HB0058S02 compared with HB0058S01

~~{Omitted text}~~ shows text that was in HB0058S01 but was omitted in HB0058S02
inserted text shows text that was not in HB0058S01 but was inserted into HB0058S02

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Insurance Code Modifications

2026 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor:Evan J. Vickers

LONG TITLE

General Description:

This bill amends provisions relating to insurance.

Highlighted Provisions:

This bill:

- defines terms;
- authorizes an insurance fraud investigator that the Insurance Department (department) employs to investigate crimes committed by a department licensee;
- amends provisions relating to a captive insurance company that is organized as a risk retention group;
- provides the type of experts the Insurance Commissioner (commissioner) may hire to conduct an examination of a licensee;
- provides that an entity that is subject to examination (examinee) shall pay the costs of an examination;
- provides that the commissioner may use a deposit an examinee makes to pay an examination cost an examinee fails to pay;

HB0058S01

- requires that a deposit an examine makes shall first be used to pay for an unpaid examination cost;
- amends provisions relating to the service of process through a state officer;
- authorizes the commissioner to make rules governing the process for winding down the business of a resident agency title insurance producer;
- exempts a risk retention group from paying an annual fee with the department;
- amends provisions relating to money appropriated from the Captive Insurance Restricted Account;
- requires that an insurer file with the commissioner and the National Association of Insurance Commissioners a quarterly statement of the insurer's financial condition;
- amends provisions relating to the payment of dividends to include domestic mutual insurance holding companies;
- requires that a mutual insurer or mutual insurance company provide the commissioner with a notification before a dividend distribution;
- removes a civil penalty for a director or officer of {~~a~~} an insurance holding company that commits certain violations;
- provides that an insurer may issue a group insurance policy offering life insurance to the trustees of a fund established, created, and maintained for the benefit of members of an association group;
- changes the day on which an insurer shall make an annual report;
- increases the liability coverage a title insurance producer shall maintain;
- amends provisions relating to the type of policies an individual title insurance producer and agency title insurance producer shall maintain;
- increases the amount of coverage an individual title insurance producer or agency title insurance producer shall maintain;
- provides that if an agency title insurance producer becomes aware of facts that indicate an electronic wire funds transfer did not reach the electronic wire funds transfer's intended recipient, the agency title insurance producer make a report of the facts;
- requires that a title insurer report to the commissioner the termination of an appointment of a title insurance producer;
- requires that a nonresident title insurance agency deposit a Utah home buyer's escrow in a depository institution's Utah branch;

- provides that an individual title insurance producer or agency title insurance producer notify the parties to a real estate transaction of a closing protection letter;
- provides that a title insurance licensee is not required to deposit money in a depository institution under certain circumstances;
- repeals certain reporting requirements relating to licensee compensation;
- provides that an insurer shall pay each claim submitted by an insured and a provider;
- amends provisions relating to required contracts involving a public adjuster;
- amends provisions relating to the compensation of a public adjuster;
- enacts provisions that authorize a property insurance policy to prohibit the assignment of property insurance policy rights and benefits;
- provides requirements for the funds a public adjuster holds;
- establishes public adjuster standards of conduct;
- establishes record retention requirements for a public adjuster;
- amends the standards for the conduct of a hearing the commissioner undertakes while engaging in an administrative action against an insurer;
- provides for the applicability of certain statutes to a risk retention group;
- amends the definition of the excess surplus of a captive insurance company;
- expands the authority of the commissioner to suspend or revoke the certificate of authority of a captive insurance company to conduct business in this state;
- changes the day on which an agency title insurance producer is required to pay an assessment;
- amends provisions relating to the actions the commissioner may take against a licensee;
- amends provisions relating to who is required to complete continuing education requirements; {~~and~~}
- **repeals training requirements related to a resident producer;**
- **provides that an ambulance membership organization is a limited health plan under Title 31A, Chapter 8, Health Maintenance Organizations and Limited Health Plans;**
- **provides the registration requirements for an ambulance membership organization;**
- **provides the renewal process for an ambulance membership organization;**
- **provides that an ambulance membership organization shall submit an annual report to the commissioner;**
-

prohibits an ambulance membership organization from selling, offering for sale, or providing an ambulance membership contract to an individual enrolled in Medicaid;

- **enacts marketing requirements and required disclosures for an ambulance membership organization;**
- **authorizes the commissioner to revoke or suspend an ambulance membership organization's license;**
- **exempts foreign ambulance membership organizations from certain sections of code;**
- **removes the director of the Department of Health and Human Services from an annual audit of internal quality control for an organization;**
- **repeals and amends provisions related to long-term care and long-term care insurance;**
- **addresses requirements for insurers that provide dental services to residents in Utah;**
- **requires insurers to allow dental providers to opt out of participation in dental plans under certain circumstances;**
- **addresses a dental insurer's obligation when a paper check is sent to a provider and is returned to the insurer;**
- **prohibits a dental insurer from imposing a fee for paying with a paper check;**
- **prohibits an insurer from interfering with an agreement for service between a patient and dental provider;**
- **addresses claim form requirements;**
- **requires an insurer to provide an explanation of benefits that addresses non-covered services to a patient and provider; and**
- makes technical and conforming changes.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

31A-2-104 , as last amended by Laws of Utah 2020, Chapter 32

31A-2-203 , as last amended by Laws of Utah 2009, Chapter 349

31A-2-205 , as last amended by Laws of Utah 2009, Chapter 355

31A-2-206 , as last amended by Laws of Utah 2007, Chapter 309

31A-2-207 , as last amended by Laws of Utah 2019, Chapter 254

31A-2-310 , as last amended by Laws of Utah 2023, Chapter 194

31A-2-404 , as last amended by Laws of Utah 2025, Chapter 175

31A-3-304 , as last amended by Laws of Utah 2025, Chapter 175

31A-4-113 , as last amended by Laws of Utah 2004, Chapter 2

31A-4-113.5 , as last amended by Laws of Utah 2024, Chapter 120

31A-5-420 , as enacted by Laws of Utah 1985, Chapter 242

31A-8-101 , as last amended by Laws of Utah 2017, Chapter 292

31A-8-102 , as enacted by Laws of Utah 1986, Chapter 204

31A-8-103 , as last amended by Laws of Utah 2018, Chapter 391

31A-8-105 , as last amended by Laws of Utah 1998, Chapter 329

31A-8-209 , as last amended by Laws of Utah 2002, Chapter 308

31A-8-211 , as last amended by Laws of Utah 2020, Chapter 32

31A-8-301 , as last amended by Laws of Utah 2013, Chapter 319

31A-8-404 , as last amended by Laws of Utah 1994, Chapter 314

31A-11-104 , as last amended by Laws of Utah 2007, Chapter 309

31A-14-206 , as last amended by Laws of Utah 2007, Chapter 309

31A-16-111 , as last amended by Laws of Utah 2023, Chapter 401 and last amended by Coordination Clause, Laws of Utah 2023, Chapter 401

31A-17-201 , as last amended by Laws of Utah 2003, Chapter 252

31A-17-202 , as last amended by Laws of Utah 1999, Chapter 131

31A-18-117 , as enacted by Laws of Utah 2025, Chapter 368

31A-20-108 , as last amended by Laws of Utah 2024, Chapter 120

31A-21-310 , as last amended by Laws of Utah 2025, Chapter 302

31A-22-309 , as last amended by Laws of Utah 2020, Chapter 130

31A-22-505 , as last amended by Laws of Utah 2021, Chapter 252

31A-22-605 , as last amended by Laws of Utah 2024, Chapter 120

31A-22-646 , as enacted by Laws of Utah 2017, Chapter 101

31A-22-650 , as last amended by Laws of Utah 2025, Chapter 473

31A-22-701 , as last amended by Laws of Utah 2025, Chapter 175

31A-22-2002 , as last amended by Laws of Utah 2024, Chapter 120

31A-22-2006 , as enacted by Laws of Utah 2020, Chapter 32

31A-23a-111 , as last amended by Laws of Utah 2025, Chapter 175

31A-23a-202 , as last amended by Laws of Utah 2016, Chapter 138

31A-23a-203 , as last amended by Laws of Utah 2017, Chapter 168

31A-23a-203.5 , as last amended by Laws of Utah 2015, Chapter 312

31A-23a-204 , as last amended by Laws of Utah 2024, Chapter 196

31A-23a-401 , as last amended by Laws of Utah 2009, Chapter 12

31A-23a-406 , as last amended by Laws of Utah 2024, Chapter 120

31A-23a-409 , as last amended by Laws of Utah 2023, Chapters 111, 194

31A-23a-501 , as last amended by Laws of Utah 2023, Chapter 16

31A-26-301 , as last amended by Laws of Utah 2002, Chapter 309

31A-26-301.6 , as last amended by Laws of Utah 2025, Chapter 276

31A-26-301.7 , as last amended by Laws of Utah 2025, Chapter 276

31A-26-401 , as enacted by Laws of Utah 2017, Chapter 168

31A-26-402 , as enacted by Laws of Utah 2017, Chapter 168

31A-28-203 , as last amended by Laws of Utah 2002, Chapter 308

31A-35-103 , as last amended by Laws of Utah 2021, Chapter 64

31A-37-102 , as last amended by Laws of Utah 2025, Chapter 175

31A-37-103 , as last amended by Laws of Utah 2019, Chapter 193

31A-37-201 , as last amended by Laws of Utah 2025, Chapter 175

31A-37-204 , as last amended by Laws of Utah 2025, Chapter 175

31A-37-302 , as last amended by Laws of Utah 2025, Chapter 175

31A-37-501 , as last amended by Laws of Utah 2025, Chapter 175

31A-37-505 , as last amended by Laws of Utah 2025, Chapter 175

31A-37-701 , as last amended by Laws of Utah 2025, Chapter 175

31A-41-202 , as last amended by Laws of Utah 2016, Chapter 138

63G-2-305 , as last amended by Laws of Utah 2025, First Special Session, Chapter 17

ENACTS:

31A-8-303 , Utah Code Annotated 1953

31A-8-601 , Utah Code Annotated 1953

31A-8-602 , Utah Code Annotated 1953

31A-8-603 , Utah Code Annotated 1953

31A-8-604 , Utah Code Annotated 1953

31A-8-605 , Utah Code Annotated 1953

31A-22-646.2 , Utah Code Annotated 1953

31A-26-301.8 , Utah Code Annotated 1953

31A-26-403.1 , Utah Code Annotated 1953

31A-26-404 , Utah Code Annotated 1953

31A-26-405 , Utah Code Annotated 1953

31A-26-406 , Utah Code Annotated 1953

RENUMBERS AND AMENDS:

31A-26-407 , (Renumbered from 31A-26-403, as enacted by Laws of Utah 2017, Chapter 168)

REPEALS:

31A-20-109 , as enacted by Laws of Utah 1985, Chapter 242

31A-22-2001 , as enacted by Laws of Utah 2020, Chapter 32

31A-22-2003 , as enacted by Laws of Utah 2020, Chapter 32

31A-22-2004 , as enacted by Laws of Utah 2020, Chapter 32

31A-22-2005 , as enacted by Laws of Utah 2020, Chapter 32

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

Section 1. Section **31A-2-104** is amended to read:

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

(1) The department shall employ professional, technical, and clerical employees as necessary to carry out the duties of the department.

(2) An insurance fraud investigator employed in accordance with Subsection (1) may as 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[~~.~~] ; and

(c) investigate crimes a department licensee commits while performing an activity regulated under this title.

Section 2. Section **31A-2-203** is amended to read:

31A-2-203. Examinations and alternatives.

(1)

(a) When the commissioner determines that information is needed about a matter related to the enforcement of this title, the commissioner may examine the affairs and condition of:

(i) a licensee under this title;

(ii) an applicant for a license under this title;

(iii) a person or organization of persons doing or in process of organizing to do an insurance business in this state; or

(iv) a person who is not, but is required to be, licensed under this title.

(b) When reasonably necessary for an examination under Subsection (1)(a), the commissioner may examine:

(i) so far as it relates to the examinee, an account, record, document, or evidence of a transaction of:

(A) the insurer or other licensee;

(B) an officer or other person who has executive authority over or is in charge of any segment of the examinee's affairs; or

(C) an affiliate of the examinee; or

(ii) a third party model or product used by the examinee.

(c)

(i) On demand, an examinee under Subsection (1)(a) shall make available to the commissioner for examination:

(A) the examinee's own account, record, file, document, or evidence of a transaction; and

(B) to the extent reasonably necessary for an examination, an account, record, file, document, or evidence of a transaction of a person described under Subsection (1)(b).

(ii) Except as provided in Subsection (1)(c)(iii), failure to make an item described in Subsection (1)(c)(i) available is concealment of records under Subsection 31A-27a-207(1)(e).

(iii) If an examinee is unable to obtain an account, record, file, document, or evidence of a transaction from a person described under Subsection (1)(b), that failure is not concealment of records if the examinee immediately terminates the relationship with the other person.

(d)

(i) The commissioner or an examiner may not remove an account, record, file, document, evidence of a transaction, or other property of an examinee from the examinee's offices unless:

(A) the examinee consents in writing; or

(B) a court grants permission.

(ii) The commissioner may make and remove a copy or abstract of the following described in Subsection (1)(d)(i):

(A) an account;

(B) a record;

(C) a file;

(D) a document;

(E) evidence of a transaction; or

(F) other property.

(2)

(a) Subject to the other provisions of this section, the commissioner shall examine as needed and as otherwise provided by law:

(i) every insurer, both domestic and nondomestic;

(ii) every licensed rate service organization; and

(iii) any other licensee.

(b) The commissioner shall examine an insurer, both domestic and nondomestic, no less frequently than once every five years, but the commissioner may use in lieu an examination under Subsection (4) to satisfy this requirement.

(c) The commissioner shall revoke the certificate of authority of an insurer or the license of a rate service organization that has not been examined, or submitted an acceptable in lieu report under Subsection (4), within the past five years.

(d)

(i) Any 25 persons who are policyholders, shareholders, or creditors of a domestic insurer may by verified petition demand a hearing under Section 31A-2-301 to determine whether the commissioner should conduct an unscheduled examination of the insurer.

(ii) Persons demanding the hearing under this Subsection (2)(d) shall be given an opportunity in the hearing to present evidence that an examination of the insurer is necessary.

(iii) If the evidence justifies an examination, the commissioner shall order an examination.

(e)

(i) If the board of directors of a domestic insurer requests that the commissioner examine the insurer, the commissioner shall examine the insurer as soon as reasonably possible.

(ii) If the examination requested under this Subsection (2)(e) is conducted within two years after completion of a comprehensive examination by the commissioner, costs of the requested examination may not be deducted from premium taxes under Section 59-9-102 unless the commissioner's order specifically provides for the deduction.

(f) A bail bond surety company, as defined in Section 31A-35-102, is exempt from:

(i) the five-year examination requirement in Subsection (2)(b);

(ii) the revocation under Subsection (2)(c); and

(iii) Subsections (2)(d) and (2)(e).

(3)

(a) The commissioner may order an independent audit or examination by one or more [~~technical experts, including a certified public accountant or actuary~~] independent contractors, including certified public accountants, investment specialists, and information technology specialists:

(i) in lieu of all or part of an examination under Subsection (1) or (2); or

(ii) in addition to an examination under Subsection (1) or (2).

(b) The commissioner may employ one or more independent contractors who are qualified by knowledge, skill, experience, training, or education to provide specialized assistance in an examination.

[~~(b)~~] (c) [~~An audit or evaluation under~~] A service performed in accordance with this Subsection (3) is subject to Subsection (5), Section 31A-2-204, and Subsection 31A-2-205(4).

(4)

(a) In lieu of all or a part of an examination under this section, the commissioner may accept the report of an examination made by:

(i) the insurance department of another state; or

(ii) another government agency in:

(A) this state;

(B) the federal government; or

(C) another state.

(b) An examination by the commissioner under Subsection (1) or (2) or accepted by the commissioner under this Subsection (4) may use:

(i) an audit completed by a certified public accountant; or

(ii) an actuarial evaluation made by an actuary approved by the commissioner.

(5)

(a) An examination may be comprehensive or limited with respect to the examinee's affairs and condition. The commissioner shall determine the nature and scope of an examination, taking into account all relevant factors, including:

(i) the length of time the examinee has been licensed in this state;

(ii) the nature of the business being examined;

(iii) the nature of the accounting or other records available;

(iv) one or more reports from:

(A) independent auditors; and

(B) self-certification entities; and

(v) the nature of examinations performed elsewhere.

(b) The examination of an alien insurer is limited to one or more insurance transactions and assets in the United States, unless the commissioner orders otherwise after finding that extraordinary circumstances necessitate a broader examination.

(6) To effectively administer this section, the commissioner:

(a) shall:

(i) maintain one or more effective financial condition and market regulation surveillance systems including:

(A) financial and market analysis; and

(B) a review of insurance regulatory information system reports;

(ii) employ a priority scheduling method that focuses on insurers and other licensees most in need of examination; and

(iii) use examination management techniques similar to those outlined in the Financial Condition Examination Handbook of the National Association of Insurance Commissioners; and

(b) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, may make rules pertaining to:

(i) a financial condition and market regulation surveillance system; and

(ii) annual financial reporting requirements similar to those outlined in the Annual Financial Reporting Model Regulation of the National Association of Insurance Commissioners.

Section 3. Section **31A-2-205** is amended to read:

31A-2-205. Examination costs.

