provider or insured receives the notice before the insurer denies the claim for failure to provide the information requested in Subsection (3)(b)(ii)(A).

(4) (a) In the case of a claim for income replacement benefits, within 45 days of the day on which the insurer receives a written claim, an insurer shall:

(i) pay the claim; or

(ii) deny the claim and provide a written explanation of the denial.

(b) Subject to Subsections (4)(d) and (e), the time period described in Subsection (4)(a) may be extended for 30 days if the insurer:

(i) determines that the extension is necessary due to matters beyond the control of the insurer; and

(ii) before the expiration of the 45-day period described in Subsection (4)(a), notifies the insured of:

(A) the circumstances requiring the extension of time; and

(B) the date by which the insurer expects to pay the claim or deny the claim with a written explanation for the denial.

(c) Subject to Subsections (4)(d) and (e), the time period for complying with Subsection (4)(a) may be extended for up to an additional 30 days from the day on which the 30-day extension period provided in Subsection (4)(b) ends if before the day on which the 30-day extension period ends, the insurer:

(i) determines that due to matters beyond the control of the insurer a decision cannot be rendered within the 30-day extension period; and

(ii) notifies the insured of:

(A) the circumstances requiring the extension; and

(B) the date as of which the insurer expects to pay the claim or deny the claim with a written explanation for the denial.

(d) A notice of extension under this Subsection (4) shall specifically explain:

(i) the standards on which entitlement to a benefit is based; and

(ii) the unresolved issues that prevent a decision on the claim.

(e) If an extension allowed by Subsection (4)(b) or (c) is necessary due to a failure of the insured to submit the information necessary to decide the claim:

(i) the notice of extension required by Subsection (4)(b) or (c) shall specifically describe the necessary information; and

(ii) the insurer shall give the insured at least 45 days from the day on which the insured receives the notice before the insurer denies the claim for failure to provide the information requested in Subsection (4)(b) or (c).

(5) If a period of time is extended as permitted under Subsection (3)(b), (4)(b), or (4)(c), due to an insured or provider failing to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the insured or provider until the date on which the insured or provider responds to the request for additional information.

(6) An insurer shall pay all sums to the provider or insured that the insurer is obligated to pay on the claim, and provide a written explanation of the insurer's decision regarding any part of the claim that is denied within 20 days of receiving the information requested under Subsection (3)(b), (4)(b), or (4)(c).

(7) (a) Whenever an insurer makes a payment to a provider on any part of a claim under this section, the insurer shall also send to the insured an explanation of benefits paid.

(b) Whenever an insurer denies any part of a claim under this section, the insurer shall also send to the insured:

(i) a written explanation of the part of the claim that was denied; and

(ii) notice of the adverse benefit determination review process established under Section 31A-22-629.

(c) This Subsection (7) does not apply to a person receiving benefits under the state Medicaid program as defined in Section 26-18-2, unless required by the Department of Health or federal law.

(8) (a) [~~Beginning with health care claims submitted on or after January 1, 2002, a~~] A late fee shall be imposed on:

(i) an insurer that fails to timely pay a claim in accordance with this section; and

(ii) a provider that fails to timely provide information on a claim in accordance with this section.

(b) For the first 90 days that a claim payment or a provider response to a request for information is late, the late fee shall be determined by multiplying together:

(i) the total amount of the claim the insurer is obliged to pay;

(ii) the total number of days the response or the payment is late; and

(iii) [~~.1%~~] 0.033% daily interest rate.

(c) For a claim payment or a provider response to a request for information that is 91 or more days late, the late fee shall be determined by adding together:

(i) the late fee for a 90-day period under Subsection (8)(b); and

(ii) the following multiplied together:

(A) the total amount of the claim the insurer is obliged to pay;

(B) the total number of days the response or payment was late beyond the initial 90-day period; and

[~~(C) the rate of interest set in accordance with Section 15-1-1.~~]

(C) 0.55% daily interest rate.

(d) Any late fee paid or collected under this section shall be separately identified on the documentation used by the insurer to pay the claim.

(e) For purposes of this Subsection (8), "late fee" does not include an amount that is less than $1.

(9) Each insurer shall establish a review process to resolve claims-related disputes between the insurer and providers.

(10) An insurer or person representing an insurer may not engage in any unfair claim settlement practice with respect to a provider. Unfair claim settlement practices include:

(a) knowingly misrepresenting a material fact or the contents of an insurance policy in connection with a claim;

(b) failing to acknowledge and substantively respond within 15 days to any written communication from a provider relating to a pending claim;

(c) denying or threatening to deny the payment of a claim for any reason that is not clearly described in the insured's policy;

(d) failing to maintain a payment process sufficient to comply with this section;

(e) failing to maintain claims documentation sufficient to demonstrate compliance with this section;

(f) failing, upon request, to give to the provider written information regarding the specific rate and terms under which the provider will be paid for health care services;

(g) failing to timely pay a valid claim in accordance with this section as a means of influencing, intimidating, retaliating, or gaining an advantage over the provider with respect to an unrelated claim, an undisputed part of a pending claim, or some other aspect of the contractual relationship;

(h) failing to pay the sum when required and as required under Subsection (8) when a violation has occurred;

(i) threatening to retaliate or actual retaliation against a provider for the provider applying this section;

(j) any material violation of this section; and

(k) any other unfair claim settlement practice established in rule or law.

(11) (a) The provisions of this section shall apply to each contract between an insurer and a provider for the duration of the contract.

(b) Notwithstanding Subsection (11)(a), this section may not be the basis for a bad faith insurance claim.

(c) Nothing in Subsection (11)(a) may be construed as limiting the ability of an insurer and a provider from including provisions in their contract that are more stringent than the provisions of this section.

(12) (a) Pursuant to Chapter 2, Part 2, Duties and Powers of Commissioner, [~~and beginning January 1, 2002,~~] the commissioner may conduct examinations to determine an insurer's level of compliance with this section and impose sanctions for each violation.

(b) The commissioner may adopt rules only as necessary to implement this section.

(c) The commissioner may establish rules to facilitate the exchange of electronic confirmations when claims-related information has been received.

(d) Notwithstanding Subsection (12)(b), the commissioner may not adopt rules

regarding the review process required by Subsection (9).

(13) Nothing in this section may be construed as limiting the collection rights of a provider under Section 31A-26-301.5.

(14) Nothing in this section may be construed as limiting the ability of an insurer to:

(a) recover any amount improperly paid to a provider or an insured:

(i) in accordance with Section 31A-31-103 or any other provision of state or federal law;

(ii) within 24 months of the amount improperly paid for a coordination of benefits error;

(iii) within 12 months of the amount improperly paid for any other reason not identified in Subsection (14)(a)(i) or (ii); or

(iv) within 36 months of the amount improperly paid when the improper payment was due to a recovery by Medicaid, Medicare, the Children's Health Insurance Program, or any other state or federal health care program;

(b) take any action against a provider that is permitted under the terms of the provider contract and not prohibited by this section;

(c) report the provider to a state or federal agency with regulatory authority over the provider for unprofessional, unlawful, or fraudulent conduct; or

(d) enter into a mutual agreement with a provider to resolve alleged violations of this section through mediation or binding arbitration.

(15) A health care provider may only seek recovery from the insurer for an amount improperly paid by the insurer within the same time frames as Subsections (14)(a) and (b).

(16) (a) (i) An insurer shall remit in full the payment the insurer is obligated to pay to a dentist or insured.

(ii) An insurer's payment under this Subsection (16)(a) may not be reduced for fees incurred for the method of payment, regardless of the payment method.

(b) An insurer may offer the remittance of payment through a credit card or other similar arrangement, if the dentist or insured is not charged a fee.

(c) (i) A dentist may elect not to receive remittance through a credit card or other similar arrangement.

(ii) An insurer:

(A) shall permit a dentist's election described in Subsection (c)(i) to apply to the dentist's entire practice; and

(B) may not require a dentist's election described in Subsection (c)(i) to be made on a patient-by-patient basis.

(d) An insurer may not require a dentist or insured to accept remittance through a credit card or other similar arrangement.

Section 47. Section **31A-27a-105** is amended to read:

31A-27a-105. Jurisdiction -- Venue.

(1) (a) A delinquency proceeding under this chapter may not be commenced by a person other than the commissioner of this state.

(b) No court has jurisdiction to entertain, hear, or determine a delinquency proceeding commenced by any person other than the commissioner of this state.

(2) Other than in accordance with this chapter, a court of this state has no jurisdiction to entertain, hear, or determine any complaint:

(a) requesting the liquidation, rehabilitation, seizure, sequestration, or receivership of an insurer; or

(b) requesting a stay, an injunction, a restraining order, or other relief preliminary to, incidental to, or relating to a delinquency proceeding.

(3) (a) The receivership court, as of the commencement of a delinquency proceeding under this chapter, has exclusive jurisdiction of all property of the insurer, wherever located, including property located outside the territorial limits of the state.

(b) The receivership court has original but not exclusive jurisdiction of all civil proceedings arising:

(i) under this chapter; or

(ii) in or related to a delinquency proceeding under this chapter.

(4) In addition to other grounds for jurisdiction provided by the law of this state, a court of this state having jurisdiction of the subject matter has jurisdiction over a person served pursuant to the Utah Rules of Civil Procedure or other applicable provisions of law in an action brought by the receiver if the person served:

(a) in an action resulting from or incident to a relationship with the insurer described in this Subsection (4)(a), is or has been an agent, broker, or other person who has at any time:

(i) written a policy of insurance for an insurer against which a delinquency proceeding is instituted; or

(ii) acted in any manner whatsoever on behalf of an insurer against which a delinquency proceeding is instituted;

(b) in an action on or incident to a reinsurance contract described in this Subsection (4)(b):

(i) is or has been an insurer or reinsurer who has at any time entered into the contract of reinsurance with an insurer against which a delinquency proceeding is instituted; or

(ii) is an intermediary, agent, or broker of or for the reinsurer, or with respect to the contract;

(c) in an action resulting from or incident to a relationship with the insurer described in this Subsection (4)(c), is or has been an officer, director, manager, trustee, organizer, promoter, or other person in a position of comparable authority or influence over an insurer against which a delinquency proceeding is instituted;

(d) in an action concerning assets described in this Subsection (4)(d), is or was at the time of the institution of the delinquency proceeding against the insurer, holding assets in which the receiver claims an interest on behalf of the insurer; or

(e) in any action on or incident to the obligation described in this Subsection (4)(e), is obligated to the insurer in any way whatsoever.

(5) (a) Subject to Subsection (5)(b), service shall be made upon the person named in the petition in accordance with the Utah Rules of Civil Procedure.

(b) In lieu of service under Subsection (5)(a), upon application to the receivership court, service may be made in such a manner as the receivership court directs whenever it is satisfactorily shown by the commissioner's affidavit:

(i) in the case of a corporation, that the officers of the corporation cannot be served because they have departed from the state or have otherwise concealed themselves with intent to avoid service;

(ii) in the case of an insurer whose business is conducted, at least in part, by an attorney-in-fact, managing general agent, or other similar entity including a reciprocal, Lloyd's association, or interinsurance exchange, that the individual attorney-in-fact, managing general agent, or other entity, or its officers of the corporate attorney-in-fact cannot be served because

of the individual's departure or concealment; or

(iii) in the case of a natural person, that the person cannot be served because of the person's departure or concealment.

(6) If the receivership court on motion of any party finds that an action should as a matter of substantial justice be tried in a forum outside this state, the receivership court may enter an appropriate order to stay further proceedings on the action in this state.

(7) (a) Nothing in this chapter deprives a reinsurer of any contractual right to pursue arbitration except:

(i) as to a claim against the estate; and

(ii) in regard to a contract rejected by the receiver under Section 31A-27a-113.

(b) A party in arbitration may bring a claim or counterclaim against the estate, but the claim or counterclaim is subject to this chapter.

(8) An action authorized by this chapter shall be brought in the Third District Court for Salt Lake County.

(9) (a) At any time after an order is entered pursuant to Section 31A-27a-201, 31A-27a-301, or 31A-27a-401, the commissioner or receiver may transfer the case to the county of the principal office of the person proceeded against.

(b) In the event of a transfer under this Subsection (9), the court in which the proceeding is commenced shall, upon application of the commissioner or receiver, direct its clerk to transmit the court's file to the clerk of the court to which the case is to be transferred.

(c) After a transfer under this Subsection (9), the proceeding shall be conducted in the same manner as if it had been commenced in the court to which the matter is transferred.

(10) (a) Except as provided in Subsection (10)(c), a person may not intervene in a liquidation proceeding in this state for the purpose of seeking or obtaining payment of a judgment, lien, or other claim of any kind.

(b) Except as provided in Subsection (10)(c), the claims procedure set for this chapter constitute the exclusive means for obtaining payment of claims from the liquidation estate.

(c) (i) An affected guaranty association or the affected guaranty association's representative may intervene as a party as a matter of right and otherwise appear and participate in any court proceeding concerning a liquidation proceeding against an insurer.

(ii) Intervention by an affected guaranty association or by an affected guaranty

association's designated representative conferred by this Subsection (10)(c) may not constitute grounds to establish general personal jurisdiction by the courts of this state.

(iii) An intervening affected guaranty association or the affected guaranty association's representative are subject to the receivership court's jurisdiction for the limited purpose for which the affected guaranty association intervenes.

(11) (a) Notwithstanding the other provisions of this section, this chapter does not confer jurisdiction on the receivership court to resolve coverage disputes between an affected guaranty association and those asserting claims against the affected guaranty association resulting from the initiation of a receivership proceeding under this chapter, except to the extent that the affected guaranty association otherwise expressly consents to the jurisdiction of the receivership court pursuant to a plan of rehabilitation or liquidation that resolves its obligations to covered policyholders.

(b) The determination of a dispute with respect to the statutory coverage obligations of an affected guaranty association by a court or administrative agency or body with jurisdiction in the affected guaranty association's state of domicile is binding and conclusive as to the affected guaranty association's claim in the liquidation proceeding.

(12) Upon the request of the receiver, the receivership court or the presiding judge of the Third District Court for Salt Lake County may order that one judge hear all cases and controversies arising out of or related to the delinquency proceeding.

(13) A delinquency proceeding is exempt from any program maintained for the early closure of civil actions.

(14) In a proceeding, case, or controversy arising out of or related to a delinquency proceeding, to the extent there is a conflict between the Utah Rules of Civil Procedure and this chapter, the provisions of this chapter govern the proceeding, case, or controversy.

Section 48. Section **31A-27a-501** is amended to read:

31A-27a-501. Turnover of assets.

(1) (a) If the receiver determines that funds or property in the possession of another person are rightfully the property of the estate, the receiver shall deliver to the person a written demand for immediate delivery of the funds or property:

(i) referencing this section by number;

(ii) referencing the court and docket number of the receivership action; and

(iii) notifying the person that any claim of right to the funds or property by the person shall be presented to the receivership court within 20 days of the day on which the person receives the written demand.

(b) (i) A person who holds funds or other property belonging to an entity subject to an order of receivership under this chapter shall deliver the funds or other property to the receiver on demand.

(ii) If the person described in Subsection (1)(b)(i) alleges a right to retain the funds or other property, the person shall:

(A) file [~~a pleading~~] an objection with the receivership court setting out that right within 20 days of the day on which the person receives the demand that the funds or property be delivered to the receiver; and

(B) serve a copy of the [~~pleading~~] objection on the receiver.