(1)

[~~(a)~~] Except as provided in [~~Subsection (3)~~] Subsection (7), an examinee that is one of the following shall [~~reimburse the department~~] pay for the reasonable costs of [~~examinations~~] an examination made under Sections 31A-2-203 and 31A-2-204:

[~~(i)~~] (a) an insurer;

[~~(ii)~~] (b) a rate service organization;

[~~(iii)~~] (c) a subsidiary of an insurer or rate service organization; or

[~~(iv)~~] (d) a life settlement provider.

[~~(b)~~] (2) [~~The following costs shall be reimbursed under this~~] An examinee shall pay the following costs of the department under Subsection (1):

[~~(i)~~] (a) an examiner's actual travel [~~expenses~~] expenses;

[~~(ii)~~] (b) an examiner's reasonable living expense allowance;

[~~(iii)~~] (c) [~~compensation at reasonable rates for all professionals reasonably employed for the examination under Subsection (4);~~] an examiner's actual rate of compensation;

[~~(iv) the administration and supervisory expense of:~~]

[~~(A) the department; and~~]

[~~(B) the attorney general's office; and~~]

(d) each administration expense, support expense, and supervisory expense of the department for the examination; and

[~~(v)~~] (e) an amount necessary to cover fringe benefits [~~authorized by~~] that the commissioner authorizes or as provided by law.

(3) An examinee shall pay the following costs of an independent contractor that the commissioner employs in accordance with Subsection 31A-2-203(3):

(a) the independent contractor's actual travel expenses;

(b) the independent contractor's reasonable living expense;

(c) the independent contractor's compensation; and

(d) an expense that the independent contractor necessarily incurs that the commissioner approves.

[~~(c)~~] (4) In determining rates, the commissioner shall consider the rates recommended and outlined in the examination manual sponsored by the National Association of Insurance Commissioners.

[~~(d)~~] (5) [~~This Subsection (1) applies~~] Subsections (1) through (4) apply to a surplus lines producer to the extent that the examinations are of the surplus line producer's surplus lines business.

[~~(2)~~] (6)

(a) An insurer requesting the examination of one of [~~its~~] the insurer's producers shall pay the cost of the examination to the extent described in Subsections (2) through (4).[~~-~~]

(b) [~~Otherwise~~] If an insurer does not request the examination of one of the insurer's producers as described in Subsection (6)(a), the department shall pay the cost of examining a licensee [~~other than those specified under~~] except for a licensee listed in Subsection (1).

[~~(3)~~] (7)

(a) On the examinee's request or at the commissioner's discretion, the department may pay all or part of the costs of an examination whenever the commissioner finds that [~~because of~~] based on the frequency of examinations or the examinee's financial condition[~~- of the examinee, -~~] :

(i) the imposition of the costs of an examination would place an unreasonable burden on the examinee; and

(ii) the department has sufficient funds to pay the costs of an examination.

(b) The commissioner shall include in the commissioner's annual report information about any instance in which the commissioner has applied this Subsection [~~(3)~~] (7).

[~~(4)~~] (8)

(a) [~~A technical expert employed~~] An independent contractor the commissioner employs under Subsection 31A-2-203(3) shall present to the commissioner [~~a statement of all expenses incurred by the technical expert in conjunction with an examination~~] an invoice for each cost described in Subsection (3).

(b) The [~~examined insurer~~] examinee shall[~~, at the commissioner's direction, pay to a technical expert~~] pay the invoice described in Subsection (8)(a) after the commissioner:

(i) reviews the invoice;

(ii) approves the invoice for payment; and

(iii) delivers the invoice to the examinee with a direction to pay the invoice.

[~~(i)~~

~~(A) actual travel expenses;~~]

[~~(B) reasonable living expenses; and~~]

[~~(C) compensation; and~~]

[~~(ii) for expenses necessarily incurred as approved by the commissioner.~~]

(c) An invoice dispute shall be resolved in accordance with rules the department makes in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

[~~(c) The examined insurer shall reimburse the department for:~~]

[~~(i) a department examiner's:~~]

[~~(A) actual travel expenses; and~~]

[~~(B) reasonable living expenses; and~~]

[~~(ii) the compensation of department examiners involved in the examination.~~]

[~~(d)~~

~~(i) The examined insurer shall certify the consolidated account of all charges and expenses for the examination.~~]

[~~(ii) The examined insurer shall:~~]

[~~(A) retain a copy of the consolidated account; and~~]

[~~(B) file a copy of the consolidated account with the department as a public record.~~]

[~~(e) An annual report of examination charges paid by examined insurers directly to persons employed under Subsection 31A-2-203(3) or to department examiners shall be included with the department's budget request.~~]

[~~(f)~~] (9) [~~Amounts paid directly by examined insurers to persons employed~~] An amount an examinee pays to an independent contractor the commissioner employs under Subsection 31A-2-203(3) or to a department [~~examiners~~] examiner may not be deducted from the department's appropriation.

[~~(5)~~] (10)

(a) The amount payable under [~~Subsection (1) ~~] Subsections (1) through (3) is due 10 days after the day on which [~~the examinee is served with a detailed account of the costs~~] the commissioner directs the examinee to pay the invoice.

(b) Payments [~~received by ~~]the department receives under this Subsection [~~(5)~~] (10) shall be handled as provided by Section 31A-3-101.

[~~(6)~~] (11)

(a) The commissioner may require an examinee under Subsection (1), or an insurer requesting an examination under Subsection [~~(2)~~] (6), either before or during an examination, to make deposits with the state treasurer to pay the costs of examination.

(b) [~~Any~~] The state treasurer shall hold a deposit [~~made~~] an examinee or an insurer makes under this Subsection [~~(6) shall be held~~] (11) in trust [~~by the state treasurer~~]until [~~applied~~] the state treasurer applies the deposit to pay the department the costs payable under this section.

(c) If a deposit made under this Subsection [~~(6)~~] (11) exceeds examination costs, the state treasurer shall refund the surplus.

(12) If an examinee does not timely pay examination costs, the commissioner may satisfy the debt by drawing on a statutory deposit the examinee files in accordance with Section 31A-2-206.

[~~(7)~~] (13) A domestic insurer may offset the examination expenses paid under this section against premium taxes under Subsection 59-9-102(2).

Section 4. Section **31A-2-206** is amended to read:

31A-2-206. Receipt and handling of deposits.

(1) As used in this chapter:

(a) "Custodian institution" means a financial institution in this state as defined under Section 7-1-103 that:

(i) has authority under Title 7, Chapter 5, Trust Business, to engage in a trust business; and

(ii) [~~is approved by~~]the commissioner approves to have custody of deposited securities, whether physically, through the Federal Reserve book-entry system, or through a clearing corporation as defined under Subsection 70A-8-101(1).

(b) "Federal Reserve book-entry system" means the computerized system sponsored by the United States Department of the Treasury and certain other agencies and instrumentalities of the United States for holding and transferring securities of the United States government and other agencies and instrumentalities.

(2) Subject to the commissioner's approval and to the requirements of this section, the state treasurer shall accept, and a custodian institution qualified under Subsection (1)(a) may accept:

(a) deposits required or permitted under this title or rules adopted under this title;

(b) deposits of domestic insurers or of alien insurers domiciled in this state if required by the laws of other states as a prerequisite to authority to do an insurance business in other states; and

(c) deposits resulting from application of any retaliatory provisions of this title.

(3) Deposits authorized under Subsection (2) shall be of securities described in Subsection (7).

(4) Unless otherwise provided by the law requiring or permitting the deposit, each deposit shall be held in trust:

(a) first, for an examination cost that an insurer has not paid in under Section 31A-2-205;

[~~(a)~~] (b) [~~first~~] second, for administrative costs under Subsection 31A-27a-701(2)(a);

[~~(b)~~] (c) [~~second~~] third, for the claimants under Subsection 31A-27a-701(2)(c);

[~~(c)~~] (d) [~~third~~] fourth, for the claimants under Subsection 31A-27a-701(2)(d); and

[~~(d)~~] (e) [~~fourth~~] fifth, for all other creditors in the order of priority established under Section 31A-27a-701.

(5) A claim may be made against the deposit of an alien insurer only if [~~it~~] the claim arises out of a transaction in the United States.

(6) Deposits may be made by:

(a) delivering physical custody and control of the deposited security to the state treasurer or a custodian institution, accompanied by a statement signed by the depositor indicating that the deposit shall be held in trust under the terms of this section and subject to the commissioner's exclusive direction until control is released by the commissioner; or

(b) delivering to the commissioner, on a form adopted by rule, a signed certificate of a custodian institution, describing securities qualifying for deposit under Subsection (7) that are on deposit with a clearing corporation or held in the Federal Reserve book-entry system in the name of the custodian institution, in trust for the purposes stated under this section, and that these securities are subject to the exclusive direction of the commissioner and [~~may not be withdrawn or transferred by any person~~] a person may not withdraw or transfer the securities, including the insurer owning the securities, without the commissioner's written approval.

(7)

(a) [~~Deposits~~] A deposit may consist of [~~any securities~~] a security authorized in Subsection (7)(b) for which there is a ready market if [~~they~~] the deposit:

(i) [~~are~~] is expressly approved by the commissioner;

(ii) [~~are~~] is subject to disposition by the state treasurer or custodian institution only with the concurrence of the commissioner; and

(iii) [~~are~~] is not available to any other person except as expressly provided by law.

(b) The authorized securities are:

(i) deposits or certificates of deposit [~~insured by~~] that the Federal Deposit Insurance Corporation insures;

(ii) bonds or other evidences of indebtedness that are guaranteed as to principal and interest by the United States;

(iii) tax anticipation bonds or notes, general obligation bonds, or revenue bonds of this state or of any county, incorporated city or town, school district, or other political subdivision of this state, if the bonds or notes are rated AAA by Standard and Poor's or an equivalent nationally recognized rating agency;

(iv) bonds or other evidences of indebtedness issued or guaranteed by an agency or instrumentality of the United States; and

(v) any other security [~~approved by~~]the commissioner approves that the commissioner considers an equivalent grade investment to [~~those~~] an authorized security enumerated under Subsections (7)(b)(i) through (iv) based on tests of the safety of principal and liquidity.

(8)

(a) Securities held on deposit shall be valued under Section 31A-17-401 as those investments are valued for life insurers, or at market, whichever is lower.

(b) [~~-~~]The securities shall be revalued whenever the commissioner requests to ensure continued compliance with the requirements of this title.

(9)

(a) The state treasurer or custodian institution shall:

(i) deliver to the depositor a receipt for all securities deposited or held;

(ii) issue a duplicate copy of the receipt to the commissioner; and

(iii) permit the depositor to inspect [~~its~~] the depositor's physically held securities at any reasonable time.

(b) On application of the depositor or when required by the law of any state or country or by the order of [~~any court of competent~~] a court with jurisdiction, the state treasurer or custodian institution shall certify that the deposit was made and what is on deposit.

(c)

(i) Depositors, the state treasurer, [~~any~~] a custodian institution, and the commissioner shall each keep a permanent record of securities deposited or held under this section and of any substitutions or withdrawals.

(ii) [~~They~~] Each person described in Subsection (9)(c)(i) shall compare records at least annually.

(10) A transfer of a deposited security, whether voluntary or by operation of law, is valid only [~~if approved in writing by~~] if the commissioner approves the transfer in writing and [~~countersigned by~~]the state treasurer or custodian institution countersigns the transfer.

(11) Neither a judgment creditor nor other person may levy upon [~~any~~] a deposit held under this section.

(12) A depositor that [~~has complied~~] complies with all provisions of this title intended to preserve [~~its~~] the depositor's financial solidity is, while solvent and complying with the laws of this state, entitled to:

(a) receive interest and cash dividends accruing on the securities held for [~~its~~] the depositor's account; and

(b) substitute for deposited securities other eligible securities, as the commissioner expressly [~~approved by the commissioner~~] approves.

(13) Within 45 days after the day on which the commissioner gives notice to a depositor that a deposit is not an acceptable deposit under Subsection (7), the depositor shall substitute other eligible securities [~~expressly approved by~~]the commissioner expressly approves and allowed under Subsection (7).

(14) A depositor may voluntarily deposit or transfer control of eligible securities in excess of requirements to absorb fluctuations in value and to facilitate substitution of securities.

(15)

(a) Upon the depositor's request and upon approval of the commissioner, any deposit or part of a deposit shall be released to, or on order of, the depositor to the extent not needed to satisfy requirements of this title.

(b) After a hearing, the commissioner may issue an order requiring that a deposit or an appropriate part of the deposit be released to the commissioner to pay an examination cost described in Subsection (4)(a).

(c) [~~-~~]On the order of a court [~~of competent~~] with jurisdiction, the deposit or appropriate part of the deposit shall be released to the person for whom [~~it~~] the deposit is held.

(16) Each depositor shall pay the cost of custody of securities by a custodian institution or by the state treasurer.

(17) The commissioner shall adopt rules to implement this section.

Section 5. Section **31A-2-207** is amended to read:

31A-2-207. Commissioner's records and reports -- Protection from disclosure of certain records.

(1) The commissioner shall maintain all department records that are:

(a) required by law;

(b) necessary for the effective operation of the department; or

(c) necessary to maintain a full record of department activities.

(2) The records of the department may be preserved, managed, stored, and made available for review consistent with:

(a) another Utah statute;

(b) the rules made under Section 63A-12-104;

(c) the decisions of the Records Management Committee made under Section 63A-12-113; or

(d) the needs of the public.

(3) A department record may not be destroyed, damaged, or disposed of without:

(a) authorization of the commissioner; and

(b) compliance with all other applicable laws.

(4) The commissioner shall maintain a permanent record of the commissioner's proceedings and important activities, including:

(a) a concise statement of the condition of each insurer examined by the commissioner; and

(b) a record of all certificates of authority and licenses issued by the commissioner.

(5)

(a) [~~Prior to~~] Before October 1 of each year, the commissioner shall prepare an annual report to the governor which shall include, for the preceding calendar year, the information concerning the department and the insurance industry which the commissioner believes will be useful to the governor and the public.

(b) The report required by this Subsection (5) shall include the information required under Chapter 27a, Insurer Receivership Act, and Subsections 31A-2-106(2), [~~31A-2-205(3)~~] 31A-2-205(7), and 31A-2-208(3).

(c) The commissioner shall make the report required by this Subsection (5) available to the public and industry in electronic format.

(6) All department records and reports are open to public inspection unless specifically provided otherwise by statute or by Title 63G, Chapter 2, Government Records Access and Management Act.

(7) On request, the commissioner shall provide to any person certified or uncertified copies of any record in the department that is open to public inspection.

(8) Notwithstanding Subsection (6) and Title 63G, Chapter 2, Government Records Access and Management Act, the commissioner shall protect from disclosure any record, as defined in Section 63G-2-103, or other document received from an insurance regulator of another jurisdiction:

(a) at least to the same extent the record or document is protected from disclosure under the laws applicable to the insurance regulator providing the record or document; or

(b) under the same terms and conditions of confidentiality as the National Association of Insurance Commissioners requires as a condition of participating in any of the National Association of Insurance Commissioners' programs.

Section 6. Section **31A-2-310** is amended to read:

31A-2-310. Procedure for service of process through state officer.

(1) Service upon the commissioner or lieutenant governor under Section 31A-2-309 is service on the principal, if:

(a) [~~the following~~] two copies of the process to be served and the required processing fee are delivered personally or to the office of the official designated in Section 31A-2-309[~~:~~] ; and

[~~(i) two copies of the process to be served; and~~]

[~~(ii) a certificate of proof of service that meets the requirements of Subsection (3), dated and signed by the official designated in Section 31A-2-309; and~~]

(b) that official mails a copy of the process to the person to be served according to [~~Subsection (2)(b)~~] Subsection (2)(c)(i).

(2)

(a) [~~The~~] Upon request, the commissioner [~~and~~] or the lieutenant governor shall give [~~receipts~~] a receipt for [~~and keep records of~~]all process served through [~~them~~] the commissioner or the lieutenant governor.

(b) The commissioner or the lieutenant governor shall keep a record of process served through the commissioner or the lieutenant governor.

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

(i) The commissioner or the lieutenant governor shall [~~immediately~~]send by certified mail [~~one~~] a copy of the process [~~received~~] the commissioner or the lieutenant governor receives to the person to be served at that person's last known principal place of business, residence, or post-office address.

(ii) [–]The commissioner or the lieutenant governor shall retain [~~the other~~] a copy [~~for his files~~] of the process in a file.

[~~(c)~~] (d) No plaintiff or complainant may take a judgment by default in [~~any~~] a proceeding in which process is served under this section and Section 31A-2-309 until the expiration of 40 days from the date of service of process under [~~Subsection (2)(b)~~] Subsection (2)(c)(i).

(3)

(a) [~~Proof~~] The official designated in Section 31A-2-309 shall evidence proof of service [~~shall be evidenced~~]by a certificate:

(i) [~~by the official designated in Section 31A-2-309,~~]showing service made upon [~~him~~] the official and mailing by [~~him,~~] the official; and

(ii) [~~-~~] that is attached to a copy of the process presented to [~~him~~] the official for that purpose.

(b) A person seeking evidence of proof of service shall:

(i) prepare the certificate described in Subsection (3)(a); and

(ii) obtain the signature of the official designated in Section 31A-2-309.

(4) When process is served under this section, the words "twenty days" in the first sentence of Rule 12(a) of the Utah Rules of Civil Procedure shall be changed to read "forty days."