(iii) The [~~pleading~~] objection described in Subsection (1)(b)(ii) shall inform the receivership court as to:

(A) the nature of the claim to the funds or property;

(B) the alleged value of the property or amount of funds held; and

(C) what action has been taken by the person to preserve any funds or to preserve and protect the property pending determination of the dispute.

(c) The relinquishment of possession of funds or property by a person who receives a demand pursuant to this section is not a waiver of a right to make a claim in the receivership.

(2) (a) If requested by the receiver, the receivership court shall hold a hearing to determine where and under what conditions the funds or property shall be held by a person described in Subsection (1) pending determination of a dispute concerning the funds or property.

(b) The receivership court may impose the conditions the receivership court considers necessary or appropriate for the preservation of the funds or property until the receivership court can determine the validity of the person's claim to the funds or property.

(c) If funds or property are allowed to remain in the possession of the person after demand made by the receiver, that person is strictly liable to the estate for any waste, loss, or damage to or diminution of value of the funds or property retained.

(3) If a person files [~~a pleading~~] an objection alleging a right to retain funds or property

as provided in Subsection (1), the receivership court shall hold a subsequent hearing to determine the entitlement of the person to the funds or property claimed by the receiver.

(4) If a person fails to deliver the funds or property or to file the [~~pleading~~] objection described by Subsection (1) within the 20-day period, the receivership court may issue a summary order:

(a) upon:

(i) petition of the receiver; and

(ii) a copy of the petition being served by the petitioner to that person;

(b) directing the immediate delivery of the funds or property to the receiver; and

(c) finding that the person waived all claims of right to the funds or property.

(5) The liquidator shall reduce the assets to a degree of liquidity that is consistent with the effective execution of the liquidation.

Section 49. Section **31A-30-117** is amended to read:

31A-30-117. Patient Protection and Affordable Care Act -- Market transition.

(1) (a) [~~After complying with the reporting requirements of Section 63N-11-106, the~~] The commissioner may adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, that change the rating and underwriting requirements of this chapter as necessary to transition the insurance market to meet federal qualified health plan standards and rating practices under PPACA.

(b) Administrative rules adopted by the commissioner under this section may include:

(i) the regulation of health benefit plans as described in [~~Subsections 31A-2-212(5)(a) and (b)~~] Subsection 31A-2-212(5); and

(ii) disclosure of records and information required by PPACA and state law.

(c) (i) The commissioner shall establish by administrative rule one statewide open enrollment period that applies to the individual insurance market that is not on the PPACA certified individual exchange.

(ii) The statewide open enrollment period:

(A) may be shorter, but no longer than the open enrollment period established for the individual insurance market offered in the PPACA certified exchange; and

(B) may not be extended beyond the dates of the open enrollment period established for the individual insurance market offered in the PPACA certified exchange.

(2) A carrier that offers health benefit plans in the individual market that is not part of the individual PPACA certified exchange:

(a) shall open enrollment:

(i) during the statewide open enrollment period established in Subsection (1)(c); and

(ii) at other times, for qualifying events, as determined by administrative rule adopted by the commissioner; and

(b) may open enrollment at any time.

(3) To the extent permitted by the Centers for Medicare and Medicaid Services policy, or federal regulation, the commissioner shall allow a health insurer to choose to continue coverage and individuals and small employers to choose to re-enroll in coverage in nongrandfathered health coverage that is not in compliance with market reforms required by PPACA.

Section 50. Section **31A-30-118** is amended to read:

31A-30-118. Patient Protection and Affordable Care Act -- State insurance mandates -- Cost of additional benefits.

(1) (a) The commissioner shall identify a new mandated benefit that is in excess of the essential health benefits required by PPACA.

(b) The state shall quantify the cost attributable to each additional mandated benefit specified in Subsection (1)(a) based on a qualified health plan issuer's calculation of the cost associated with the mandated benefit, which shall be:

(i) calculated in accordance with generally accepted actuarial principles and methodologies;

(ii) conducted by a member of the American Academy of Actuaries; and

(iii) reported to the commissioner and to the individual exchange operating in the state.

(c) The commissioner may require a proponent of a new mandated benefit under Subsection (1)(a) to provide the commissioner with a cost analysis conducted in accordance with Subsection (1)(b). The commissioner may use the cost information provided under this Subsection (1)(c) to establish estimates of the cost to the state under Subsection (2).

(2) If the state is required to defray the cost of additional required benefits under the provisions of 45 C.F.R. 155.170:

(a) the state shall make the required payments:

(i) in accordance with Subsection (3); and

(ii) directly to the qualified health plan issuer in accordance with 45 C.F.R. 155.170;

(b) an issuer of a qualified health plan that receives a payment under the provisions of Subsection (1) and 45 C.F.R. 155.170 shall:

(i) reduce the premium charged to the individual on whose behalf the issuer will be paid under Subsection (1), in an amount equal to the amount of the payment under Subsection (1); or

(ii) notwithstanding Subsection 31A-23a-402.5(5), provide a premium rebate to an individual on whose behalf the issuer received a payment under Subsection (1), in an amount equal to the amount of the payment under Subsection (1); and

(c) a premium rebate made under this section is not a prohibited inducement under Section 31A-23a-402.5.

(3) A payment required under 45 C.F.R. 155.170(c) shall:

(a) unless otherwise required by PPACA, be based on a statewide average of the cost of the additional benefit for all issuers who are entitled to payment under the provisions of 45 C.F.R. [~~155.70~~] 155.170; and

(b) be submitted to an issuer through a process established [~~and administered by the federal marketplace exchange for the state under PPACA for individual health plans~~] by the commissioner.

(4) The commissioner may adopt rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:

(a) [~~adopt rules as necessary to~~] administer the provisions of this section and 45 C.F.R. 155.170; and

(b) establish or implement a process for submitting a payment to an issuer under Subsection (3)(b).

Section 51. Section **31A-35-402** is amended to read:

31A-35-402. Authority related to bail bonds.

(1) A bail bond agency may only sell bail bonds.

(2) In accordance with Section 31A-23a-205, a bail bond producer may not execute or issue a bail bond in this state without holding a current appointment from a surety insurer or a current designation from a bail bond agency.

(3) A bail bond [~~surety~~] agency or surety insurer may not allow any person who is not a bail bond producer to engage in the bail bond insurance business on the bail bond agency's or surety insurer's behalf, except for individuals:

(a) employed solely for the performance of clerical, stenographic, investigative, or other administrative duties that do not require a license as:

(i) a bail bond agency; or

(ii) a bail bond producer; and

(b) whose compensation is not related to or contingent upon the number of bail bonds written.

Section 52. Section **31A-37-303** is amended to read:

31A-37-303. Reinsurance.

(1) (a) A captive insurance company may cede risks to any insurance company approved by the commissioner.

(b) A captive insurance company may provide reinsurance, as authorized in this title, on risks ceded [~~for the benefit of a parent, affiliate, or controlled unaffiliated business~~] by any other insurer with prior approval of the commissioner.

(2) (a) A captive insurance company may take credit for reserves on risks or portions of risks ceded to reinsurers if the captive insurance company complies with Section 31A-17-404, 31A-17-404.1, 31A-17-404.3, or 31A-17-404.4 or if the captive insurance company complies with other requirements as the commissioner may establish by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(b) Unless the reinsurer is in compliance with Section 31A-17-404, 31A-17-404.1, 31A-17-404.3, or 31A-17-404.4 or a rule adopted under Subsection (2)(a), a captive insurance company may not take credit for:

(i) reserves on risks ceded to a reinsurer; or

(ii) portions of risks ceded to a reinsurer.