Section 7. Section **31A-2-404** is amended to read:

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

(1)

(a) Notwithstanding the other provisions of this chapter, to the extent provided in this part, the commissioner shall administer and enforce the provisions in this title related to a title insurance matter.

(b)

(i) The commissioner may impose a penalty:

(A) under this title related to a title insurance matter;

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

(C) that [~~is enforced by~~]the commissioner enforces.

(ii) The commissioner shall consult with and seek concurrence of the commission in a meeting subject to Title 52, Chapter 4, Open and Public Meetings Act, regarding the imposition of a penalty, and if concurrence cannot be reached, the commissioner has final authority.

(c)

(i) Unless a provision of this title grants specific authority to the commission, the commissioner has authority over the implementation of this title related to a title insurance matter.

(ii) When a provision requires concurrence between the commission and commissioner, and concurrence cannot be reached, the commissioner has final authority.

(d) Except as provided in Subsection (1)(e), when this title requires concurrence between the commissioner and commission related to a title insurance matter:

(i) the commissioner shall report to and update the commission on a regular basis related to that title insurance matter; and

(ii) the commission shall review the report [~~submitted by~~]the commissioner submits under this Subsection (1)(d)[~~;~~] and:

(A) concur with the report; or

(B) provide a reason for not concurring with the report and provide recommendations to the commissioner.

(e) When this title requires concurrence between the commissioner and commission under Subsection (2), (3), or (4):

(i) the commission shall report to and update the commissioner on a regular basis related to that title insurance matter; and

(ii) the commissioner shall review a report [~~submitted by~~]the commission submits under this Subsection (1)(e) and concur with the report or:

(A) provide a reason for not concurring with the report; and

(B) provide recommendations to the commission.

(2) The commission shall:

(a) subject to Subsection (4), make rules for the administration of the provisions in this title related to title insurance matters including rules related to:

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

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

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

(iv) standards of conduct for a title licensee;

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

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

(d) on a regular basis advise the commissioner of the most critical matters affecting the title insurance industry and request the commissioner to direct the department's investigative resources to investigate and enforce those matters;

(e) in accordance with Section 31A-23a-204, participate in the annual license testing evaluation [~~conducted by~~]the commissioner's test administrator conducts;

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

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

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

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

(b) subject to Subsection (4).

(4)

(a) The commission may make a rule under this title only:

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

(ii) with the concurrence of the commissioner, except that if concurrence cannot be reached, the commissioner has final authority; and

(iii) if at the time the commission files the commission's proposed rule and rule analysis with the Office of Administrative Rules in accordance with Section 63G-3-301, the commission provides the Real Estate Commission that same information.

(b) The commission may not make a rule regarding adjudicative procedures.

(c) In accordance with Section 31A-2-201, the commissioner may make rules regarding adjudicative procedures.

(5)

(a) The commissioner shall annually report the information described in Subsection (5)(b) in writing to the commission.

(b) The information required to be reported under this Subsection (5):

(i) may not identify a person; and

(ii) shall include:

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

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

(C) for each complaint described in Subsection (5)(b)(ii)(A):

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

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

(6) The commissioner may make rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, that govern the process for winding down the business of a resident agency title insurance producer.

Section 8. Section **31A-3-304** is amended to read:

31A-3-304. Annual fees -- Other taxes or fees prohibited -- Captive Insurance Restricted Account.

(1)

(a) A captive insurance company, other than a risk retention group, shall pay an annual fee imposed under this section to obtain or renew a certificate of authority.

(b) [~~The~~] Except as provided in Subsection (1)(c), the commissioner shall:

(i) determine the annual fee in accordance with Section 31A-3-103; and

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

(c) The annual fee for a captive insurance company organized as a risk retention group formed in this state as a corporation or other limited liability entity under the Liability Risk Retention Act of 1986, 15 U.S.C. Sec. 3901 et seq.:

(i) subject to Subsection (1)(c)(ii), shall be 2% of the company's gross written premiums; and

(ii) may not exceed $200,000.

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

(3)

(a) A captive insurance company that pays one of the following fees is exempt from Title 59, Chapter 7, Corporate Franchise and Income Taxes, and Title 59, Chapter 9, Taxation of Admitted Insurers:

(i) a fee under this section;

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

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

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

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

(4) A captive insurance company shall pay the fee imposed by this section to the commissioner by June 1 of each year.

(5)

(a) The commissioner shall deposit money received from a fee described in Subsection (3)(a) into the Captive Insurance Restricted Account.

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

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

(d)

(i) The commissioner shall administer the Captive Insurance Restricted Account.

(ii) [–]Subject to appropriations by the Legislature, the commissioner shall use the money [~~deposited~~] the commissioner deposits into the Captive Insurance Restricted Account to:

[~~(i)~~] (A) administer and enforce[~~:~~]

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

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

[~~(ii)~~] (B) promote the captive insurance industry in Utah.

(e) An appropriation from the Captive Insurance Restricted Account is nonlapsing, except that at the end of each fiscal year, money [~~received by~~]the commissioner receives in excess of the legislative appropriation for the fiscal year that just ended shall be treated as free revenue in the General Fund:

[~~(i) for fiscal year 2025, in excess of $1,650,000; and~~]

[~~(ii)~~] (i) for fiscal year 2026[~~ and subsequent fiscal years~~], in excess of $1,668,500[~~.~~] ; and

(ii) for fiscal year 2027 and subsequent fiscal years, in excess of $1,687,500.

Section 9. Section **31A-4-113** is amended to read:

31A-4-113. Annual and quarterly statements.

(1)

(a) Each authorized insurer shall annually, on or before March 1, file with the commissioner and the NAIC a true statement of the authorized insurer's financial condition, transactions, and affairs as of December 31 of the preceding year.

(b) The statement required by Subsection (1)(a) shall be:

(i) verified by the oaths of at least two of the insurer's principal officers; and

(ii) in the general form and provide the information as prescribed by the commissioner by rule.

[~~(c) The commissioner may, for good cause shown, extend the date for filing the statement required by Subsection (1)(a).~~]

(2)

(a) Each authorized insurer shall file with the commissioner and the NAIC a true statement of the insurer's financial condition, transactions, and affairs within 45 days after the close of the first, second, and third quarters of a calendar year.

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

(i) verified by the oath of at least two of the insurer's principal officers; and

(ii) in the general form and provide the information the commissioner requires by rule.

[~~(2)~~] (3) The annual statement of an alien insurer shall:

(a) relate only to the alien insurer's transactions and affairs in the United States unless the commissioner requires otherwise; and

(b) be verified by:

(i) the insurer's United States manager; or

(ii) the insurer's authorized officers.

(4) The commissioner may, for good cause shown, extend the date for filing a statement required by this section.

Section 10. Section **31A-4-113.5** is amended to read:

31A-4-113.5. Filing requirements -- National Association of Insurance Commissioners.

(1)

(a) Each domestic, foreign, and alien insurer who is authorized to transact insurance business in this state shall annually file with the NAIC:

(i) [-]a copy of the insurer's:

[~~(i)~~] (A) annual statement convention blank on or before March 1;

[~~(ii)~~] (B) market conduct annual statements on or before the applicable date determined by the NAIC; and

(C) quarterly report required by Subsection 31A-4-113(2); and

[~~(iii)~~] (ii) any additional [~~filings required by~~] filing the commissioner requires for the preceding year.

(b)

(i) The information [~~filed~~] an insurer files with the NAIC under Subsection [~~(1)(a)(i)~~] (1)(a)(i)(A) shall:

(A) be prepared in accordance with the NAIC's:

(I) annual statement instructions; and

(II) Accounting Practices and Procedures Manual; and

(B) include:

(I) the signed jurat page; and

(II) the actuarial certification.

(ii) An insurer shall file with the NAIC amendments and addenda to information filed with the commissioner under Subsection [~~(1)(a)(i)~~] (1)(a)(i)(A).

(c) [~~The~~] An insurer shall prepare the information [~~filed~~] an insurer files with the NAIC under [~~Subsection (1)(a)(ii) shall be prepared~~] Subsections (1)(a)(i)(B) and (C) in accordance with the NAIC's Market Conduct Annual Statement Industry User Guide.

(d) At the time an insurer makes a filing under this Subsection (1), the insurer shall pay any filing fees assessed by the NAIC.

(e) A foreign insurer that is domiciled in a state that has a law substantially similar to this section shall be considered to be in compliance with this section.

(2) All financial analysis ratios and examination synopses concerning insurance companies that are submitted to the department by the Insurance Regulatory Information System are confidential and may not be disclosed by the department.

(3) The commissioner may suspend, revoke, or refuse to renew the certificate of authority of [~~any~~] an insurer [~~failing~~] that fails to:

(a) submit the filings under Subsection (1)(a) when due or within any extension of time granted for good cause by:

(i) the commissioner; or

(ii) the NAIC; or

(b) pay by the time specified in Subsection (3)(a) a fee the insurer is required to pay under this section to:

(i) the commissioner; or

(ii) the NAIC.

Section 11. Section **31A-5-420** is amended to read:

31A-5-420. Payment of dividends by mutual insurers and mutual insurance holding companies.

(1) When [~~it~~] doing so is in the best interests of the company, the directors of a domestic mutual insurer or a domestic mutual insurance holding company shall declare, apportion, and pay to [~~its~~] the domestic mutual insurer's or the domestic mutual insurance holding company's members dividends from [~~its~~] the domestic mutual insurer's or the domestic mutual insurance holding company's net savings and earnings.

(2)

(a) The mutual insurer or mutual insurance holding company shall make a reasonable classification of [~~its~~] the mutual insurer's or the mutual insurance holding company's participating policies and [~~its~~] the mutual insurer's or the mutual insurance holding company's assumed risks.

(b) [–]No dividend shall be paid that is inequitable, unfairly discriminates between classifications of insurance contracts, or unfairly discriminates between policies within the same classification.

(3) Unless stated in the policy, no dividend, otherwise earned, shall be contingent upon the payment of the renewal premium on [~~any~~] a policy.

(4) Subsection (1) may not be construed to require [~~an insurer determined by~~] a mutual insurer or mutual insurance holding company that the United States Internal Revenue Service determines to be a nonprofit organization to pay a dividend in a manner which would jeopardize that status.

(5)

(a) At least 30 days before the day on which a dividend distribution occurs, a mutual insurer or mutual insurance holding company shall file with the commissioner a schedule explaining the basis for the dividend distribution.

(b) The commissioner shall keep a schedule a mutual insurer or mutual insurance holding company files in accordance with this Subsection (5) confidential unless the commissioner finds that the interests of insureds and the public require that the commissioner make the schedule public.

Section 12. Section **31A-8-101** is amended to read:

31A-8-101. Definitions.

[~~For purposes of~~] As used in this chapter:

(1)

(a) "Ambulance membership organization" means a person that offers an ambulance membership plan.

(b) "Ambulance membership organization" does not include a person that offers ambulance services.

(2) "Ambulance membership plan" means a contract in which one party agrees to reimburse the following expenses for another party in the event of an emergency:

(a) air ambulance charges;

(b) ground ambulance charges;

(c) transportation expenses to return the member to the member's primary residence;

(d) transportation expenses to return a member's companion to the companion's primary residence;

(e) vehicle return expenses; and

(f) other transportation and related services, if:

(i) the commissioner approves the transportation and related services; and

(ii) the transportation and related services are consistent with this chapter.

[~~(1)~~] (3) "Basic health care services" means:

(a) emergency care;

(b) inpatient hospital and physician care;

(c) outpatient medical services; and

(d) out-of-area coverage.

(4) "Companion" means an individual who travels with a member.

(5) "Governmental entity" means the governing body of a county or municipality in this state.

[~~(2)~~] (6) "Health maintenance organization" means any person:

(a) other than:

(i) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance Corporations; or

(ii) an individual who contracts to render professional or personal services that the individual directly performs; and

(b) that:

(i) furnishes at a minimum, either directly or through arrangements with others, basic health care services to an enrollee in return for prepaid periodic payments agreed to in amount [~~prior to~~] before the time during which the health care may be furnished; and

(ii) is obligated to the enrollee to arrange for or to directly provide available and accessible health care.

[~~(3)~~] (7)

(a) "Limited health plan" means, except as [~~limited under~~] provided in Subsection [~~(3)(b),~~] (7)(b):

(i) [~~-~~]a person who furnishes dental or vision services, either directly or through arrangements with others:

[~~(i)~~] (A) to an enrollee;

[~~(ii)~~] (B) in return for prepaid periodic payments agreed to in amount [~~prior to~~] before the time during which the services may be furnished; and

[~~(iii)~~] (C) for which the person is obligated to the enrollee to arrange for or directly provide the available and accessible services described in this Subsection [~~(3)(a).~~] (7)(a); or

(ii) an ambulance membership plan.

(b) "Limited health plan" does not include:

(i) a health maintenance organization;

(ii) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance Corporations; or

(iii) an individual who contracts to render professional or personal services that the individual performs.

(8) "Medicaid program" means the same as that term is defined in Section 26B-3-101.

[~~(4)~~] (9)

(a) "Nonprofit organization" or "nonprofit corporation" means an organization no part of the income of which is distributable to its members, trustees, or officers, or a nonprofit cooperative association, except in a manner allowed under Section 31A-8-406.

(b) "Nonprofit health maintenance organization" and "nonprofit limited health plan" are used when referring specifically to one of the types of organizations with "nonprofit" status.

[~~(5)~~] (10) "Organization" means a health maintenance organization and limited health plan, unless used in the context of:

(a) "organization expenses," which is described in Section 31A-8-208[~~.~~] ; or

(b) "organization permit," which is described in Sections 31A-8-204 and 31A-8-206[~~; or~~] .

[~~(6)~~] (11) "Uncovered expenditures" means the costs of health care services that are covered by an organization for which an enrollee is liable in the event of the organization's insolvency.

[~~(7)~~] (12) "Unusual or infrequently used health services" means those health services that are projected to involve fewer than 10% of the organization's enrollees' encounters with providers, measured on an annual basis over the organization's entire enrollment.

Section 13. Section **31A-8-102** is amended to read:

31A-8-102. Scope and purposes.

(1) No person may operate an organization in this state without complying with and obtaining a certificate of authority under this chapter.

(2) The purposes of this chapter include to:

(a) provide for the establishment of health maintenance organizations which provide readily available, accessible, and quality comprehensive health care to their enrollees;

(b) provide for the establishment of limited health plans which provide readily available, accessible, and quality care to their enrollees;

(c) encourage the development of organizations as an alternative method of health care delivery; and

(d) assure that organizations [~~offering health plans~~]within this state are financially and administratively sound and that these organizations are in fact able to deliver the benefits as promised.

Section 14. Section **31A-8-103** is amended to read:

31A-8-103. Applicability to other provisions of law.

(1)

(a) Except for exemptions specifically granted under this title, an organization is subject to regulation under all of the provisions of this title.

(b) Notwithstanding any provision of this title, an organization licensed under this chapter:

(i) is wholly exempt from:

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

(B) Chapter 9, Insurance Fraternals;

(C) Chapter 10, Annuities;

(D) Chapter 11, Motor Clubs;

(E) Chapter 12, State Risk Management Fund; and

(F) Chapter 19a, Utah Rate Regulation Act; and

(ii) is not subject to:

(A) Chapter 3, Department Funding, Fees, and Taxes, except for Part 1, Funding the Insurance Department;

(B) Section 31A-4-107;

(C) Chapter 5, Domestic Stock and Mutual Insurance Corporations, except for provisions specifically made applicable by this chapter;

(D) Chapter 14, Foreign Insurers, except for provisions specifically made applicable by this chapter;

(E) Chapter 17, Determination of Financial Condition, except:

(I) Part 2, Qualified Assets, and Part 6, Risk-Based Capital; or

(II) as made applicable by the commissioner by rule consistent with this chapter;

(F) Chapter 18, Investments, except as made applicable by the commissioner by rule consistent with this chapter; and

(G) Chapter 22, Contracts in Specific Lines, except for Part 6, Accident and Health Insurance, Part 7, Group Accident and Health Insurance, and Part 12, Reinsurance.

(2) The commissioner may by rule waive other specific provisions of this title that the commissioner considers inapplicable to limited health plans, upon a finding that the waiver will not endanger the interests of:

(a) enrollees;

(b) investors; or

(c) the public.

(3) Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, and Title 16, Chapter 10a, Utah Revised Business Corporation Act, do not apply to an organization except as specifically made applicable by:

(a) this chapter;

(b) a provision referenced under this chapter; or

(c) a rule adopted by the commissioner to deal with corporate law issues of health maintenance organizations that are not settled under this chapter.

(4)

(a) Whenever in this chapter, Chapter 5, Domestic Stock and Mutual Insurance Corporations, or Chapter 14, Foreign Insurers, is made applicable to an organization, the application is:

(i) of those provisions that apply to a mutual corporation if the organization is nonprofit; and

(ii) of those that apply to a stock corporation if the organization is for profit.

(b) When Chapter 5, Domestic Stock and Mutual Insurance Corporations, or Chapter 14, Foreign Insurers, is made applicable to an organization under this chapter, "mutual" means nonprofit organization.

(5) Solicitation of enrollees by an organization is not a violation of any provision of law relating to solicitation or advertising by health professionals if that solicitation is made in accordance with:

(a) this chapter; and

(b) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries.

(6) This title does not prohibit any health maintenance organization from meeting the requirements of any federal law that enables the health maintenance organization to:

(a) receive federal funds; or

(b) obtain or maintain federal qualification status.