Section 53. Section **31A-37-701** is amended to read:

31A-37-701. Certificate of dormancy.

(1) In accordance with the provisions of this section, a captive insurance company, other than a risk retention group may apply, without fee, to the commissioner for a certificate of dormancy.

(2) (a) A captive insurance company, other than a risk retention group, is eligible for a certificate of dormancy if the captive insurance company:

(i) has ceased transacting the business of insurance, including the issuance of insurance policies; and

(ii) has no remaining insurance liabilities or obligations associated with insurance business transactions or insurance policies.

(b) For purposes of Subsection (2)(a)(ii), the commissioner may disregard liabilities or obligations for which the captive insurance company has withheld sufficient funds or that are otherwise sufficiently secured.

(3) Except as provided in Subsection (5), a captive insurance company that holds a certificate of dormancy is subject to all requirements of this chapter.

(4) A captive insurance company that holds a certificate of dormancy:

(a) shall possess and maintain unimpaired paid-in capital and unimpaired paid-in surplus of:

(i) in the case of a pure captive insurance company or a special purpose captive insurance company, not less than $25,000;

(ii) in the case of an association captive insurance company, not less than $75,000; or

(iii) in the case of a sponsored captive insurance company, not less than $100,000, of which at least $35,000 is provided by the sponsor; and

(b) is not required to:

(i) subject to Subsection (5), submit an annual audit or statement of actuarial opinion;

(ii) maintain an active agreement with an independent auditor or actuary; or

(iii) hold an annual meeting of the captive insurance company in the state.

(5) The commissioner may require a captive insurance company that holds a certificate of dormancy to submit an annual audit if the commissioner determines that there are concerns regarding the captive insurance company's solvency or liquidity.

(6) To maintain a certificate of dormancy and in lieu of a certificate of authority renewal fee, no later than July 1 of each year, a captive insurance company shall pay an annual dormancy renewal fee that is equal to 50% of the captive insurance's company's certificate of authority renewal fee.

(7) A captive insurance company may consecutively renew a certificate [~~or~~] of

dormancy no more than five times.

Section 54. Section **34A-2-202** is amended to read:

34A-2-202. Assessment on self-insured employers including the state, counties, cities, towns, or school districts paying compensation direct.

(1) (a) (i) A self-insured employer, including a county, city, town, or school district, shall pay annually, on or before March 31, an assessment in accordance with this section and rules made by the commission under this section.

(ii) For purposes of this section, "self-insured employer" is as defined in Section 34A-2-201.5, except it includes the state if the state self-insures under Section 34A-2-203.

(b) The assessment required by Subsection (1)(a) is:

(i) to be collected by the State Tax Commission;

(ii) paid by the State Tax Commission into the state treasury as provided in Subsection 59-9-101(2); and

(iii) subject to the offset provided in Section 34A-2-202.5.

(c) The assessment under Subsection (1)(a) shall be based on a total calculated premium multiplied by the premium assessment rate established pursuant to Subsection 59-9-101(2).

(d) The total calculated premium, for purposes of calculating the assessment under Subsection (1)(a), shall be calculated by:

(i) multiplying the total of the standard premium for each class code calculated in Subsection (1)(e) by the self-insured employer's experience modification factor; and

(ii) multiplying the total under Subsection (1)(d)(i) by a safety factor determined under Subsection (1)(g).

(e) A standard premium shall be calculated by:

(i) multiplying the [~~prospective~~] advisory loss cost for the year being considered, as filed with the insurance department pursuant to Section 31A-19a-406, for each applicable class code by 1.10 to determine the manual rate for each class code; and

(ii) multiplying the manual rate for each class code under Subsection (1)(e)(i) by each $100 of the self-insured employer's covered payroll for each class code.

(f) (i) Each self-insured employer paying compensation direct shall annually obtain the experience modification factor required in Subsection (1)(d)(i) by using:

(A) the rate service organization designated by the insurance commissioner in Section 31A-19a-404; or

(B) for a self-insured employer that is a public agency insurance mutual, an actuary approved by the commission.

(ii) If a self-insured employer's experience modification factor under Subsection (1)(f)(i) is less than 0.50, the self-insured employer shall use an experience modification factor of 0.50 in determining the total calculated premium.

(g) To provide incentive for improved safety, the safety factor required in Subsection (1)(d)(ii) shall be determined based on the self-insured employer's experience modification factor as follows:

EXPERIENCE MODIFICATION FACTOR	SAFETY FACTOR
Less than or equal to 0.90	0.56
Greater than 0.90 but less than or equal to 1.00	0.78
Greater than 1.00 but less than or equal to 1.10	1.00
Greater than 1.10 but less than or equal to 1.20	1.22
Greater than 1.20	1.44

(h) (i) A premium or premium assessment modification other than a premium or premium assessment modification under this section may not be allowed.

(ii) If a self-insured employer paying compensation direct fails to obtain an experience modification factor as required in Subsection (1)(f)(i) within the reasonable time period established by rule by the State Tax Commission, the State Tax Commission shall use an experience modification factor of 2.00 and a safety factor of 2.00 to calculate the total calculated premium for purposes of determining the assessment.

(iii) [~~Prior to~~] Before calculating the total calculated premium under Subsection (1)(h)(ii), the State Tax Commission shall provide the self-insured employer with written notice that failure to obtain an experience modification factor within a reasonable time period, as established by rule by the State Tax Commission:

(A) shall result in the State Tax Commission using an experience modification factor of 2.00 and a safety factor of 2.00 in calculating the total calculated premium for purposes of

determining the assessment; and

(B) may result in the division revoking the self-insured employer's right to pay compensation direct.

(i) The division may immediately revoke a self-insured employer's certificate issued under Sections 34A-2-201 and 34A-2-201.5 that permits the self-insured employer to pay compensation direct if the State Tax Commission assigns an experience modification factor and a safety factor under Subsection (1)(h) because the self-insured employer failed to obtain an experience modification factor.

(2) Notwithstanding the annual payment requirement in Subsection (1)(a), a self-insured employer whose total assessment obligation under Subsection (1)(a) for the preceding year was $10,000 or more shall pay the assessment in quarterly installments in the same manner provided in Section 59-9-104 and subject to the same penalty provided in Section 59-9-104 for not paying or underpaying an installment.

(3) (a) The State Tax Commission shall have access to all the records of the division for the purpose of auditing and collecting any amounts described in this section.

(b) Time periods for the State Tax Commission to allow a refund or make an assessment shall be determined in accordance with Title 59, Chapter 1, Part 14, Assessment, Collections, and Refunds Act.

(4) (a) A review of appropriate use of job class assignment and calculation methodology may be conducted as directed by the division at any reasonable time as a condition of the self-insured employer's certification of paying compensation direct.

(b) The State Tax Commission shall make any records necessary for the review available to the commission.

(c) The commission shall make the results of any review available to the State Tax Commission.

Section 55. Section **36-29-106** is amended to read:

36-29-106. Health Reform Task Force.

(1) There is created the Health Reform Task Force consisting of the following 11 members:

(a) four members of the Senate appointed by the president of the Senate, no more than three of whom are from the same political party; and

(b) seven members of the House of Representatives appointed by the speaker of the House of Representatives, no more than five of whom are from the same political party.

(2) (a) The president of the Senate shall designate a member of the Senate appointed under Subsection (1)(a) as a cochair of the task force.

(b) The speaker of the House of Representatives shall designate a member of the House of Representatives appointed under Subsection (1)(b) as a cochair of the task force.

(3) Salaries and expenses of the members of the task force shall be paid in accordance with Section 36-2-2 and Legislative Joint Rules, Title 5, Chapter 3, Legislator Compensation.

(4) The Office of Legislative Research and General Counsel shall provide staff support to the task force.

(5) The task force shall review and make recommendations on health system reform, including the following issues:

(a) the need for state statutory and regulatory changes in response to federal actions affecting health care;

(b) Medicaid and reforms to the Medicaid program;

(c) options for increasing state flexibility, including the use of federal waivers;

(d) the state's health insurance marketplace;

(e) health insurance code modifications;

(f) insurance network adequacy standards and balance billing; and

[~~(g) health care provider workforce in the state;~~]

[~~(h)~~] (g) rising health care costs[~~; and~~].

[~~(i) non-opiate pain management options.~~]

(6) A final report, including any proposed legislation, shall be presented to the Business and Labor Interim Committee and Health and Human Services Interim Committee before November 30, 2019, and November 30, 2020.

Section 56. Section **63A-5-205.5** is amended to read:

63A-5-205.5. Health insurance requirements -- Penalties.

(1) As used in this section:

(a) "Aggregate" means the sum of all contracts, change orders, and modifications related to a single project.

(b) "Change order" means the same as that term is defined in Section 63G-6a-103.

(c) "Employee" means, as defined in Section 34A-2-104, an "employee," "worker," or "operative" who:

(i) works at least 30 hours per calendar week; and

(ii) meets employer eligibility waiting requirements for health care insurance, which may not exceed the first day of the calendar month following 60 days after the day on which the individual is hired.

(d) "Health benefit plan" means:

(i) the same as that term is defined in Section 31A-1-301[.]; or

(ii) an employee welfare benefit plan:

(A) established under the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001 et seq.;

(B) for an employer with 100 or more employees; and

(C) in which the employer establishes a self-funded or partially self-funded group health plan to provide medical care for the employer's employees and dependents of the employees.

(e) "Qualified health [~~insurance~~] coverage" means the same as that term is defined in Section 26-40-115.

(f) "Subcontractor" means the same as that term is defined in Section 63A-5-208.

(g) "Third party administrator" or "administrator" means the same as that term is defined in Section 31A-1-301.

(2) Except as provided in Subsection (3), the requirements of this section apply to:

(a) a contractor of a design or construction contract entered into by the division or the State Building Board on or after July 1, 2009, if the prime contract is in an aggregate amount equal to or greater than $2,000,000; and

(b) a subcontractor of a contractor of a design or construction contract entered into by the division or State Building Board on or after July 1, 2009, if the subcontract is in an aggregate amount equal to or greater than $1,000,000.

(3) The requirements of this section do not apply to a contractor or subcontractor described in Subsection (2) if:

(a) the application of this section jeopardizes the receipt of federal funds;

(b) the contract is a sole source contract; or

(c) the contract is an emergency procurement.

(4) A person that intentionally uses change orders, contract modifications, or multiple contracts to circumvent the requirements of this section is guilty of an infraction.

(5) (a) A contractor that is subject to the requirements of this section shall demonstrate to the director that the contractor has and will maintain an offer of qualified health [~~insurance~~] coverage for the contractor's employees and the employees' dependents by submitting to the director a written statement that:

(i) the contractor offers qualified health [~~insurance~~] coverage that complies with Section 26-40-115;

(ii) is from:

(A) an actuary selected by the contractor or the contractor's insurer; [~~or~~]

(B) an underwriter who is responsible for developing the employer group's premium rates; [~~and~~] or

(C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or underwriter selected by a third party administrator; and

(iii) was created within one year before the day on which the statement is submitted.

(b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii) shall provide the actuary or underwriter selected by an administrator, as described in Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's contribution to the health benefit plan and the actuarial value of the health benefit plan meet the requirements of qualified health coverage.

(ii) A contractor may not make a change to the contractor's contribution to the health benefit plan, unless the contractor provides notice to:

(A) the actuary or underwriter selected by an administrator, as described in Subsection (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in Subsection (5)(a) in compliance with this section; and

(B) the division.

[~~(b)~~] (c) A contractor that is subject to the requirements of this section shall:

(i) place a requirement in each of the contractor's subcontracts that a subcontractor that is subject to the requirements of this section shall obtain and maintain an offer of qualified health [~~insurance~~] coverage for the subcontractor's employees and the employees' dependents

during the duration of the subcontract; and

(ii) obtain from a subcontractor that is subject to the requirements of this section a written statement that:

(A) the subcontractor offers qualified health [~~insurance~~] coverage that complies with Section 26-40-115;

(B) is from an actuary selected by the subcontractor or the subcontractor's insurer, [~~or~~] an underwriter who is responsible for developing the employer group's premium rates, or if the subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or underwriter selected by an administrator; and

(C) was created within one year before the day on which the contractor obtains the statement.

[~~(c)~~] (d) (i) (A) A contractor that fails to maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the division under Subsection (6).

(B) A contractor is not subject to penalties for the failure of a subcontractor to obtain and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)[~~(b)~~](c)(i).

(ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)[~~(b)~~](c)(i) during the duration of the subcontract is subject to penalties in accordance with administrative rules adopted by the division under Subsection (6).

(B) A subcontractor is not subject to penalties for the failure of a contractor to maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a).

(6) The division shall adopt administrative rules:

(a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(b) in coordination with:

(i) the Department of Environmental Quality in accordance with Section 19-1-206;

(ii) the Department of Natural Resources in accordance with Section 79-2-404;

(iii) a public transit district in accordance with Section 17B-2a-818.5;

(iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;

(v) the Department of Transportation in accordance with Section 72-6-107.5; and

(vi) the Legislature's Administrative Rules Review Committee; and

(c) that establish:

(i) the requirements and procedures a contractor and a subcontractor shall follow to demonstrate compliance with this section, including:

(A) that a contractor or subcontractor's compliance with this section is subject to an audit by the division or the Office of the Legislative Auditor General;

(B) that a contractor that is subject to the requirements of this section shall obtain a written statement described in Subsection (5)(a); and

(C) that a subcontractor that is subject to the requirements of this section shall obtain a written statement described in Subsection (5)[~~(b)~~](c)(ii);

(ii) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of this section, which may include:

(A) a three-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the first violation;

(B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation;

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6a-904 upon the third or subsequent violation; and

(D) monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health [~~insurance~~] coverage for employees and dependents of employees of the contractor or subcontractor who were not offered qualified health [~~insurance~~] coverage during the duration of the contract; and

(iii) a website on which the department shall post the commercially equivalent benchmark for the qualified health [~~insurance~~] coverage that is provided by the Department of Health in accordance with Subsection 26-40-115(2).

(7) (a) During the duration of a contract, the division may perform an audit to verify a contractor or subcontractor's compliance with this section.

(b) Upon the division's request, a contractor or subcontractor shall provide the division:

(i) a signed actuarial certification that the coverage the contractor or subcontractor offers is qualified health [~~insurance~~] coverage; or

(ii) all relevant documents and information necessary for the division to determine compliance with this section.

(c) If a contractor or subcontractor provides the documents and information described in Subsection (7)(b)(ii), the Insurance Department shall assist the division in determining if the coverage the contractor or subcontractor offers is qualified health [~~insurance~~] coverage.

(8) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor or subcontractor that intentionally violates the provisions of this section is liable to the employee for health care costs that would have been covered by qualified health [~~insurance~~] coverage.

(ii) An employer has an affirmative defense to a cause of action under Subsection (8)(a) if:

(A) the employer relied in good faith on a written statement described in Subsection (5)(a) or (5)[~~(b)~~](c)(ii); or

(B) the department determines that compliance with this section is not required under the provisions of Subsection (3).

(b) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (8).

(9) Any penalties imposed and collected under this section shall be deposited into the Medicaid Restricted Account created by Section 26-18-402.

(10) The failure of a contractor or subcontractor to provide qualified health [~~insurance~~] coverage as required by this section:

(a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under:

(i) Section 63G-6a-1602; or

(ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

(b) may not be used by the procurement entity or a prospective bidder, offeror, or contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design or construction.