(7) Except as provided in Chapter 45, Managed Care Organizations, an organization is exempt from statutes in this title or department rules that restrict or limit the organization's freedom of choice in contracting with or selecting health care providers, including Section 31A-22-618.

(8) An organization is exempt from the assessment or payment of premium taxes imposed by Sections 59-9-101 through 59-9-104.

(9) An ambulance membership organization that complies with this chapter is exempt from the requirements of Section 31A-4-113.5.

Section 15. Section **31A-8-105** is amended to read:

31A-8-105. General powers of organizations.

[~~Organizations~~]

(1) Except as provided in Subsection (2), an organization may:

[~~(1)~~] (a) buy, sell, lease, encumber, construct, renovate, operate, or maintain hospitals, health care clinics, other health care facilities, and other real and personal property incidental to and reasonably necessary for the transaction of the business and for the accomplishment of the purposes of the organization;

[~~(2)~~] (b) furnish health care through providers which are under contract with the organization;

[~~(3)~~] (c) contract with insurance companies licensed in this state or with health service corporations authorized to do business in this state for insurance, indemnity, or reimbursement for the cost of health care furnished by the organization;

[~~(4)~~] (d) offer to [~~its~~] the organization's enrollees, in addition to health care, insured indemnity benefits, but only for emergency care, out-of-area coverage, unusual or infrequently used health services as defined in [-]Section 31A-8-101, and adoption benefits as provided in Section 31A-22-610.1;

[~~(5)~~] (e) receive from governmental or private agencies payments covering all or part of the cost of the health care furnished by the organization;

[~~(6)~~] (f) lend money to a medical group under contract with it or with a corporation under its control to acquire or construct health care facilities or for other uses to further its program of providing health care services to its enrollees;

[~~(7)~~] (g) be owned jointly by health care professionals and persons not professionally licensed without violating Utah law; and

[~~(8)~~] (h) do all other things necessary for the accomplishment of the purposes of the organization.

(2) An ambulance membership organization may not offer any benefit other than an ambulance membership plan.

Section 16. Section **31A-8-209** is amended to read:

31A-8-209. Minimum capital or minimum permanent surplus.

(1)

(a) A health maintenance organization being organized or operating under this chapter shall have and maintain a minimum capital or minimum permanent surplus of $100,000.

(b) Each health maintenance organization authorized to do business in this state shall have and maintain qualified assets as defined in Subsection 31A-17-201(2) in an amount not less than the total of:

(i) the health maintenance organization's liabilities;

(ii) the health maintenance organization's minimum capital or minimum permanent surplus required by Subsection (1)(a); and

(iii) the greater of:

(A) the company action level RBC as defined in Subsection 31A-17-601(8)(b); or

(B) $1,300,000.

(2)

(a) [~~The~~] Except as provided in Subsection (3), the minimum required capital or minimum permanent surplus for a limited health plan may not:

(i) be less than $10,000; or

(ii) exceed $100,000.

(b) The initial minimum required capital or minimum permanent surplus for a limited health plan required by Subsection (2)(a) shall be set by the commissioner, after:

(i) a hearing; and

(ii) consideration of:

(A) the services to be provided by the limited health plan;

(B) the size and geographical distribution of the population the limited health plan anticipates serving;

(C) the nature of the limited health plan's arrangements with providers; and

(D) the arrangements, agreements, and relationships of the limited health plan in place or reasonably anticipated with respect to:

(I) insolvency insurance;

(II) reinsurance;

(III) lenders subordinating to the interests of enrollees and trade creditors;

(IV) personal and corporate financial guarantees;

(V) provider withholds and assessments;

(VI) surety bonds;

(VII) hold harmless agreements in provider contracts; and

(VIII) other arrangements, agreements, and relationships impacting the security of enrollees.

(c) Upon a material change in the scope or nature of a limited health plan's operations, the commissioner may, after a hearing, alter the limited health plan's minimum required capital or minimum permanent surplus.

(3)

(a) An ambulance membership organization organized under this chapter shall:

(i) establish and maintain a funded reserve account consisting of unencumbered assets of either cash or cash equivalents, equal to at least 20% of the gross earned fee income the ambulance membership organization receives on all active ambulance membership contracts that the ambulance membership organization sells or renews in this state on or after May 6, 2026;

(ii) post a surety bond with one or more surety companies that the commissioner approves in an amount of at least $5,000 for every 100 members of the ambulance membership organization who are residents of this state;

(iii) maintain additional securities the commissioner requires by rule in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and

(iv) pay the costs of collection upon a judgment in favor of a member and attorney fees in a successful action brought by member against the ambulance membership organization.

(b) The reserve account described in Subsection (3)(a) shall be:

(i) maintained in a financial institution that the commissioner approves; and

(ii) a separate, auditable account for the ambulance membership organization's ambulance membership contracts in force in this state.

[~~(3)~~] (4) The commissioner may allow the minimum capital or permanent surplus account of an organization to be designated by some other name.

[~~(4)~~] (5) A pattern of persistent deviation from the accounting and investment standards under this section may be grounds for the commissioner to find that the one or more persons with authority to make the organization's accounting or investment decisions are incompetent for purposes of Subsection 31A-5-410(3).

Section 17. 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) 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~~] Subject to Subsection (3)(c), 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.

(c) This Subsection (3) does not apply to an ambulance membership organization.

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

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

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

(2)

(a) To do business in this state as an organization, a foreign corporation doing a similar business in other states shall incorporate a subsidiary and license [~~it~~] the subsidiary under Part 2, Domestic Organizations, for [~~its~~] the foreign organization's Utah business.

(b) [–]Except as [~~to~~] provided in Chapter 16, Insurance Holding Companies, the laws applicable to a domestic organization apply only to the domestic organization and not to [~~its~~] the domestic organization's foreign parent corporation.

(3) A foreign ambulance membership organization with a limited health plan certificate of authority that complies with Part 2, Domestic Organizations, is exempt from this part.

Section 19. Section **19** is enacted to read:

31A-8-303. Foreign ambulance membership organizations.

A foreign ambulance membership organization limited health plan is exempt from:

(1) Section 31A-8-204;

(2) Section 31A-8-205;

(3) Section 31A-8-206;

(4) Section 31A-8-211;

(5) Section 31A-8-214;

(6) Section 31A-8-215;

(7) Section 31A-8-216; and

(8) Section 31A-8-217.

Section 20. Section **31A-8-404** is amended to read:

31A-8-404. Annual audit of internal quality control.

(1) Each organization shall prepare an annual report of the effectiveness of the organization's internal quality control.

(2) [–]The annual report shall be:

(a) [-]in a form [~~prescribed by~~]the commissioner [~~after consultation with the director of the Department of Health,~~] approves; and

(b) [~~-shall be~~]certified and signed by two officers of the organization.

(3) [–]The commissioner may at any time require an audit of an organization's quality control system.

(4) [–]The audit shall be performed by qualified persons designated by the commissioner.

(5) [–]Auditors shall have full access to all records of the organization and [~~its~~] the organization's providers, including medical records of individual patients.

(6) [–]The information contained in the medical records of individual patients shall remain confidential, and information derived from those records may not be used in a manner that could directly or indirectly identify an individual.

(7) [–]All information, interviews, reports, statements, memoranda, or other data furnished by reason of the audit and any findings or conclusions of the auditors are privileged and are not subject to discovery, use, or receipt in evidence in [~~any~~] a legal proceeding except hearings before the commissioner [~~or the director of the Department of Health~~]concerning alleged violations of the provisions of this chapter.

Section 21. Section **21** is enacted to read:

Part 6. Ambulance Membership Plans

31A-8-601. Definitions.

Reserved.

Section 22. Section **22** is enacted to read:

31A-8-602. Ambulance membership plan requirements.

(1) An ambulance membership organization may assess a one-time application processing fee to the ambulance membership organization's members that may not exceed $25.

(2) If an ambulance membership organization cancels an ambulance membership plan for any reason other than nonpayment of charges by a member, the ambulance membership organization shall issue a pro rata refund of all periodic charges and membership fees to the member.

(3) An ambulance membership organization, or a person that sells an ambulance membership plan for an ambulance membership organization, shall disclose each charge and fee for each ambulance membership plan to each prospective member.

(4) An ambulance membership organization shall provide the terms and conditions of an ambulance membership plan to each prospective enrollee before the day on which the prospective enrollee enters into the ambulance membership plan.

(5) An ambulance membership organization shall file a copy of each ambulance membership plan with the commissioner before the ambulance membership plan goes into effect.

(6) An ambulance membership plan described in Subsection (5) shall:

(a) identify the ambulance membership organization, including the ambulance membership organization's:

(i) physical address;

(ii) website address; and

(iii) toll-free phone number;

(b) conspicuously state:

(i) the total purchase price of the ambulance membership plan, including any membership fees; and

(ii) that the ambulance membership plan is not an insurance contract;

(c) state:

(i) the terms under which the ambulance membership plan is to be paid;

(ii) any cost sharing requirements;

(iii) the services the ambulance membership organization shall provide under the ambulance membership plan, and any limitation, exception, or exclusion;

(iv) any term, restriction, or condition that governs the cancellation of the ambulance membership plan by either the enrollee or the ambulance membership organization;

(v) that if the enrollee cancels the ambulance membership plan within 30 days after the day on which the enrollee purchases the ambulance membership plan, the ambulance membership organization shall refund to the enrollee:

(A) any one-time charge the enrollee pays that exceeds $25; and

(B) each periodic charge and membership fee the enrollee pays; and

(vi) what constitutes acceptable insurance coverage if eligibility for the ambulance membership plan is conditioned on the member's current and continuing health insurance coverage; and

(d) define "medical necessity," if membership coverage of a transport is conditioned on a finding of medical necessity.

Section 23. Section **23** is enacted to read:

31A-8-603. Certificate of authority renewal -- Reporting requirements.

(1) At least 90 days before the day on which an ambulance membership organization's certificate of authority expires, the ambulance membership organization seeking renewal of the ambulance membership organization's certificate of authority shall submit an annual report to the commission in a form the commissioner approves.

(2) The report described in Subsection (1) shall include:

(a) an updated list of the name and address of each ambulance provider of the ambulance membership organization, including:

(i) the extent and nature of any contract or arrangement with the ambulance provider; and

(ii) any possible conflict of interest between the ambulance membership organization and ambulance provider;

(b) the number of members in this state who are enrolled in an ambulance membership plan that the ambulance membership organization offers;

(c) a list of each ambulance membership plan currently active or entered into with a governmental entity that provides membership of the ambulance membership organization to each resident of the governmental entity; and

(d) any other information related to the ambulance membership organization that the commissioner requires to ensure compliance with this chapter.

(3)

(a) The commissioner may not renew an ambulance membership organization's certificate of authority if the ambulance membership organization fails to file a complete annual report in accordance with Subsection (1).

(b) If the commissioner does not renew an ambulance membership organization's certificate of authority in accordance with Subsection (3)(a), the ambulance membership organization may not enroll new members or do business in this state until:

(i) the ambulance membership organization submits a new application for a certificate of authority; and

(ii) the commissioner approves the application.

Section 24. Section **24** is enacted to read:

31A-8-604. Ambulance membership restrictions -- Medicaid program.

(1) An ambulance membership organization may not knowingly sell, offer for sale, or provide an ambulance membership plan to an individual who is enrolled in the Medicaid program.

(2)

(a) If an individual who enters into an ambulance membership plan subsequently enrolls in the Medicaid program during the term of the ambulance membership plan, the individual shall notify the ambulance membership organization of the enrollment within 30 days of the day on which the individual enrolls in the Medicaid program.

(b) If the individual notifies the ambulance membership organization in accordance with Subsection (2)(a), the ambulance membership organization shall provide the individual a prorated refund of any consideration the individual pays for the period from the effective date of the Medicaid program enrollment through the day on which the ambulance membership plan expires.

(c) If the individual does not notify the ambulance membership organization in accordance with Subsection (2)(a):

(i) the individual is not entitled to a prorated refund; and

(ii) the ambulance membership organization shall unenroll the individual from the ambulance membership plan within 30 days of the day on which the ambulance membership organization receives notice of the individual's enrollment in the Medicaid program.

Section 25. Section **25** is enacted to read:

31A-8-605. Marketing requirements -- Required disclosures.

(1) Each advertisement, marketing material, brochure, ambulance membership card, presentation, and any other communication of an ambulance membership organization shall be truthful and not misleading in fact or in implication.

(2) An ambulance membership organization advertising or marketing the ambulance membership organization's ambulance membership plan to residents of this state:

(a) shall file each written advertisement and marketing material to the commissioner for review in compliance with this chapter; and

(b) may not:

(i) use language in the ambulance membership organization's advertisements or marketing that could reasonably mislead a person into believing that the ambulance membership plan is insurance;

(ii) use language in the ambulance membership organization's advertisement, marketing material, brochure, or presentation in relation to the following that could reasonably mislead an individual into believing that the ambulance membership plan is insurance or has been endorsed by the state or a governmental entity:

(A) the ambulance membership organization's certificate of authority or registration with the department or other state department of insurance; or

(B) the ambulance membership organization's relationship to a governmental entity; or

(iii) have a restriction on access to the ambulance membership organization, including a waiting period or notification period.

(3) An ambulance membership organization shall make the following general disclosures in writing, in bold, and in at least 12-point font on the first content page of an advertisement, marketing material, or brochure the ambulance membership organization makes available to prospective members or the public:

(a) the ambulance membership plan is a membership plan and is not insurance coverage; and

(b) the toll-free phone number and website address where the ambulance membership organization's prospective members may obtain additional information about the services the ambulance membership organization offers.

(4) An ambulance membership organization shall provide the disclosures required by Subsection (3) orally to an individual who makes initial contact with the ambulance membership organization by telephone.

(5) Before a person enters into an ambulance membership plan with an ambulance membership organization, the ambulance membership organization shall mail, give, or, with consent of the person, email to the person a separate document that, in bold and in at least 12-point font, states the following disclosures:

(a) the ambulance membership plan is not insurance coverage;

(b) if eligible and covered under Medicare, the prospective enrollee may consult with a representative of the Medicare program to determine:

(i) the extent of applicable Medicare coverage; and

(ii) what the prospective member's payment obligations would be if the prospective enrollee were transported by ambulance;

(c) a detailed list of each one-time and periodic fee the ambulance membership organization charges or will charge to the prospective enrollee to join the ambulance membership organization and continue membership in the ambulance membership organization;

(d) the counties and areas in this state that the ambulance membership organization serves, including any restrictions to specific service areas;

(e) if, in an emergency, the prospective enrollee is outside of the ambulance membership organization's service area, that the prospective enrollee may be responsible for the entirety of the cost of the ambulance membership organization's services; and

(f) if an enrollee cancels the ambulance membership plan before 30 days after the day on which the enrollee purchases the ambulance membership plan, the ambulance membership organization shall refund to the member:

(i) any one-time charges the enrollee pays that exceed $25; and

(ii) all periodic charges or fees that the enrollee pays.

Section 26. Section **31A-11-104** is amended to read:

31A-11-104. Applicability of other portions of this title.

(1) In addition to this chapter, motor clubs are subject to the applicable sections of:

(a) Chapter 1, General Provisions, Chapter 2, Administration of the Insurance Laws, Chapter 4, Insurers in General, Chapter 16, Insurance Holding Companies, Chapter 21, Insurance Contracts in General, Chapter 22, Contracts in Specific Lines, Chapter 26, Insurance Adjusters, [~~Chapter 27, Delinquency Administrative Action Provisions~~] Chapter 27, Administrative Supervision of Insurers, and Chapter 27a, Insurer Receivership Act;

(b) Chapter 3, Part 1, Funding the Insurance Department;

(c) Chapter 23a, Part 1, General Provisions, Part 4, Marketing Practices, and Part 5, Compensation of Producers and Consultants; and

(d) Section 31A-23a-207.

(2) Sections 31A-14-204 and 31A-14-216 apply to nondomestic motor clubs.

(3) Section 31A-5-401 applies to domestic motor clubs.

(4) Sections 31A-5-105, 31A-5-106, and 31A-5-216 apply to both domestic and nondomestic motor clubs.

(5) Both domestic and nondomestic motor clubs are subject to the department fees under Section 31A-3-103. Other provisions of this title apply to motor clubs only as specifically provided in this chapter.

Section 27. Section **31A-14-206** is amended to read:

31A-14-206. Commercially domiciled insurers.

(1) As used in this section, and except as to title insurers, the commissioner may consider a foreign insurer to be "commercially domiciled" in this state if:

(a) during the three immediately preceding calendar years, the foreign insurer wrote more insurance premiums in this state than [~~it~~] the foreign insurer wrote in [~~its~~] the foreign insurer's state of domicile during the same period; or

(b) during the same three-year period, the foreign insurer's gross premiums written in this state constituted 15% or more of the insurer's total gross premiums written in the United States.

(2)

(a) Subject to Subsection (3), an insurer determined by the commissioner to be commercially domiciled in this state may be subjected to Chapter 16, Insurance Holding Companies, Chapter 17, Determination of Financial Condition, Chapter 18, Investments, [~~Chapter 27, Delinquency~~

~~Administrative Action Provisions~~] Chapter 27, Administrative Supervision of Insurers, and Chapter 27a, Insurer Receivership Act, and Chapter 27a, Part 4, Liquidation, Part 5, Asset Recovery, and Part 6, Claims, in the same manner and to the same extent as domestic insurers.

(b) [~~–~~]The commissioner shall, by order, notify any commercially domiciled insurer not exempt under Subsection (3) of the extent to which the insurer is subject to the provisions listed under this Subsection (2).