(11) An administrator, including an administrator's actuary or underwriter, who provides a written statement under Subsection (5)(a) or (c) regarding the qualified health coverage of a contractor or subcontractor who provides a health benefit plan described in

Subsection (1)(d)(ii):

(a) subject to Subsection (11)(b), is not liable for an error in the written statement, unless the administrator commits gross negligence in preparing the written statement;

(b) is not liable for any error in the written statement if the administrator relied in good faith on information from the contractor or subcontractor; and

(c) may require as a condition of providing the written statement that a contractor or subcontractor hold the administrator harmless for an action arising under this section.

Section 57. Section **63C-9-403** is amended to read:

63C-9-403. Contracting power of executive director -- Health insurance coverage.

(1) As used in this section:

(a) "Aggregate" means the sum of all contracts, change orders, and modifications related to a single project.

(b) "Change order" means the same as that term is defined in Section 63G-6a-103.

(c) "Employee" means, as defined in Section 34A-2-104, an "employee," "worker," or "operative" who:

(i) works at least 30 hours per calendar week; and

(ii) meets employer eligibility waiting requirements for health care insurance, which may not exceed the first of the calendar month following 60 days after the day on which the individual is hired.

(d) "Health benefit plan" means:

(i) the same as that term is defined in Section 31A-1-301[.]; or

(ii) an employee welfare benefit plan:

(A) established under the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001 et seq.;

(B) for an employer with 100 or more employees; and

(C) in which the employer establishes a self-funded or partially self-funded group health plan to provide medical care for the employer's employees and dependents of the employees.

(e) "Qualified health [~~insurance~~] coverage" means the same as that term is defined in Section 26-40-115.

(f) "Subcontractor" means the same as that term is defined in Section 63A-5-208.

(g) "Third party administrator" or "administrator" means the same as that term is defined in Section 31A-1-301.

(2) Except as provided in Subsection (3), the requirements of this section apply to:

(a) a contractor of a design or construction contract entered into by the board, or on behalf of the board, on or after July 1, 2009, if the prime contract is in an aggregate amount equal to or greater than $2,000,000; and

(b) a subcontractor of a contractor of a design or construction contract entered into by the board, or on behalf of the board, on or after July 1, 2009, if the subcontract is in an aggregate amount equal to or greater than $1,000,000.

(3) The requirements of this section do not apply to a contractor or subcontractor described in Subsection (2) if:

(a) the application of this section jeopardizes the receipt of federal funds;

(b) the contract is a sole source contract; or

(c) the contract is an emergency procurement.

(4) A person that intentionally uses change orders, contract modifications, or multiple contracts to circumvent the requirements of this section is guilty of an infraction.

(5) (a) A contractor subject to the requirements of this section shall demonstrate to the executive director that the contractor has and will maintain an offer of qualified health [~~insurance~~] coverage for the contractor's employees and the employees' dependents during the duration of the contract by submitting to the executive director a written statement that:

(i) the contractor offers qualified health [~~insurance~~] coverage that complies with Section 26-40-115;

(ii) is from:

(A) an actuary selected by the contractor or the contractor's insurer; [~~or~~]

(B) an underwriter who is responsible for developing the employer group's premium rates; [~~and~~] or

(C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or underwriter selected by a third party administrator; and

(iii) was created within one year before the day on which the statement is submitted.

(b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii) shall provide the actuary or underwriter selected by the administrator, as described in

Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's contribution to the health benefit plan and the health benefit plan's actuarial value meets the requirements of qualified health coverage.

(ii) A contractor may not make a change to the contractor's contribution to the health benefit plan, unless the contractor provides notice to:

(A) the actuary or underwriter selected by the administrator, as described in Subsection (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in Subsection (5)(a) in compliance with this section; and

(B) the executive director.

[~~(b)~~] (c) A contractor that is subject to the requirements of this section shall:

(i) place a requirement in each of the contractor's subcontracts that a subcontractor that is subject to the requirements of this section shall obtain and maintain an offer of qualified health [~~insurance~~] coverage for the subcontractor's employees and the employees' dependents during the duration of the subcontract; and

(ii) obtain from a subcontractor that is subject to the requirements of this section a written statement that:

(A) the subcontractor offers qualified health [~~insurance~~] coverage that complies with Section 26-40-115;

(B) is from an actuary selected by the subcontractor or the subcontractor's insurer, [~~or~~] an underwriter who is responsible for developing the employer group's premium rates, or if the subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or underwriter selected by an administrator; and

(C) was created within one year before the day on which the contractor obtains the statement.

[~~(c)~~] (d) (i) (A) A contractor that fails to maintain an offer of qualified health [~~insurance~~] coverage as described in Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the division under Subsection (6).

(B) A contractor is not subject to penalties for the failure of a subcontractor to obtain and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)[~~(b)~~](c)(i).

(ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)[~~(b)~~](c)(i) during the duration of the subcontract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6).

(B) A subcontractor is not subject to penalties for the failure of a contractor to maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a).

(6) The department shall adopt administrative rules:

(a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(b) in coordination with:

(i) the Department of Environmental Quality in accordance with Section 19-1-206;

(ii) the Department of Natural Resources in accordance with Section 79-2-404;

(iii) the State Building Board in accordance with Section 63A-5-205.5;

(iv) a public transit district in accordance with Section 17B-2a-818.5;

(v) the Department of Transportation in accordance with Section 72-6-107.5; and

(vi) the Legislature's Administrative Rules Review Committee; and

(c) that establish:

(i) the requirements and procedures a contractor and a subcontractor shall follow to demonstrate compliance with this section, including:

(A) that a contractor or subcontractor's compliance with this section is subject to an audit by the department or the Office of the Legislative Auditor General;

(B) that a contractor that is subject to the requirements of this section shall obtain a written statement described in Subsection (5)(a); and

(C) that a subcontractor that is subject to the requirements of this section shall obtain a written statement described in Subsection (5)[~~(b)~~](c)(ii);

(ii) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of this section, which may include:

(A) a three-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the first violation;

(B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation;

(C) an action for debarment of the contractor or subcontractor in accordance with

Section 63G-6a-904 upon the third or subsequent violation; and

(D) monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health [~~insurance~~] coverage for employees and dependents of employees of the contractor or subcontractor who were not offered qualified health [~~insurance~~] coverage during the duration of the contract; and

(iii) a website on which the department shall post the commercially equivalent benchmark, for the qualified health [~~insurance~~] coverage identified in Subsection (1)(e), that is provided by the Department of Health, in accordance with Subsection 26-40-115(2).

(7) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor or subcontractor who intentionally violates the provisions of this section is liable to the employee for health care costs that would have been covered by qualified health [~~insurance~~] coverage.

(ii) An employer has an affirmative defense to a cause of action under Subsection (7)(a)(i) if:

(A) the employer relied in good faith on a written statement described in Subsection (5)(a) or (5)[~~(b)~~](c)(ii); or

(B) the department determines that compliance with this section is not required under the provisions of Subsection (3).

(b) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (7).

(8) Any penalties imposed and collected under this section shall be deposited into the Medicaid Restricted Account created in Section 26-18-402.

(9) The failure of a contractor or subcontractor to provide qualified health [~~insurance~~] coverage as required by this section:

(a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under:

(i) Section 63G-6a-1602; or

(ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

(b) may not be used by the procurement entity or a prospective bidder, offeror, or contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design or construction.

(10) An administrator, including the administrator's actuary or underwriter, who provides a written statement under Subsection (5)(a) or (c) regarding the qualified health coverage of a contractor or subcontractor who provides a health benefit plan described in Subsection (1)(d)(ii):

(a) subject to Subsection (10)(b), is not liable for an error in the written statement, unless the administrator commits gross negligence in preparing the written statement;

(b) is not liable for any error in the written statement if the administrator relied in good faith on information from the contractor or subcontractor; and

(c) may require as a condition of providing the written statement that a contractor or subcontractor hold the administrator harmless for an action arising under this section.

Section 58. Section **72-6-107.5** is amended to read:

72-6-107.5. Construction of improvements of highway -- Contracts -- Health insurance coverage.

(1) As used in this section:

(a) "Aggregate" means the sum of all contracts, change orders, and modifications related to a single project.

(b) "Change order" means the same as that term is defined in Section 63G-6a-103.

(c) "Employee" means, as defined in Section 34A-2-104, an "employee," "worker," or "operative" who:

(i) works at least 30 hours per calendar week; and

(ii) meets employer eligibility waiting requirements for health care insurance, which may not exceed the first day of the calendar month following 60 days after the day on which the individual is hired.

(d) "Health benefit plan" means:

(i) the same as that term is defined in Section 31A-1-301[.]; or

(ii) an employee welfare benefit plan:

(A) established under the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001 et seq.;

(B) for an employer with 100 or more employees; and

(C) in which the employer establishes a self-funded or partially self-funded group health plan to provide medical care for the employer's employees and dependents of the

employees.

(e) "Qualified health [~~insurance~~] coverage" means the same as that term is defined in Section 26-40-115.

(f) "Subcontractor" means the same as that term is defined in Section 63A-5-208.

(g) "Third party administrator" or "administrator" means the same as that term is defined in Section 31A-1-301.

(2) Except as provided in Subsection (3), the requirements of this section apply to:

(a) a contractor of a design or construction contract entered into by the department on or after July 1, 2009, if the prime contract is in an aggregate amount equal to or greater than $2,000,000; and

(b) a subcontractor of a contractor of a design or construction contract entered into by the department on or after July 1, 2009, if the subcontract is in an aggregate amount equal to or greater than $1,000,000.

(3) The requirements of this section do not apply to a contractor or subcontractor described in Subsection (2) if:

(a) the application of this section jeopardizes the receipt of federal funds;

(b) the contract is a sole source contract; or

(c) the contract is an emergency procurement.

(4) A person that intentionally uses change orders, contract modifications, or multiple contracts to circumvent the requirements of this section is guilty of an infraction.

(5) (a) A contractor subject to the requirements of this section shall demonstrate to the department that the contractor has and will maintain an offer of qualified health [~~insurance~~] coverage for the contractor's employees and the employees' dependents during the duration of the contract by submitting to the department a written statement that:

(i) the contractor offers qualified health [~~insurance~~] coverage that complies with Section 26-40-115;

(ii) is from:

(A) an actuary selected by the contractor or the contractor's insurer; [~~or~~]

(B) an underwriter who is responsible for developing the employer group's premium rates; [~~and~~] or

(C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii),

an actuary or underwriter selected by a third party administrator; and

(iii) was created within one year before the day on which the statement is submitted.

(b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii) shall provide the actuary or underwriter selected by an administrator, as described in Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's contribution to the health benefit plan and the actuarial value of the health benefit plan meet the requirements of qualified health coverage.

(ii) A contractor may not make a change to the contractor's contribution to the health benefit plan, unless the contractor provides notice to:

(A) the actuary or underwriter selected by an administrator, as described in Subsection (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in Subsection (5)(a) in compliance with this section; and

(B) the department.

[~~(b)~~] (c) A contractor that is subject to the requirements of this section shall:

(i) place a requirement in each of the contractor's subcontracts that a subcontractor that is subject to the requirements of this section shall obtain and maintain an offer of qualified health [~~insurance~~] coverage for the subcontractor's employees and the employees' dependents during the duration of the subcontract; and

(ii) obtain from a subcontractor that is subject to the requirements of this section a written statement that:

(A) the subcontractor offers qualified health [~~insurance~~] coverage that complies with Section 26-40-115;

(B) is from an actuary selected by the subcontractor or the subcontractor's insurer, [~~or~~] an underwriter who is responsible for developing the employer group's premium rates, or if the subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or underwriter selected by an administrator; and

(C) was created within one year before the day on which the contractor obtains the statement.

[~~(c)~~] (d) (i) (A) A contractor that fails to maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the department under

Subsection (6).

(B) A contractor is not subject to penalties for the failure of a subcontractor to obtain and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)[~~(b)~~](c)(i).

(ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)[~~(b)~~](c) during the duration of the subcontract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6).

(B) A subcontractor is not subject to penalties for the failure of a contractor to maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a).

(6) The department shall adopt administrative rules:

(a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(b) in coordination with:

(i) the Department of Environmental Quality in accordance with Section 19-1-206;

(ii) the Department of Natural Resources in accordance with Section 79-2-404;

(iii) the State Building Board in accordance with Section 63A-5-205.5;

(iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;

(v) a public transit district in accordance with Section 17B-2a-818.5; and

(vi) the Legislature's Administrative Rules Review Committee; and

(c) that establish:

(i) the requirements and procedures a contractor and a subcontractor shall follow to demonstrate compliance with this section, including:

(A) that a contractor or subcontractor's compliance with this section is subject to an audit by the department or the Office of the Legislative Auditor General;

(B) that a contractor that is subject to the requirements of this section shall obtain a written statement described in Subsection (5)(a); and

(C) that a subcontractor that is subject to the requirements of this section shall obtain a written statement described in Subsection (5)[~~(b)~~](c)(ii);

(ii) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of this section, which may include:

(A) a three-month suspension of the contractor or subcontractor from entering into

future contracts with the state upon the first violation;

(B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation;

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6a-904 upon the third or subsequent violation; and

(D) monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health [~~insurance~~] coverage for an employee and a dependent of the employee of the contractor or subcontractor who was not offered qualified health [~~insurance~~] coverage during the duration of the contract; and

(iii) a website on which the department shall post the commercially equivalent benchmark, for the qualified health [~~insurance~~] coverage identified in Subsection (1)(e), that is provided by the Department of Health, in accordance with Subsection 26-40-115(2).

(7) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor or subcontractor who intentionally violates the provisions of this section is liable to the employee for health care costs that would have been covered by qualified health [~~insurance~~] coverage.

(ii) An employer has an affirmative defense to a cause of action under Subsection (7)(a)(i) if:

(A) the employer relied in good faith on a written statement described in Subsection (5)(a) or (5)[~~(b)~~](c)(ii); or

(B) the department determines that compliance with this section is not required under the provisions of Subsection (3).

(b) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (7).

(8) Any penalties imposed and collected under this section shall be deposited into the Medicaid Restricted Account created in Section 26-18-402.

(9) The failure of a contractor or subcontractor to provide qualified health [~~insurance~~] coverage as required by this section:

(a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under:

(i) Section 63G-6a-1602; or

(ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

(b) may not be used by the procurement entity or a prospective bidder, offeror, or contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design or construction.

(10) An administrator, including an administrator's actuary or underwriter, who provides a written statement under Subsection (5)(a) or (c) regarding the qualified health coverage of a contractor or subcontractor who provides a health benefit plan described in Subsection (1)(d)(ii):

(a) subject to Subsection (10)(b), is not liable for an error in the written statement, unless the administrator commits gross negligence in preparing the written statement;

(b) is not liable for any error in the written statement if the administrator relied in good faith on information from the contractor or subcontractor; and

(c) may require as a condition of providing the written statement that a contractor or subcontractor hold the administrator harmless for an action arising under this section.

Section 59. Section **79-2-404** is amended to read:

79-2-404. Contracting powers of department -- Health insurance coverage.

(1) As used in this section:

(a) "Aggregate" means the sum of all contracts, change orders, and modifications related to a single project.

(b) "Change order" means the same as that term is defined in Section 63G-6a-103.