(3) The commissioner may exempt from the provisions of this section any commercially domiciled insurer if the commissioner determines that the insurer has assets physically located in this state or an asset to liability ratio sufficient to justify the conclusion that there is no reasonable danger that the operations or conduct of the business of the insurer could present a danger of loss to Utah policyholders.

(4) Subsection 31A-14-205(4) applies to the conflict of the laws of this state with the laws of the insurer's domicile for foreign insurers, including commercially domiciled insurers, under this section.

(5) This section does not excuse or exempt any foreign insurer from complying with the provisions under this title which are otherwise applicable to a foreign insurer.

Section 28. Section **31A-16-111** is amended to read:

31A-16-111. Required sale of improperly acquired stock -- Penalties.

(1) If the commissioner finds that the acquiring person has not substantially complied with the requirements of this chapter in acquiring control of a domestic insurer, the commissioner may require the acquiring person to sell the acquiring person's stock of the domestic insurer in the manner specified in Subsection (2).

(2)

(a) The commissioner shall effect the sale required by Subsection (1) in the manner [~~which~~] that, under the particular circumstances, appears most likely to result in the payment of the full market value for the stock by persons who have the collective competence, experience, financial resources, and integrity to obtain approval under Subsection 31A-16-103(8).

(b) Sales made under this section are subject to approval by a court with jurisdiction under Title 78A, Judiciary and Judicial Administration, which court has the authority to effect the terms of the sale.

(3)

(a) The proceeds from sales [~~made~~] a person makes under this section shall be distributed first to the person required by this section to sell the stock, but only up to the amount the person originally [~~paid by the person~~] paid for the securities.

(b) [–]Additional sale proceeds shall be [~~paid to~~] deposited into the General Fund.

(4) The person required to sell and persons related to or affiliated with the seller may not purchase the stock at the sale conducted under this section.

(5)

[~~(a)~~] A director or officer of an insurance holding company system violates this chapter if the director or officer knowingly:

[~~(i)~~] (a) participates in or assents to a transaction or investment that:

[~~(A)~~] (i) has not been properly reported or submitted [~~pursuant to~~] in accordance with:

[~~(I)~~] (A) Subsections 31A-16-105(1) and (2); or

[~~(II)~~] (B) Subsection 31A-16-106(1)(b); or

[~~(B)~~] (ii) otherwise violates this chapter; or

[~~(ii)~~] (b) permits any of the officers or agents of the insurer to engage in a transaction or investment described in Subsection [~~(5)(a)(i)~~] (5)(a).

[~~(b) A director or officer in violation of Subsection (5)(a) shall pay, in the director's or officer's individual capacity, a civil penalty of not more than $20,000 per violation:~~]

[~~(i) upon a finding by the commissioner of a violation; and~~]

[~~(ii) after notice and hearing before the commissioner.~~]

[~~(c) In determining the amount of the civil penalty under Subsection (5)(b), the commissioner shall take into account:~~]

[~~(i) the appropriateness of the penalty with respect to the gravity of the violation;~~]

[~~(ii) the history of previous violations; and~~]

[~~(iii) any other matters that justice requires.~~]

(6)

(a) When [~~it appears to~~]the commissioner suspects that any insurer or any director, officer, employee, or agent of the insurer, has committed a willful violation of this chapter, the commissioner may refer the violation to the appropriate prosecutor.

(b)

(i) An insurer that willfully violates this chapter may be fined not more than $20,000.

(ii) Any individual who willfully violates this chapter is guilty of a third degree felony, and upon conviction may be:

(A) fined in that person's individual capacity not more than $5,000;

(B) imprisoned; or

(C) both fined and imprisoned.

(7) This section does not limit the other sanctions applicable to violations of this title under Section 31A-2-308.

Section 29. Section **31A-17-201** is amended to read:

31A-17-201. Qualified assets.

(1) Except as provided under Subsections (3) and (4), only the qualified assets listed in Subsection (2) may be used in determining the financial condition of an insurer, except to the extent an insurer has shown to the commissioner that the insurer has excess surplus, as defined in Section 31A-1-301.

(2) For purposes of Subsection (1), "qualified assets" means:

(a) any of the following acquired or held in accordance with Sections 31A-18-105,[~~and~~] 31A-18-106, and 31A-18-110:

(i) an investment;

(ii) a security;

(iii) property; or

(iv) a loan;

(b) the income due and accrued on an asset listed in Subsection (2)(a);

(c) assets other than an asset listed in Subsection (2)(a) that are determined to be admitted in the Accounting Practices and Procedures Manual, published by the National Association of Insurance Commissioners; and

(d) other assets [~~authorized by~~] that the commissioner authorizes by rule.

(3)

(a) Subject to Subsection (5) and even if the assets could not otherwise be counted under this chapter, assets acquired in the bona fide enforcement of creditors' rights may be counted for the purposes of Subsection (1) and Sections 31A-18-105,[~~and~~] 31A-18-106, and 31A-18-110:

(i) for five years after the acquisition of the assets if the assets are real property; and

(ii) for one year if the assets are not real property.

(b)

(i) The commissioner may allow reasonable extensions of the periods described in Subsection (3)(a), if disposal of the assets within the periods given is not possible without substantial loss.

(ii) Extensions under Subsection (3)(b)(i) may not, as to any particular asset, exceed a total of five years.

(4) Subject to Subsection (5), and even though under this chapter the assets could not otherwise be counted, assets acquired in connection with mergers, consolidations, or bulk reinsurance, or as a dividend or distribution of assets, may be counted for the same purposes, in the same manner, and for the same periods as assets acquired under Subsection (3).

(5) Assets described under Subsection (3) or (4) may not be counted for the purposes of Subsection (1), except to the extent they are counted as assets in determining insurer solvency under the laws of the state of domicile of the creditor or acquired insurer.

Section 30. Section **31A-17-202** is amended to read:

31A-17-202. Status of assets that are not "qualified assets."

(1)

(a) Except as provided in Subsection (1)(b), if an insurer owns assets that are not qualified assets under Section 31A-17-201, the assets shall be disregarded in determining and reporting the financial condition of the insurer.

(b) An insurer may invest [~~its~~] the insurer's funds in investments that are permitted under Section [~~31A-18-105~~] 31A-18-110 but in excess of the limits under [~~Sections 31A-18-103 and 31A-18-106~~] Section 31A-18-111 or other assets [~~approved by~~] that the commissioner approves and these assets may be recognized and reported in the financial condition of the insurer to the extent the insurer has excess surplus, as that term is defined under Section 31A-1-301.

(2) Insurers bear the burden of establishing the extent to which they have excess surplus.

Section 31. Section **31A-18-117** is amended to read:

31A-18-117. Conflicts of laws and other standards.

(1) [~~Except as provided in Subsection (2), the~~] The provisions of this chapter apply if there is a conflict between this chapter and another provision of state statute, except:[~~.~~]

[~~(2)~~] (a) Chapter 16, Insurance Holding Companies, purporting to authorize an insurer to make a particular investment, supersedes this chapter[~~.~~] if there is a conflict between this chapter and Chapter 16, Insurance Holding Companies; and

(b) Chapter 37, Captive Insurance Companies Act, supersedes this chapter if there is a conflict between this chapter and Chapter 37, Captive Insurance Companies Act.

[~~(3)~~] (2) An insurer shall value the insurer's assets in accordance with the valuation standards of the NAIC to the extent those standards remain consistent with the statutes of this state or the rules or orders of the commissioner.

Section 32. Section **31A-20-108** is amended to read:

31A-20-108. Single risk limitation.

(1) As used in this section, "single risk" includes all losses reasonably expected as a result of the same event.

[~~(1)~~] (2) This section applies to all lines of insurance, including ocean marine and reinsurance, except:

(a) title insurance;

(b) workers' compensation insurance;

(c) occupational disease insurance;

(d) employers' liability insurance; and

(e) health insurance.

[~~(2)~~] (3)

(a) Except as provided under [~~Subsections (3) and (4) and under Section 31A-20-109~~] Subsection (4), an insurer authorized to do [~~an~~]insurance business in Utah may not expose itself to loss on a single risk in an amount exceeding 10% of [~~its~~] the insurer's capital and surplus.

(b) The commissioner may adopt rules to calculate surplus under this section.

(c) An insurer may deduct the portion of a risk reinsured by a reinsurance contract worthy of a reserve credit under Sections 31A-17-404 through 31A-17-404.4 in determining the limitation of risk under this section.

[~~(3)~~] (4)

(a) The commissioner may adopt rules, after hearings held with notice as required by law, to specify the maximum exposure to which an assessable mutual may subject itself.

(b) The rules described in Subsection [~~(3)(a)~~] (4)(a) may provide for classifications of insurance and insurers to preserve the solidity of insurers.

[~~(4) As used in this section, a "single risk" includes all losses reasonably expected as a result of the same event.~~]

(5) A company transacting fidelity or surety insurance may expose itself to a risk or hazard in excess of the amount prescribed in Subsection [~~(2)~~] (3), if the commissioner, after considering all the facts and circumstances, approves the risk.

Section 33. Section **31A-21-310** is amended to read:

31A-21-310. Dividends on policies.

(1) Section 31A-22-418 applies to life insurance and annuities.

(2)

(a) [~~Any~~] An insurer may distribute a portion of surplus attributable to policies other than life insurance or annuities, in amounts and with classifications the board of directors determines to be fair and reasonable.

(b) [~~This~~] A distribution under this Subsection (2) may not be contingent on the renewal of [~~any~~] a policy or of premium payments unless the policy stated that limitation when [~~it~~] the policy was written.

(c) [~~]A schedule explaining the basis for the distribution shall be filed with the commissioner [~~prior to~~] before the distribution.

(d) [~~]The commissioner shall keep the schedule confidential[~~shall be kept confidential by the commissioner ~~]unless the commissioner finds that the interests of insureds and the public require that [~~it be made~~] the commissioner make the schedule public.

(3)

(a) [~~Any~~] An insurer may distribute surplus to any class of policyholder, even if [~~their~~] the insurer's policies do not provide for [~~it~~] the distribution.

(b) [~~A~~] The insurer shall file a schedule explaining the basis for the distribution [~~shall be filed~~]with the commissioner [~~under~~] in accordance with Subsection (2) at least 30 days [~~prior to the distribution~~] before the day on which the distribution occurs.

(c) [~~]The commissioner shall disallow [~~any~~] a distribution [~~which~~] that:

(i) [~~]is materially unfair to other policyholders; or

(ii) [~~ which ~~]would place the insurer in a financially hazardous condition.

(4) [~~It is permissible to ~~] An insurer may provide an indivisible dividend to classes of policyholders having more than one type of policy, including a combination of life or annuities with other types of insurance.

(5)

(a) The provisions of this section do not apply to a member dividend that a mutual insurer or mutual insurance holding company pays.

(b) Section 31A-5-420 applies to a member dividend that a mutual insurer or mutual insurance holding company pays.

Section 34. Section **31A-22-309** is amended to read:

31A-22-309. Limitations, exclusions, and conditions to personal injury protection.

(1)

(a) A person who has or is required to have direct benefit coverage under a policy [~~which~~] that includes personal injury protection may not maintain a cause of action for general damages arising out of personal injuries alleged to have been caused by an automobile accident, except where the person [~~has sustained~~] sustains one or more of the following:

(i) death;

(ii) dismemberment;

(iii) permanent disability or permanent impairment based upon objective findings;

(iv) permanent disfigurement;

(v) a bone fracture; or

(vi) medical expenses to a person in excess of $3,000.

(b) Subsection (1)(a) does not apply to a person making an uninsured motorist claim.

(2)

(a) [~~Any~~] An insurer issuing personal injury protection coverage under this part may only exclude from this coverage benefits:

(i) for [~~any~~] an injury [~~sustained by~~]the insured sustains while occupying another motor vehicle owned by or furnished for the regular use of the insured or a resident family member of the insured and not insured under the policy;

(ii) for [~~any~~] an injury [~~sustained by any~~] a person sustains while operating the insured motor vehicle without the express or implied consent of the insured or while not in lawful possession of the insured motor vehicle;

(iii) to [~~any~~] an injured person, if the person's conduct contributed to the person's injury:

(A) by intentionally causing injury to the person; or

(B) while committing a felony;

(iv) for [~~any~~] an injury [~~sustained by any person~~] a person sustains arising out of the use of [~~any~~] a motor vehicle while located for use as a residence or premises;

(v) for [~~any~~] an injury due to war, whether [~~or not~~]declared, civil war, insurrection, rebellion, or revolution, or to [~~any~~] an act or a condition incident to [~~any of the foregoing~~] a war, civil war, insurrection, rebellion, or revolution; or

(vi) for [~~any~~] an injury resulting from the radioactive, toxic, explosive, or other hazardous properties of nuclear materials.

(b) This Subsection (2) does not limit the exclusions that may be contained in other types of coverage.

(3) The benefits payable to [~~any~~] an injured person under Section 31A-22-307 are reduced by:

(a) any benefits [~~which~~]that the injured person receives or is entitled to receive as a result of an accident covered in this code under any workers' compensation or similar statutory plan; and

(b) any amounts [~~which~~]that the injured person receives or is entitled to receive from the United States or any of [~~its~~] the United States' agencies because that person is on active duty in the military service.

(4) When a person injured is also an insured party under any other policy, including those policies complying with this part, primary coverage is given by the policy insuring the motor vehicle in use during the accident.

(5)

(a) Payment of the benefits provided for in Section 31A-22-307 shall be made on a monthly basis as expenses are incurred.

(b) Benefits for any period are overdue if [~~they are not paid~~] the insurer does not pay the benefits within 30 days after the day on which the insurer receives reasonable proof of the fact and amount of expenses incurred during the period.

(c) [–]If reasonable proof is not supplied as to the entire claim, the amount supported by reasonable proof is overdue if not paid within 30 days after the insurer receives that proof[~~ is received by the insurer~~].

(d) [–]Any part or all of the remainder of the claim that is later supported by reasonable proof is also overdue if not paid within 30 days after the day on which the insurer receives the proof[~~ is received by the insurer~~].

[~~(c)~~] (e) If the insurer fails to pay the expenses when due, these expenses shall bear interest at the rate of 1-1/2% per month after the due date.

[~~(d)~~] (f)

(i) The person entitled to the benefits may bring an action in contract to recover the expenses plus the applicable interest.

(ii) [-]If the insurer is required by the action to pay any overdue benefits and interest, the insurer is also required to pay a reasonable attorney's fee to the claimant.

(6)

(a) Except as provided in Subsection (6)(b), [~~every~~] a policy [~~providing~~] that provides personal injury protection coverage is subject to the following:

(i) that where the insured under the policy is or would be held legally liable for the personal injuries sustained by any person to whom benefits required under personal injury protection have been paid by another insurer, the insurer of the person who would be held legally liable shall reimburse the other insurer for the payment, but not in excess of the amount of damages recoverable; and

(ii) that the issue of liability for that reimbursement and [~~its~~] the reimbursement's amount shall be decided by mandatory, binding arbitration between the insurers.

(b) There shall be no right of reimbursement between insurers under Subsection (6)(a) if the insurer of the person who would be held legally liable for the personal injuries sustained has tendered [~~its~~] the insurer's policy limit.

(c)

(i) If the insurer of the person who would be held legally liable for the personal injuries sustained reimburses a no-fault insurer [~~prior to~~] before settling a third party liability claim with an injured person and subsequently determines that some or all of the reimbursed amount is needed to settle a third party claim, the insurer of the person who would be held legally liable for the personal injuries sustained shall provide written notice to the no-fault insurer that some or all of the reimbursed amount is needed to settle a third party liability claim.

(ii) The written notice described under Subsection (6)(c)(i) shall:

(A) identify the amount of the reimbursement that is needed to settle a third party liability claim;

(B) provide notice to the no-fault insurer that the no-fault insurer has 15 days to return the amount described in Subsection (6)(c)(ii)(A); and

(C) identify the third party liability insurer that the returned amount shall be paid to.

(iii) A no-fault insurer that receives a notice under this Subsection (6)(c) shall return the portion of the reimbursement identified under Subsection (6)(c)(ii) to the third party liability insurer identified under Subsection (6)(c)(ii)(C) within 15 business days [~~from receipt of~~] after the day on which the no-fault insurer receives a notice under this Subsection (6)(c).

Section 35. Section **31A-22-505** is amended to read:

31A-22-505. Association groups.

(1) An insurer may issue a group insurance policy offering life insurance to an association group or to the trustees of a fund established, created, and maintained for the benefit of the members of the association group if:

(a) the commissioner authorizes the association group;

(b) the benefits of the group insurance policy are reasonable in relation to the premiums charged for the policy; and

(c) the association group:

(i) purchases insurance on a group basis on behalf of the association group's members;

(ii) is formed and maintained for a shared substantially common purpose that:

(A) is not related to obtaining insurance; and

(B) is the same profession, trade, or occupation or has some common economic, representation of interest, or genuine organizational relationship;

(iii) has at least 100 members;

(iv) has been actively in existence for at least five years;

(v) has a constitution and bylaws that require:

(A) the association to hold regular meetings not less than annually to further the purpose of the association's members; and

(B) members of the association to have voting privileges and representation on any governing board or committee;

(vi) does not condition membership in the association group on any health status-related factor;

(vii) makes insurance offered through the association group available exclusively to a member of the association; and

(viii) only offers insurance through the association group in connection with a member of the association group.