(c) "Employee" means, as defined in Section 34A-2-104, an "employee," "worker," or "operative" who:

(i) works at least 30 hours per calendar week; and

(ii) meets employer eligibility waiting requirements for health care insurance, which may not exceed the first day of the calendar month following 60 days after the day on which the individual is hired.

(d) "Health benefit plan" means:

(i) the same as that term is defined in Section 31A-1-301[-]; or

(ii) an employee welfare benefit plan:

(A) established under the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001 et seq.;

(B) for an employer with 100 or more employees; and

(C) in which the employer establishes a self-funded or partially self-funded group health plan to provide medical care for the employer's employees and dependents of the employees.

(e) "Qualified health [~~insurance~~] coverage" means the same as that term is defined in Section 26-40-115.

(f) "Subcontractor" means the same as that term is defined in Section 63A-5-208.

(g) "Third party administrator" or "administrator" means the same as that term is defined in Section 31A-1-301.

(2) Except as provided in Subsection (3), the requirements of this section apply to:

(a) a contractor of a design or construction contract entered into by, or delegated to, the department or a division, board, or council of the department on or after July 1, 2009, if the prime contract is in an aggregate amount equal to or greater than $2,000,000; and

(b) a subcontractor of a contractor of a design or construction contract entered into by, or delegated to, the department or a division, board, or council of the department on or after July 1, 2009, if the subcontract is in an aggregate amount equal to or greater than $1,000,000.

(3) This section does not apply to contracts entered into by the department or a division, board, or council of the department if:

(a) the application of this section jeopardizes the receipt of federal funds;

(b) the contract or agreement is between:

(i) the department or a division, board, or council of the department; and

(ii) (A) another agency of the state;

(B) the federal government;

(C) another state;

(D) an interstate agency;

(E) a political subdivision of this state; or

(F) a political subdivision of another state; or

(c) the contract or agreement is:

(i) for the purpose of disbursing grants or loans authorized by statute;

(ii) a sole source contract; or

(iii) an emergency procurement.

(4) A person that intentionally uses change orders, contract modifications, or multiple contracts to circumvent the requirements of this section is guilty of an infraction.

(5) (a) A contractor subject to the requirements of this section shall demonstrate to the department that the contractor has and will maintain an offer of qualified health [~~insurance~~] coverage for the contractor's employees and the employees' dependents during the duration of the contract by submitting to the department a written statement that:

(i) the contractor offers qualified health [~~insurance~~] coverage that complies with Section 26-40-115;

(ii) is from:

(A) an actuary selected by the contractor or the contractor's insurer; [~~or~~]

(B) an underwriter who is responsible for developing the employer group's premium rates; [~~and~~] or

(C) if the contractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or underwriter selected by a third party administrator; and

(iii) was created within one year before the day on which the statement is submitted.

(b) (i) A contractor that provides a health benefit plan described in Subsection (1)(d)(ii) shall provide the actuary or underwriter selected by an administrator, as described in Subsection (5)(a)(ii)(C), sufficient information to determine whether the contractor's contribution to the health benefit plan and the actuarial value of the health benefit plan meet the requirements of qualified health coverage.

(ii) A contractor may not make a change to the contractor's contribution to the health benefit plan, unless the contractor provides notice to:

(A) the actuary or underwriter selected by an administrator, as described in Subsection (5)(a)(ii)(C), for the actuary or underwriter to update the written statement described in Subsection (5)(a) in compliance with this section; and

(B) the department.

[~~(b)~~] (c) A contractor that is subject to the requirements of this section shall:

(i) place a requirement in each of the contractor's subcontracts that a subcontractor that is subject to the requirements of this section shall obtain and maintain an offer of qualified health [~~insurance~~] coverage for the subcontractor's employees and the employees' dependents during the duration of the subcontract; and

(ii) obtain from a subcontractor that is subject to the requirements of this section a written statement that:

(A) the subcontractor offers qualified health [~~insurance~~] coverage that complies with Section 26-40-115;

(B) is from an actuary selected by the subcontractor or the subcontractor's insurer, [~~or~~] an underwriter who is responsible for developing the employer group's premium rates, or if the subcontractor provides a health benefit plan described in Subsection (1)(d)(ii), an actuary or underwriter selected by an administrator; and

(C) was created within one year before the day on which the contractor obtains the statement.

[~~(c)~~] (d) (i) (A) A contractor that fails to maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6).

(B) A contractor is not subject to penalties for the failure of a subcontractor to obtain and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)[~~(b)~~](c)(i).

(ii) (A) A subcontractor that fails to obtain and maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)[~~(b)~~](c) during the duration of the subcontract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6).

(B) A subcontractor is not subject to penalties for the failure of a contractor to maintain an offer of qualified health [~~insurance~~] coverage described in Subsection (5)(a).

(6) The department shall adopt administrative rules:

(a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(b) in coordination with:

(i) the Department of Environmental Quality in accordance with Section 19-1-206;

(ii) a public transit district in accordance with Section 17B-2a-818.5;

(iii) the State Building Board in accordance with Section 63A-5-205.5;

(iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;

(v) the Department of Transportation in accordance with Section 72-6-107.5; and

(vi) the Legislature's Administrative Rules Review Committee; and

(c) that establish:

(i) the requirements and procedures a contractor and a subcontractor shall follow to demonstrate compliance with this section, including:

(A) that a contractor or subcontractor's compliance with this section is subject to an audit by the department or the Office of the Legislative Auditor General;

(B) that a contractor that is subject to the requirements of this section shall obtain a written statement described in Subsection (5)(a); and

(C) that a subcontractor that is subject to the requirements of this section shall obtain a written statement described in Subsection (5)[~~(b)~~](c)(ii);

(ii) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of this section, which may include:

(A) a three-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the first violation;

(B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation;

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6a-904 upon the third or subsequent violation; and

(D) monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health [~~insurance~~] coverage for an employee and a dependent of an employee of the contractor or subcontractor who was not offered qualified health [~~insurance~~] coverage during the duration of the contract; and

(iii) a website on which the department shall post the commercially equivalent benchmark, for the qualified health [~~insurance~~] coverage identified in Subsection (1)(e), provided by the Department of Health, in accordance with Subsection 26-40-115(2).

(7) (a) (i) In addition to the penalties imposed under Subsection (6)(c)(ii), a contractor or subcontractor who intentionally violates the provisions of this section is liable to the employee for health care costs that would have been covered by qualified health [~~insurance~~] coverage.

(ii) An employer has an affirmative defense to a cause of action under Subsection (7)(a)(i) if:

(A) the employer relied in good faith on a written statement described in Subsection (5)(a) or (5)[~~(b)~~](c)(ii); or

(B) the department determines that compliance with this section is not required under the provisions of Subsection (3).

(b) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (7).

(8) Any penalties imposed and collected under this section shall be deposited into the Medicaid Restricted Account created in Section 26-18-402.

(9) The failure of a contractor or subcontractor to provide qualified health [~~insurance~~] coverage as required by this section:

(a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under:

(i) Section 63G-6a-1602; or

(ii) any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

(b) may not be used by the procurement entity or a prospective bidder, offeror, or contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design or construction.

(10) An administrator, including an administrator's actuary or underwriter, who provides a written statement under Subsection (5)(a) or (c) regarding the qualified health coverage of a contractor or subcontractor who provides a health benefit plan described in Subsection (1)(d)(ii):

(a) subject to Subsection (10)(b), is not liable for an error in the written statement, unless the administrator commits gross negligence in preparing the written statement;

(b) is not liable for any error in the written statement if the administrator relied in good faith on information from the contractor or subcontractor; and

(c) may require as a condition of providing the written statement that a contractor or subcontractor hold the administrator harmless for an action arising under this section.