(2) A group insurance policy offering life insurance that an insurer issues to an association group 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 following shall pay the premium under a group insurance policy offering life insurance that an insurer issues to an association group:

(i) the policyholder from funds contributed by the association;

(ii) employer members, from funds contributed by the covered persons; or

(iii) from any combination of 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.

(4)

(a) An association group that meets the requirements described under Subsection (1) shall disclose the following to each insured member:

(i) each cost related to joining and maintaining membership in the association;

(ii) that membership fees or dues are in addition to the policy premium;

(iii) that the association group holds the master group insurance policy;

(iv) that the association group and insurer determine the amount of the premium charged and the terms and conditions of coverage under the group insurance policy; and

(v) that the association group policyholder and insurer may change the premium and terms and conditions of coverage under the insurance policy:

(A) through agreement; and

(B) without the consent of the individual certificate holder.

(b) If an insurer collects membership fees or dues on behalf of an association, the insurer shall disclose to each member of the association that the insurer is billing and collecting membership fees and dues on behalf of the association.

Section 36. Section **31A-22-605** is amended to read:

31A-22-605. Accident and health insurance standards.

(1) The purposes of this section include:

(a) reasonable standardization and simplification of terms and coverages of individual and franchise accident and health insurance policies, including accident and health insurance contracts of insurers licensed under Chapter 7, Nonprofit Health Service Insurance Corporations, and Chapter 8, Health Maintenance Organizations and Limited Health Plans, to facilitate public understanding and comparison in purchasing;

(b) elimination of provisions contained in individual and franchise accident and health insurance contracts that may be misleading or confusing in connection with either the purchase of those types of coverages or the settlement of claims; and

(c) full disclosure in the sale of individual and franchise accident and health insurance contracts.

(2) This section applies to all individual and franchise accident and health policies.

(3) The commissioner shall adopt rules, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, relating to the following matters:

(a) standards for the manner and content of policy provisions, and disclosures to be made in connection with the sale of policies covered by this section, dealing with at least the following matters:

(i) terms of renewability;

(ii) initial and subsequent conditions of eligibility;

(iii) nonduplication of coverage provisions;

(iv) coverage of dependents;

(v) preexisting conditions;

(vi) termination of insurance;

(vii) probationary periods;

(viii) limitations;

(ix) exceptions;

(x) reductions;

(xi) elimination periods;

(xii) requirements for replacement;

(xiii) recurrent conditions;

(xiv) coverage of [~~persons~~] an individual eligible for Medicare; and

(xv) definition of terms;

(b) minimum standards for benefits under each of the following categories of coverage in policies covered in this section:

(i) basic hospital expense coverage;

(ii) basic medical-surgical expense coverage;

(iii) hospital confinement indemnity coverage;

(iv) major medical expense coverage;

(v) income replacement coverage;

(vi) accident only coverage;

(vii) specified disease or specified accident coverage;

(viii) limited benefit health coverage;

(ix) dental coverage; and

[~~(ix)~~] (x) nursing home and long-term care coverage;

(c) the content and format of the outline of coverage, in addition to that required under Subsection (5);

(d) the method of identification of policies and contracts based upon coverages provided; and

(e) rating practices.

(4) Nothing in Subsection (3)(b) precludes the issuance of policies that combine categories of coverage in Subsection (3)(b) provided that any combination of categories meets the standards of a component category of coverage.

(5) The commissioner may adopt rules, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, relating to the following matters:

(a) establishing disclosure requirements for insurance policies covered in this section, designed to adequately inform the prospective insured of the need for and extent of the coverage offered, and requiring that this disclosure be furnished to the prospective insured with the application form, unless it is a direct response insurance policy;

(b)

(i) prescribing caption or notice requirements designed to inform prospective insureds that particular insurance coverages are not Medicare supplement insurance; and

(ii) applying the requirements of Subsection (5)(b)(i) to all insurance policies and certificates sold to [~~persons~~] an individual eligible for Medicare; and

(c) requiring the disclosures or information brochures to be furnished to the prospective insured on direct response insurance policies, [~~upon his request~~] if the prospective insured requests the disclosure or information brochures or, in any event, no later than the time of the policy delivery.

(6)

(a) A policy covered by this section may be issued only if [~~it~~] the policy meets the minimum standards established by the commissioner under Subsection (3), an outline of coverage accompanies the policy or is delivered to the applicant at the time of the application, and, except with respect to direct response insurance policies, an acknowledged receipt is provided to the insurer.[~~-~~]

(b) The outline of coverage shall include:

[~~(a)~~] (i) a statement identifying the applicable categories of coverage provided by the policy as prescribed under Subsection (3);

[~~(b)~~] (ii) a description of the principal benefits and coverage;

[~~(c)~~] (iii) a statement of the exceptions, reductions, and limitations contained in the policy;

[~~(d)~~] (iv) a statement of the renewal provisions, including any reservation by the insurer of a right to change premiums;

[~~(e)~~] (v) a statement that the outline is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions; and

[~~(f)~~] (vi) any other contents the commissioner prescribes.

(7) If a policy is issued on a basis other than that applied for, the outline of coverage shall accompany the policy when it is delivered and it shall clearly state that it is not the policy for which application was made.

(8)

(a) Notwithstanding Subsection 31A-22-606(1), limited accident and health policies or certificates issued to [~~persons~~] an individual eligible for Medicare shall contain a notice prominently printed on or attached to the cover or front page which states that the policyholder or certificate holder has the right to return the policy for any reason within 30 days after its delivery and to have the premium refunded.

(b) This Subsection (8) does not apply to a policy issued to an employer group.

Section 37. Section **31A-22-646** is amended to read:

31A-22-646. Dental insurance -- Contract provision for noncovered services.

(1) For purposes of this section:

(a) "Covered services" means dental services for which reimbursement:

(i) is available or would be reimbursable under an enrollee's dental plan but for the application of one or more of the following contractual provisions:

(A) deductibles;

(B) copayments;

(C) coinsurance;

(D) waiting periods;

(E) annual or lifetime maximums;

(F) frequency limitations; or

(G) alternative benefit payments; and

(ii) is not merely nominal, for the purpose of avoiding the requirements of this section.

(b) "Dental plan" means:

(i) a health benefit plan that includes coverage for dental services; and

(ii) a policy or certificate that provides coverage solely for dental services.

(c) [~~"Dentist"~~] "Dental provider" means an individual licensed under Title 58, Chapter 69, Dentist and Dental Hygienist Practice Act.

(2)

(a) This section applies to:

(i) a dental plan that is entered into or renewed on or after January 1, 2018; and

(ii) an administrator providing third-party administration services or a provider network for a dental plan.

(b) This section does not apply to a self-insured dental plan that is regulated by federal law.

(3) A contract between a dental plan and a dentist to provide covered services may not:

(a) require, directly or indirectly, that a dentist provide dental services to a covered individual at a fee set by, or a fee subject to the approval of, the dental plan unless:

(i) the dental services are covered services under the dental plan; or

(ii)

(A) the dental services are not reimbursed by the dental plan;

(B) the dental services are discounted for individuals who are part of a discount dental rates plan; and

(C) the dentist who provided the dental services has elected to participate in the discount dental rates plan; and

(b) prohibit a dentist from offering or providing noncovered dental services to a covered individual at a fee determined by the dentist and the individual who will receive the noncovered services.

Section 38. Section **38** is enacted to read:

31A-22-646.2. Dental services jurisdiction.

(1)

(a) Notwithstanding Section 31A-1-103, an insurer that provides coverage for dental services that are completed in Utah to a patient that is a Utah resident shall comply with all Utah laws related to covered services, non-covered services, and reimbursement for services if 10% or more of the certificate holders or insureds are residents of this state.

(b) Subsection (1)(a) applies regardless of:

(i) the location of the insurer's domicile or principle place of business;

(ii) the location where the dental plan was written, issued, or delivered; or

(iii) a contractual choice-of-law provision.

(2)

(a) A signed provider agreement shall govern the contractual rights and obligations of the parties for dental services provided in Utah.

(b) A provider handbook that is provided to a dental provider by an insurer in connection with a provider agreement shall be deemed part of the provider contract.

(c) An insurer may not require a dental provider to comply with a provider handbook or policy that is not provided to the dental provider.

(d) An insurer shall notify a dental provider if the insurer issues a new provider handbook or updates an existing provider handbook.

Section 39. Section **31A-22-650** is amended to read:

31A-22-650. Health care preauthorization requirements.

(1) As used in this section:

(a) "Adverse preauthorization determination" means a determination by an insurer that health care does not meet the preauthorization requirement for the health care.

(b) "Authorization" means a determination by an insurer that for health care with a preauthorization requirement:

(i) the proposed drug, device, or covered service meets all requirements, restrictions, limitations, and clinical criteria for authorization [~~established by~~] that the insurer establishes;

(ii) the drug, device, or covered service is covered by the enrollee's insurance policy; and

(iii) the insurer will provide coverage for the drug, device, or covered service subject to the provisions of the insurance policy, including any cost sharing responsibilities of the enrollee.

(c) "Device" means a prescription device as defined in Section 58-17b-102.

(d) "Drug" means the same as that term is defined in Section 58-17b-102.

(e) "Insurer" means the same as that term is defined in Section 31A-22-634.

(f) "Preauthorization requirement" means a requirement by an insurer that an enrollee obtain authorization for a drug, device, or service covered by the insurance policy, before receiving the drug, device, or service.

(2)

(a) An insurer may not modify an existing requirement for authorization unless, at least 30 days before the day on which the modification takes effect, the insurer:

(i) posts a notice of the modification on the website described in Subsection 31A-22-613.5(6)(a); and

(ii) if requested by a network provider or the network provider's representative, provides to the network provider by mail or email a written notice of modification to a particular requirement for authorization described in the request from the network provider.

(b) Subsection (2)(a) does not apply if:

(i) complying with Subsection (2)(a) would create a danger to the enrollee's health or safety; or

(ii) the modification is for a newly covered drug or device.

(c) An insurer may not revoke an authorization for a drug, device, or covered service if:

(i) the network provider submits a request for authorization for the drug, device, or covered service to the insurer;

(ii) the insurer grants the authorization requested under Subsection (2)(c)(i);

(iii) the network provider renders the drug, device, or covered service to the enrollee in accordance with the authorization and any terms and conditions of the network provider's contract with the insurer;

(iv) on the day on which the network provider renders the drug, device, or covered service to the enrollee:

(A) the enrollee is eligible for coverage under the enrollee's insurance policy; and

(B) the enrollee's condition or circumstances related to the enrollee's care have not changed;

(v) the network provider submits an accurate claim that matches the information in the request for authorization under Subsection (2)(c)(i); and

(vi) the authorization was not based on fraudulent or materially incorrect information from the network provider.

(3)

(a) An insurer that receives a request for authorization shall treat the request as a pre-service claim as that term is defined in 29 C.F.R. Sec. 2560.503-1 and process the request in accordance with:

(i) 29 C.F.R. Sec. 2560.503-1, regardless of whether the coverage is offered through an individual or group health insurance policy;

(ii) Subsection 31A-4-116(2); and

(iii) Section 31A-22-629.

(b) If a network provider submits a claim to an insurer that includes an unintentional error that results in a denial of the claim, the insurer shall permit the network provider with an opportunity to resubmit the claim with corrected information within a reasonable amount of time.

(c) Except as provided in Subsection (3)(d), the appeal of an adverse preauthorization determination regarding clinical or medical necessity as requested by a physician may only be reviewed by a physician who is currently licensed as a physician and surgeon in a state, district, or territory of the United States.

(d) The appeal of an adverse determination requested by a physician regarding clinical or medical necessity of a drug, may only be reviewed by an individual who is currently licensed in a state, district, or territory of the United States as:

(i) a physician and surgeon; or

(ii) a pharmacist.

(e) An insurer shall ensure that an adverse preauthorization determination regarding clinical or medical necessity is made by an individual who:

(i) has knowledge of the medical condition or disease of the enrollee for whom the authorization is requested; or

(ii) consults with a specialist who has knowledge of the medical condition or disease of the enrollee for whom the authorization is requested regarding the request before making the determination.

(f) An insurer shall specify how long an authorization is valid.

(4)

(a) An insurer that removes a drug from the insurer's formulary shall:

(i) permit an enrollee, an enrollee's designee, or an enrollee's network provider to request an exemption from the change to the formulary for the purpose of providing the patient with continuity of care; and

(ii) have a process to review and make a decision regarding an exemption requested under Subsection (4)(a)(i).

(b) If an insurer makes a change to the formulary for a drug in the middle of a plan year, the insurer may not implement the changes for an enrollee that is on an active course of treatment for the drug unless the insurer provides the enrollee with notice at least 30 days before the day on which the change is implemented.

(5)

(a) Each April 1, an insurer with a preauthorization requirement shall report to the department, for the previous calendar year, the percentage of authorizations, not including a claim involving urgent care as defined in 29 C.F.R. Sec. 2560.503-1, for which the insurer notified a provider regarding an authorization or adverse preauthorization determination more than one week after the day on which the insurer received the request for authorization.

(b) Before [~~March~~] April 1, 2026, and each [~~March~~] April 1 thereafter, an insurer shall report to the department the following for the previous calendar year:

(i) a list of services that have preauthorization requirements;

(ii) for pre-service preauthorization requests that were not urgent, the percentage of individual service requests that:

(A) were approved;

(B) were denied;

(C) were approved after appeal;

(D) the time frame for review was extended, and the request was approved;

(E) were denied due to incomplete information from the health care provider; and

(F) were received through fax, phone, and electronic portal; and

(iii) for urgent pre-service preauthorization requests, the percentage of individual service requests that:

(A) were approved;

(B) were denied;

(C) were denied due to incomplete information from the health care provider; and

(D) were received through fax, phone, and electronic portal.

(c) Data provided to the department under Subsections (5)(b)(ii) and (iii) shall be aggregated for all services.

(d) Subsection (5)(b) does not require an insurer to report information regarding prescription drugs.

(e) The department shall compile the information described in Subsection (5)(b) and publish the information on the department's website.

(6) An insurer may not have a preauthorization requirement for emergency health care as described in Section 31A-22-627.

(7) For each adverse preauthorization determination [~~made by~~]an insurer makes, the insurer shall provide to the enrollee and the enrollee's health care provider:

(a) a detailed and specific explanation that explains why the [~~determination was made~~] insurer made the determination; and

(b) a notice explaining the enrollee may appeal the determination [~~may be appealed~~]and the process for appealing the determination, including how to begin an expedited appeal process as described in Section 31A-22-629.

(8) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the department may make rules to implement Subsection (5)(b).

Section 40. Section **31A-22-701** is amended to read:

31A-22-701. Groups eligible for group or blanket insurance.

(1) A group insurance policy offering accident and health insurance may be issued to:

(a) a group:

(i) to which a group life insurance policy may be issued under Section 31A-22-502, 31A-22-503, 31A-22-504, 31A-22-505, 31A-22-506, 31A-22-507, or 31A-22-508[~~, or 31A-22-509~~]; and

(ii) that is formed and maintained in good faith for a purpose other than obtaining insurance;

(b) a group [~~specifically authorized by~~] that the commissioner specifically authorizes, upon a finding that:

(i) authorization is not contrary to the public interest;

(ii) the group is actuarially sound;

(iii) formation of the proposed group may result in economies of scale in acquisition, administrative, marketing, and brokerage costs;

(iv) the insurance policy, insurance certificate, or other indicia of coverage that will be offered to the proposed group is substantially equivalent to insurance policies that are otherwise available to similar groups;

(v) the group would not present hazards of adverse selection;

(vi) the premiums for the insurance policy and any contributions by or on behalf of the insured persons are reasonable in relation to the benefits provided; and

(vii) the group is formed and maintained in good faith for a purpose other than obtaining insurance; or

(c) a postsecondary educational institution covering students, upon a finding that:

(i) the policy provides standards for financial soundness;

(ii) the policy protects the students covered;

(iii) the policy provides for the establishment of a financially viable alternative to traditional health care plans;

(iv) authorization is not contrary to the public interest;

(v) the policy would not present hazards of adverse selection; and

(vi) the premiums for the policy and any contributions by or on behalf of the insured persons are reasonable in relation to the benefits provided.

(2) A blanket insurance policy offering accident and health insurance:

(a) covers a defined class of persons;

(b) may not be offered or underwritten on an individual basis;

(c) shall cover only a group that is:

(i) actuarially sound; and

(ii) formed and maintained in good faith for a purpose other than obtaining insurance; and

(d) may be issued only to:

(i) a common carrier or an operator, owner, or lessee of a means of transportation, as policyholder, covering persons who may become passengers as defined by reference to the person's travel status;

(ii) an employer, as policyholder, covering any group of employees, dependents, or guests, as defined by reference to specified hazards incident to any activities of the policyholder;

(iii) an institution of learning, including a school district, a school jurisdictional unit, or the head, principal, or governing board of a school jurisdictional unit, as policyholder, covering students, teachers, or employees;

(iv) a religious, charitable, recreational, educational, or civic organization, or branch of one of those organizations, as policyholder, covering a group of members or participants as defined by reference to specified hazards incident to the activities sponsored or supervised by the policyholder;

(v) a sports team, camp, or sponsor of a sports team or camp, as policyholder, covering members, campers, employees, officials, or supervisors;

(vi) a volunteer fire department, first aid, civil defense, or other similar volunteer organization, as policyholder, covering a group of members or participants as defined by reference to specified hazards incident to activities sponsored, supervised, or participated in by the policyholder;

(vii) a newspaper or other publisher, as policyholder, covering a newspaper's or publisher's carriers;

(viii) a labor union, as a policyholder, covering a group of members or participants as defined by reference to specified hazards incident to the activities or operations sponsored or supervised by the policyholder;

(ix) an association that has a constitution and bylaws covering a group of members or participants as defined by reference to specified hazards incident to the activities or operations sponsored or supervised by the policyholder; or

(x) any other class of risks that, in the judgment of the commissioner, may be properly eligible for a blanket insurance policy offering accident and health insurance.

(3) The judgment of the commissioner may be exercised on the basis of:

(a) individual risks;

(b) a class of risks; or

(c) both risks described in Subsections (3)(a) and (b).

(4) A group insurance policy offering accident and health insurance issued to a group authorized under Subsection 31A-22-504(1)(b)(ii) is subject to the provisions of Section 31A-22-602.

Section 41. Section **31A-22-2002** is amended 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(1).~~]

[~~(4)~~] (1)

[~~(a)~~] "Limited long-term care"[~~ insurance"~~] means [~~an insurance policy, endorsement, or rider that is advertised, marketed, offered, or designed to provide~~]coverage:

[~~(i)~~] (a) for less than 12 consecutive months for each covered person;

[~~(ii)~~] (b) on an expense-incurred, indemnity, prepaid or other basis; and

[~~(iii)~~] (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.

[~~(b) "Limited long-term care insurance" includes a policy or rider described in Subsection (4)(a) that provides for payment of benefits based on cognitive impairment or the loss of functional capacity.~~]

(2)

(a) "Limited long-term care insurance" means an insurance policy, endorsement, or rider that is advertised, marketed, offered, or designed to provide coverage for limited long-term care.

[~~(c)~~] (b) "Limited long-term care insurance" does not include an insurance policy that is offered primarily to provide:

(i) basic Medicare supplement insurance 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 42. Section **31A-22-2006** is amended to read:

31A-22-2006. Rulemaking.

In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner[~~:~~]

[~~(1) shall makes rules~~] may make rules:

[~~(a) in the event of a substantial rate increase, promoting premium adequacy and protecting the policy holder;~~]

[~~(b)~~] (1) 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)~~] (2) prescribing the content and a standard format, including style, arrangement, and overall appearance of an outline of coverage; and

[~~(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)~~] (3) [~~may make rules~~]establishing loss-ratio standards for individual limited long-term care insurance policies.

Section 43. 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~~] the commissioner revokes or suspends the license under Subsection (5);

(b) [~~surrendered~~] the licensee surrenders the license to the commissioner and [~~accepted by the commissioner~~] the commissioner accepts the license 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~~] the license lapses under Section 31A-23a-113; or

(e) [~~voluntarily surrendered~~] the licensee voluntarily surrenders the license.

(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) a licensee no longer meets the qualifications pertaining to a line of authority[~~ are no longer met by the licensee~~];

(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) is more than 60 days past due on a final judgment;

(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 the licensee's or license applicant's 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, or has entered a plea in abeyance as that term is defined in Section 77-2a-1 to:

(A) a felony; or

(B) a misdemeanor involving fraud, misrepresentation, theft, or dishonesty;

(xv) admits or is found to have committed an 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 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[~~.~~] ; or

(xxvi) fails to maintain an active resident license in the home state or designated home state.

(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~~] the agency's 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;

(iv) a violation of an insurance law or rule; or

(v) payment of money.

(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 ordered by a court.

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

Section 44. Section **31A-23a-202** is amended to read:

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

(1) [~~Pursuant to~~] In accordance with this section, the commissioner shall by rule prescribe the continuing education requirements for a producer and a consultant.

(2)

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

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

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

(3)

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

(b)

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

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

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

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

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

(A) classroom attendance;

(B) home study;

(C) watching a video recording;

(D) experience credit; or

(E) another method provided by rule.

(iii)

(A) Notwithstanding Subsections (3)(b)(i)(A) and (B), an individual title insurance producer is required to complete 12 credit hours of continuing education for every two-year licensing period, with 3 of the credit hours being ethics courses unless the individual title insurance producer is licensed in this state as an individual title insurance producer for 20 or more consecutive years.

(B) If an individual title insurance producer is licensed in this state as an individual title insurance producer for 20 or more consecutive years, the individual title insurance producer is required to complete 6 credit hours of continuing education for every two-year licensing period, with 3 of the credit hours being ethics courses.

(C) Notwithstanding Subsection (3)(b)(iii)(A) or (B), an individual title insurance producer is considered to have met the continuing education requirements imposed under Subsection (3)(b)(iii)(A) or (B) if at the time of license renewal the individual title insurance producer:

(I) provides the department evidence that the individual title insurance producer is an active member in good standing with the Utah State Bar;

(II) is in compliance with the continuing education requirements of the Utah State Bar; and

(III) if requested by the department, provides the department evidence that the individual title insurance producer complied with the continuing education requirements of the Utah State Bar.

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

(d)

(i) A licensee is exempt from continuing education requirements under this section if:

(A) the licensee was first licensed before December 31, [~~1982~~] 1988;

(B) the license does not have a continuous lapse for a period of more than one year, except for a license for which the licensee has had an exemption approved before May 11, 2011;

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

(D) the department approves the exemption.

(ii) If the department approves the exemption under Subsection (3)(d)(i), the licensee is not required to apply again for the exemption.

(e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner shall, by rule:

(i) publish a list of insurance professional designations whose continuing education requirements can be used to meet the requirements for continuing education under Subsection (3)(b);

(ii) authorize a continuing education provider or a state or national professional producer or consultant association to:

(A) offer a qualified program for a license type or line of authority on a geographically accessible basis; and

(B) collect a reasonable fee for funding and administration of a continuing education program, subject to the review and approval of the commissioner; and

(iii) provide that membership by a producer or consultant in a state or national professional producer or consultant association is considered a substitute for the equivalent of two hours for each year during which the producer or consultant is a member of the professional association, except that the commissioner may not give more than two hours of continuing education credit in a year regardless of the number of professional associations of which the producer or consultant is a member.

(f) A fee permitted under Subsection (3)(e)(ii)(B) that is charged for attendance at a professional producer or consultant association program may be less for an association member, on the basis of the member's affiliation expense, but shall preserve the right of a nonmember to attend without affiliation.

(4) The commissioner shall approve a continuing education provider or continuing education course that satisfies the requirements of this section.

(5) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner shall by rule set the processes and procedures for continuing education provider registration and course approval.

(6) The requirements of this section apply only to a producer or consultant who is an individual.

(7) A nonresident producer or consultant is considered to have satisfied this state's continuing education requirements if the nonresident producer or consultant satisfies the nonresident producer's or consultant's home state's continuing education requirements for a licensed insurance producer or consultant.

(8) A producer or consultant subject to this section shall keep documentation of completing the continuing education requirements of this section for two years after the end of the two-year licensing period to which the continuing education applies.

Section 45. Section **31A-23a-203** is amended to read:

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

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

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

(b) has been a producer with property or casualty or both lines of authority for at least three years during the four years immediately preceding the date of application; and

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

(2) A person is eligible to become a consultant only if the person has acted in a capacity that would provide the person with preparation to act as an insurance consultant for a period aggregating not less than three years during the four years immediately preceding the date of application.

[~~(3)~~

~~(a) A resident producer with an accident and health line of authority may only sell long-term care insurance if the producer:~~]

[~~(i) initially completes a minimum of three hours of long-term care training before selling long-term care coverage; and~~]

[~~(ii) after completing the training required by Subsection (3)(a)(i), completes a minimum of three hours of long-term care training during each subsequent two-year licensing period.~~]

[~~(b) A course taken to satisfy a long-term care training requirement may be used toward satisfying a producer continuing education requirement.~~]

[~~(c) Long-term care training is not a continuing education requirement to renew a producer license.~~]

[~~(d) An insurer that issues long-term care insurance shall demonstrate to the commissioner, upon request, that a producer who is appointed by the insurer and who sells long-term care insurance coverage is in compliance with this Subsection (3).~~]

[~~(4)~~] (3)

(a) A resident producer with a property line of authority may only sell flood insurance coverage under the National Flood Insurance Program if the producer completes a minimum of three hours of flood insurance training related to the National Flood Insurance Program before selling flood insurance coverage.

(b) A course taken to satisfy a flood insurance training requirement may be used toward satisfying a producer continuing education requirement.

(c) Flood insurance training is not a continuing education requirement to renew a producer license.

(d) An insurer that issues flood insurance shall demonstrate to the commissioner, upon request, that a producer who is appointed by the insurer and who sells flood insurance coverage is in compliance with this Subsection [~~(4)~~] (3).

[~~(5)~~] (4) The training periods required under this section apply only to an individual applying for a license under this chapter.

Section 46. Section **31A-23a-203.5** is amended to read:

31A-23a-203.5. Errors and omissions coverage requirements.

(1) In accordance with this section, a resident individual producer shall ensure that the resident individual producer is covered:

(a) for the legal liability of the resident individual producer as the result of an erroneous act or failure to act in the resident individual producer's capacity as a producer; and

(b) at all times during the term of the resident individual producer's license.

(2) The coverage required by Subsection (1) shall consist of:

(a) a policy naming the resident individual producer;

(b) a policy naming the agency that designates the resident individual producer in accordance with this chapter; or

(c) a written agreement by an insurer or group of affiliated insurers, on behalf of a resident individual producer who is or will become an exclusive agent of the insurer or group of affiliated insurers, under which the insurer or group of affiliated insurers agrees to assume responsibility, to the benefit of an aggrieved person, for legal liability of the resident individual producer as the result of an erroneous act or failure to act in the resident individual producer's capacity as a producer for the insurer or group of affiliated insurers.

(3) The commissioner may, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, provide for:

(a) the terms and conditions of the coverage required under Subsection (1); and

(b) if the coverage required by Subsection (1) is terminated during a resident individual producer's license term, requirements to:

(i) provide notice; and

(ii) replace the coverage.

(4) An individual title insurance producer is considered to be in compliance with this section when:

(a) the individual title insurance producer who is not designated by an agency title producer maintains the individual title insurance producer's own bond, policy, or other financial protection in accordance with Subsection [~~31A-23a-204(2)~~] 31A-23a-204(3);

(b) the individual title insurance producer is designated by an agency title insurance producer that maintains a bond, policy, or other financial protection in accordance with Subsection [~~31A-23a-204(2)~~] 31A-23a-204(3); or

(c) the individual title insurance producer is an employee of and is appointed by a title insurer.

(5) Notwithstanding the other provisions of this section, a resident individual producer is exempt from the requirement to maintain coverage as provided in this section during a period in which the resident individual producer is not either:

(a) appointed by an insurer under this title; or

(b) designated by an agency under this title.

(6) A limited lines producer is exempt from this section.

Section 47. Section **31A-23a-204** is amended to read:

31A-23a-204. Special requirements for title insurance producers and agencies.

[~~An individual title insurance producer or agency title insurance producer shall be licensed in accordance with this chapter, with the additional requirements listed in this section.~~]

(1) An individual title insurance producer or agency title insurance producer shall be licensed in accordance with this chapter, with the additional requirements listed in this section.

[~~(1)~~] (2)

(a) A person that receives a new license under this title as an agency title insurance producer shall at the time of licensure be owned or managed by at least one individual who is licensed for at least three of the five years immediately [~~preceding the date on~~] before the day on which the agency title insurance producer applies for a license with both:

(i) a title examination line of authority; and

(ii) an escrow line of authority.

(b) An agency title insurance producer subject to Subsection [~~(1)(a)~~] (2)(a) may comply with Subsection [~~(1)(a)~~] (2)(a) by having the agency title insurance producer owned or managed by:

(i) one or more individuals who are licensed with the title examination line of authority for the time period provided in Subsection [~~(1)(a)~~] (2)(a); and

(ii) one or more individuals who are licensed with the escrow line of authority for the time period provided in Subsection [~~(1)(a)~~] (2)(a).

(c) A person licensed as an agency title insurance producer shall at all times during the term of licensure be owned or managed by at least one individual who is licensed for at least three years within the preceding five-year period with both:

(i) a title examination line of authority; and

(ii) an escrow line of authority.

(d) The Title and Escrow Commission may by rule, subject to Section 31A-2-404, exempt an attorney with real estate experience from the experience requirements in Subsection [~~(1)(a)~~] (2)(a).

(e)

(i) An individual who satisfies the requirements of this Subsection [~~(1)~~] (2) is known as a "qualifying licensee."

(ii) [–]At any given time, an individual may be a qualifying licensee for not more than two agency title insurance producers.

[~~(2)~~] (3)

(a) An individual title insurance producer or agency title insurance producer [~~appointed by an insurer~~] that an insurer appoints shall maintain:

(i)

(A) a fidelity bond that covers loss of third party funds that the producer holds and covers theft of funds by an owner of the producer; or

(B) a [~~fidelity bond~~] crime insurance policy that covers loss of third party funds that the producer holds and covers theft of funds by an owner of the producer; and

(ii) a professional liability insurance policy[~~; or~~] .

[~~(iii) a financial protection:~~]

[~~(A) equivalent to that described in Subsection (2)(a)(i) or (ii); and~~]

[~~(B) that the commissioner considers adequate.~~]

(b) The [~~bond, ~~]insurance[~~, or financial protection~~] required by this Subsection [~~(2)~~] (3):

(i) shall be supplied under a contract [~~approved by ~~]the commissioner approves to provide protection against the improper performance of [~~any~~] a service, including escrow service, in conjunction with the issuance of a contract or policy of title insurance; and

(ii) be in a face amount no less than [~~$250,000~~] $500,000.

(c) The Title and Escrow Commission may by rule, subject to Section 31A-2-404, exempt individual title insurance producer or agency title insurance producers from the requirements of this Subsection

[~~(2)~~] (3) upon a finding that, and only [~~so long as~~] if, the required [~~policy or bond~~] insurance is generally unavailable at reasonable rates.

[~~(3)~~] (4) An individual title insurance producer or agency title insurance producer appointed by an insurer may maintain a reserve fund to the extent money was deposited before July 1, 2008, and not withdrawn to the income of the individual title insurance producer or agency title insurance producer.

[~~(4)~~] (5) An examination for licensure shall include questions regarding the examination of title to real property.

[~~(5)~~] (6) An individual title insurance producer may not perform the functions of escrow unless the individual title insurance producer has been examined on the fiduciary duties and procedures involved in those functions.

[~~(6)~~] (7) The Title and Escrow Commission may adopt rules, establishing an examination for a license that will satisfy this section, subject to Section 31A-2-404, and after consulting with the commissioner's test administrator.

[~~(7)~~] (8) A license may be issued to an individual title insurance producer or agency title insurance producer who has qualified:

(a) to perform only examinations of title as specified in Subsection [~~(4)~~] (5);

(b) to handle only escrow arrangements as specified in Subsection [~~(5)~~] (6); or

(c) to act as a title marketing representative.

[~~(8)~~] (9)

(a) A person licensed to practice law in Utah is exempt from the requirements of Subsections [~~(2)~~] (3) and [~~(3)~~] (4) if that person issues 12 or less policies in any 12-month period.

(b) In determining the number of policies issued by a person licensed to practice law in Utah for purposes of Subsection [~~(8)(a)~~] (9)(a), if the person licensed to practice law in Utah issues a policy to more than one party to the same closing, the person is considered to have issued only one policy.

[~~(9)~~] (10) A person licensed to practice law in Utah, whether exempt under Subsection [~~(8)~~] (9) or not, shall maintain a trust account separate from a law firm trust account for all title and real estate escrow transactions.

[~~(10)~~] (11)

(a) The [~~department~~] commissioner may, in accordance with Title 63G, Chapter 4, Administrative Procedures Act, take [~~any of the following actions~~] an action described in Subsection (11)(b) against a title insurance producer if the title insurance producer:

(i)

(A) conducts title insurance business without an appointment from a title insurer; or

(B) [~~does not have an appointment~~] has not had an appointment for a period of more than 28 consecutive days from a title insurer as described in Section 31A-23a-115[~~:~~] .

(b) If the commissioner makes a finding under Subsection (11)(a), the commissioner may:

[~~(a)~~] (i) suspend or revoke the title insurance producer's license;

[~~(b)~~] (ii) freeze a bank account associated with the title insurance producer's business;

[~~(c)~~] (iii) subpoena the title insurance producer's records;

[~~(d)~~] (iv) enjoin the title producer's business operations; or

[~~(e)~~] (v) post, at the title producer's business location, a notice of an action listed in Subsections [~~(10)(a)~~] (11)(b)(i) through [~~(10)(d)~~] (iv).

(12)

(a) If an agency title insurance producer becomes aware of facts that support a reasonable belief that an electronic wire funds transfer related to a real estate or title insurance transaction did not reach the intended recipient of the electronic wire funds transfer within two business days after the day on which the transfer occurs, the agency title insurance producer shall report the facts to:

(i) the commissioner; and

(ii) each insurer with whom the producer has an appointment.

(b) An agency title insurance producer shall make a report described in Subsection (12)(a) no later than seven business days after the day on which the agency title insurance producer became aware of the facts that initiated the report.

(c) A report described in Subsection (12)(a) is not required if the electronic funds transfer is successfully sent to, and received by, the intended recipient within one business day after the agency title insurance producer becomes aware of the facts described in Subsection (12)(a).

(d) The requirement described in Subsection (12)(a) applies if:

(i) the agency title insurance producer initiated the transfer; or

(ii) the agency title insurance producer was the intended recipient of the transfer.

(e)

(i) Except as provided in Subsection (12)(e)(ii), an agency title insurance producer is immune from civil action, civil penalty, or damages, if the producer makes a good faith report under this Subsection (12).

(ii) Subsection (12)(e)(i) does not apply in an action that the department commences against a producer for the violation of this title.

(f) The identity of an agency title insurance producer that makes a report under Subsection (12)(a)(i) is a protected record under Title 63G, Chapter 2, Government Records Access and Management Act.

(13)

(a) A title insurer shall report to the commissioner the termination of an appointment of a title insurance producer within seven days after the day on which termination occurs.

(b) A title insurance producer shall report to the commissioner a title insurer's termination of the title insurance producer's appointment within seven days after the day on which termination occurs.

(c) The requirements of this Subsection (13) are in addition to the requirements of Section 31A-23a-115.

Section 48. Section **31A-23a-401** is amended to read:

31A-23a-401. Disclosure of conflicting interests.

(1)

(a) Except as provided under Subsection (1)(b):

(i) a licensee under this chapter may not act in the same or any directly related transaction as:

(A) a producer for the insured or consultant; and

(B) producer for the insurer; and

(ii) a producer for the insured or consultant may not recommend or encourage the purchase of insurance from or through an insurer or other producer:

(A) of which the producer for the insured or consultant or producer for the insured's or consultant's spouse is an owner, executive, or employee; or

(B) to which the producer for the insured or consultant has the type of relation that a material benefit would accrue to the producer for the insured or consultant or spouse as a result of the purchase.

(b) Subsection (1)(a) does not apply if the following three conditions are met:

(i) [~~Prior to~~] Before performing the consulting services, the producer for the insured or consultant shall disclose to the client, prominently, in writing:

(A) the producer for the insured's or consultant's interest as a producer for the insurer, or the relationship to an insurer or other producer; and

(B) that as a result of those interests, the producer for the insured's or the consultant's recommendations should be given appropriate scrutiny.

(ii) The producer for the insured's or consultant's fee shall be agreed upon, in writing, after the disclosure required under Subsection (1)(b)(i), but before performing the requested services.

(iii) Any report resulting from requested services shall contain a copy of the disclosure made under Subsection (1)(b)(i).

(2) A licensee under this chapter may not act as to the same client as both a producer for the insurer and a producer for the insured without the client's prior written consent based on full disclosure.

(3) Whenever a person applies for insurance coverage through a producer for the insured, the producer for the insured shall disclose to the applicant, in writing, that the producer for the insured is not the producer for the insurer or the potential insurer. This disclosure shall also inform the applicant that the applicant likely does not have the benefit of an insurer being financially responsible for the conduct of the producer for the insured.

[~~(4) If a licensee is subject to both this section and Subsection 31A-23a-501(4), the licensee shall provide the disclosure required under each statute.~~]

Section 49. Section **31A-23a-406** is amended to read:

31A-23a-406. Title insurance producer's business.

(1) As used in this section:

(a) [~~"Automated clearing house network" or~~]"ACH network" means a national electronic funds transfer system regulated by the Federal Reserve and the Office of the Comptroller of the Currency.

(b) "Depository institution" means the same as that term is defined in Section 7-1-103.

(c) "Funds transfer system" means the same as that term is defined in Section 70A-4a-105.

(2) An individual title insurance producer or agency title insurance producer may do escrow involving real property transactions if all of the following exist:

(a) the individual title insurance producer or agency title insurance producer is licensed with:

(i) the title line of authority; and

(ii) the escrow subline of authority;

(b) a title insurer authorized to do business in this state appoints the individual title insurance producer or agency title insurance producer[~~is appointed by a title insurer authorized to do business in the state~~];

(c) except as provided in Subsection (4), the individual title insurance producer or agency title insurance producer issues one or more of the following as part of the transaction:

(i) an owner's policy offering title insurance;

(ii) a lender's policy offering title insurance; or

(iii) if the transaction does not involve a transfer of ownership, an endorsement to an owner's or a lender's policy offering title insurance;

(d) money deposited with the individual title insurance producer or agency title insurance producer in connection with any escrow is deposited:

(i) in a federally insured depository institution, as defined in Section 7-1-103, that:

(A) has a branch in this state[~~, if the individual title insurance producer or agency title insurance producer depositing the money is a resident licensee~~]; and

(B) [~~is authorized by~~]the depository institution's primary regulator authorizes to engage in trust business, as defined in Section 7-5-1, in this state; and

(ii) in a trust account that is separate from all other trust account money that is not related to real estate transactions;

(e) money deposited with the individual title insurance producer or agency title insurance producer in connection with any escrow is the property of the one or more persons entitled to the money under the provisions of the escrow;

(f) money deposited with the individual title insurance producer or agency title insurance producer in connection with an escrow is segregated escrow by escrow in the records of the individual title insurance producer or agency title insurance producer;

(g) earnings on money held in escrow may be paid out of the trust account to any person in accordance with the conditions of the escrow;

(h) the escrow does not require the individual title insurance producer or agency title insurance producer to hold:

(i) construction money; or

(ii) money held for exchange under Section 1031, Internal Revenue Code; and

(i) the individual title insurance producer or agency title insurance producer[~~shall~~] :

(i) [~~maintain~~] maintains a physical office in Utah staffed by a person with an escrow subline of authority who processes the escrow[~~.~~] ; and

(ii) upon initial delivery of a commitment for a title insurance policy, notifies the parties proposed to be insured under the commitment of the availability of a closing protection letter described in Section 31A-4-117.

(3) Notwithstanding Subsection (2), an individual title insurance producer or agency title insurance producer may engage in the escrow business if:

(a) the escrow involves:

(i) a mobile home;

(ii) a grazing right;

(iii) a water right; or

(iv) other personal property [~~authorized by~~] that the commissioner authorizes; and

(b) the individual title insurance producer or agency title insurance producer complies with this section except for Subsection (2)(c).

(4)

(a) Subsection (2)(c) does not apply if the transaction is for the transfer of real property from the School and Institutional Trust Lands Administration.

(b) This subsection does not prohibit an individual title insurance producer or agency title insurance producer from issuing a policy described in Subsection (2)(c) as part of a transaction described in Subsection (4)(a).

(5) Money held in escrow:

(a) is not subject to any debts of the individual title insurance producer or agency title insurance producer;

(b) may only be used to fulfill the terms of the individual escrow under which the money is accepted; and

(c) may not be used until the conditions of the escrow are met.

(6) Assets or property other than escrow money [~~received by~~] that an individual title insurance producer or agency title insurance producer receives in accordance with an escrow shall be maintained in a manner that will:

(a) reasonably preserve and protect the asset or property from loss, theft, or damages; and

(b) otherwise comply with the general duties and responsibilities of a fiduciary or bailee.

(7)

(a) A check from the trust account described in Subsection (2)(d) may not be drawn, executed, or dated, or money otherwise disbursed unless the segregated trust account from which money is to be disbursed contains a sufficient credit balance consisting of collected and cleared money at the time the check is drawn, executed, or dated, or money is otherwise disbursed.

(b) As used in this Subsection (7), money is considered to be "collected and cleared," and may be disbursed as follows:

(i) cash may be disbursed on the same day the cash is deposited;

(ii) a wire transfer may be disbursed on the same day the wire transfer is deposited;

(iii) the proceeds of one or more of the following financial instruments may be disbursed on the same day the financial instruments are deposited if received from a single party to the real estate transaction and if the aggregate of the financial instruments for the real estate transaction is less than $10,000:

(A) a cashier's check, certified check, or official check that is drawn on an existing account at a federally insured financial institution;

(B) a check drawn on the trust account of a principal broker or associate broker licensed under Title 61, Chapter 2f, Real Estate Licensing and Practices Act, if the individual title insurance producer or agency title insurance producer has reasonable and prudent grounds to believe sufficient money will be available from the trust account on which the check is drawn at the time of disbursement of proceeds from the individual title insurance producer or agency title insurance producer's trust account;

(C) a personal check not to exceed $500 per closing; or

(D) a check drawn on the trust account of another individual title insurance producer or agency title insurance producer, if the individual title insurance producer or agency title insurance producer in the escrow transaction has reasonable and prudent grounds to believe that sufficient money will be available for withdrawal from the account upon which the check is drawn at the time of disbursement of money from the trust account of the individual title insurance producer or agency title insurance producer in the escrow transaction;

(iv) deposits made through the ACH network may be disbursed on the same day the deposit is made if:

(A) the transferred funds remain uniquely designated and traceable throughout the entire ACH network transfer process;

(B) except as a function of the ACH network process, the transferred funds are not subject to comingling or third party access during the transfer process;

(C) the transferred funds are deposited into the title insurance producer's trust account and are available for disbursement; and

(D) either the ACH network payment type or the title insurance producer's systems prevent the transaction from being unilaterally canceled or reversed by the consumer once the transferred funds are deposited to the individual title insurance producer or agency title producer; or

(v) deposits may be disbursed on the same day the deposit is made if the deposit is made via:

(A) the Federal Reserve Bank through the Federal Reserve's Fedwire funds transfer system; or

(B) a funds transfer system provided by an association of federally insured depository institutions.

(c) A check or deposit not described in Subsection (7)(b) may be disbursed:

(i) within the time limits provided under the Expedited Funds Availability Act, 12 U.S.C. Sec. 4001 et seq., as amended, and related regulations of the Federal Reserve System; or

(ii) upon notification from the financial institution to which the money has been deposited that final settlement has occurred on the deposited financial instrument.

(8) An individual title insurance producer or agency title insurance producer shall maintain a record of a receipt or disbursement of escrow money.

(9) An individual title insurance producer or agency title insurance producer shall comply with:

(a) Section 31A-23a-409;

(b) Title 46, Chapter 1, Notaries Public Reform Act; and

(c) any rules adopted by the Title and Escrow Commission, subject to Section 31A-2-404, that govern escrows.

(10) If an individual title insurance producer or agency title insurance producer conducts a search for real estate located in the state, the individual title insurance producer or agency title insurance producer shall conduct a reasonable search of the public records.

Section 50. Section **31A-23a-409** is amended to read:

31A-23a-409. Trust obligation for money collected.

(1)

(a) Subject to Subsection (7), a licensee is a trustee for money that is paid to, received by, or collected by a licensee for forwarding to insurers or to insureds.

(b)

(i) Except as provided in Subsection (1)(b)(ii), a licensee may not commingle trust funds with:

(A) the licensee's own money; or

(B) money held in any other capacity.

(ii) This Subsection (1)(b) does not apply to:

(A) amounts necessary to pay bank charges; and

(B) money paid by insureds and belonging in part to the licensee as a fee or commission.

(c) Except as provided under Subsection (4), a licensee owes to insureds and insurers the fiduciary duties of a trustee with respect to money to be forwarded to insurers or insureds through the licensee.

(d)

(i) Unless money is sent to the appropriate payee by the close of the next business day after their receipt, the licensee shall deposit them in an account authorized under Subsection (2).

(ii) Money deposited under this Subsection (1)(d) shall remain in an account authorized under Subsection (2) until sent to the appropriate payee.

(2)

(a) [~~Money~~] A licensee shall deposit money required to be deposited under Subsection (1)[~~shall be deposited~~]:

[~~(a)~~] (i) into a federally insured trust account in a depository institution, as defined in Section 7-1-103, [~~which~~] that:

[~~(i)~~] (A) has a branch in this state, if the [~~individual title insurance producer or agency title insurance producer depositing the money~~] licensee is a resident licensee;

[~~(ii)~~] (B) has federal deposit insurance; and

[~~(iii)~~] (C) [~~is authorized by its~~] the depository institution's primary regulator authorizes to engage in the trust business, as that term is defined by Section 7-5-1, in this state; or

[~~(b)~~] (ii) into some other account, that:

[~~(i)~~] (A) the commissioner approves by rule or order; and

[~~(ii)~~] (B) provides safety comparable to an account described in Subsection [~~(2)(a)~~] (2)(a)(i).

(b) This Subsection (2) does not apply to a title insurance licensee.

(3) [~~It is not a violation of~~] A licensee does not violate Subsection [~~(2)(a)~~] (2)(a)(i) if the amounts in the accounts exceed the amount of the federal insurance on the accounts.

(4)

(a) A trust account into which a licensee deposits money [~~is deposited~~]may be interest bearing.

(b) [–]The interest accrued on the account may be paid to the licensee, [~~so long as~~] if the licensee otherwise complies with this section and with the contract with the insurer.

(5) A depository institution or other organization holding trust funds under this section may not offset or impound trust account funds against debts and obligations [~~incurred by~~]the licensee incurs.

(6) A licensee who, not being lawfully entitled to do so, diverts or appropriates any portion of the money held under Subsection (1) to the licensee's own use, is guilty of theft under Title 76, Chapter 6, Part 4, Theft. Sanctions under Section 31A-2-308 also apply.

(7) A nonresident licensee:

(a) shall comply with Subsection (1)(a) by complying with the trust account requirements of the nonresident licensee's home state; and

(b) is not required to comply with the other provisions of this section.

Section 51. Section **31A-23a-501** is amended to read:

31A-23a-501. Licensee compensation.

(1) As used in this section:

(a) "Commission compensation" includes funds paid to or credited for the benefit of a licensee from:

(i) commission amounts deducted from insurance premiums on insurance sold by or placed through the licensee;

(ii) commission amounts received from an insurer or another licensee as a result of the sale or placement of insurance; or

(iii) overrides, bonuses, contingent bonuses, or contingent commissions received from an insurer or another licensee as a result of the sale or placement of insurance.

(b)

(i) "Compensation from an insurer or third party administrator" means commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes, or any other form of valuable consideration:

(A) whether [~~or not~~]payable [~~pursuant to~~] in accordance with a written agreement; and

(B) received from:

(I) an insurer; or

(II) a third party to the transaction for the sale or placement of insurance.

(ii) "Compensation from an insurer or third party administrator" does not mean compensation from a customer that is:

(A) a fee or pass-through costs as provided in Subsection (1)(e); or

(B) a fee or amount collected by or paid to the producer that does not exceed an amount [~~established by~~]the commissioner establishes by administrative rule.

(c)

(i) "Customer" means:

(A) the person signing the application or submission for insurance; or

(B) the authorized representative of the insured actually negotiating the placement of insurance with the producer.

(ii) "Customer" does not mean a person who is a participant or beneficiary of:

(A) an employee benefit plan; or

(B) a group or blanket insurance policy or group annuity contract [~~sold, solicited, or negotiated by the producer or affiliate~~] the producer or affiliate sells, solicits, or negotiates.

(d)

(i) "Noncommission compensation" includes all funds paid to or credited for the benefit of a licensee other than commission compensation.

(ii) "Noncommission compensation" does not include charges for pass-through costs incurred by the licensee in connection with obtaining, placing, or servicing an insurance policy.

(e) "Pass-through costs" include:

(i) costs for copying documents to be submitted to the insurer; and

(ii) bank costs for processing cash or credit card payments.

(2)

(a) Except as provided in Subsection (3), a licensee may receive from an insured or from a person purchasing an insurance policy, noncommission compensation.

(b) Noncommission compensation shall be:

(i) limited to actual or reasonable expenses incurred for services; and

(ii) uniformly applied to all insureds or prospective insureds in a class or classes of business or for a specific service or services.

(c) The following additional noncommission compensation is authorized:

(i) compensation a surety bond's principal debtor pays, under procedures approved by a rule or order of the commissioner, to a producer of a compensation corporate surety for an extra service;

(ii) compensation an insurance producer receives for services performed for an insured in connection with a claim adjustment, if the producer:

(A) does not receive and is not promised compensation for aiding in the claim adjustment before the claim occurs; and

(B) is also licensed as a public adjuster in accordance with Section 31A-26-203;

(iii) compensation a consultant receives as a consulting fee, if the consultant complies with the requirements under Section 31A-23a-401; and

(iv) a compensation arrangement that the commissioner approves after finding that the arrangement:

(A) does not violate Section 31A-23a-401; and

(B) is not harmful to the public.

(d) All accounting records relating to noncommission compensation shall be maintained in a manner that facilitates an audit.

(3)

(a) A surplus lines producer may receive noncommission compensation when acting as a producer for the insured in a surplus lines transaction, if:

(i) the producer and the insured have agreed on the producer's noncommission compensation; and

(ii) the producer has disclosed to the insured the existence and source of any other compensation that accrues to the producer as a result of the transaction.

(b) The disclosure required by this Subsection (3) shall:

(i) include the signature of the insured or prospective insured acknowledging the noncommission compensation;

(ii) clearly specify:

(A) the amount of any known noncommission compensation;

(B) the type and amount, if known, of any potential and contingent noncommission compensation; and

(C) the existence and source of any other compensation; and

(iii) be provided to the insured or prospective insured before the performance of the service.

[~~(4)~~

~~(a) For purposes of this Subsection (4):~~]

[~~(i) "Large customer" means an employer who, with respect to a calendar year and to a plan year:~~]

[~~(A) employed an average of at least 100 eligible employees on each business day during the preceding calendar year; and~~]

[~~(B) employs at least two employees on the first day of the plan year.~~]

[~~(ii) "Producer" includes:~~]

[~~(A) a producer;~~]

[~~(B) an affiliate of a producer; or~~]

[~~(C) a consultant.~~]

[~~(b) A producer may not accept or receive any compensation from an insurer or third party administrator for the initial placement of a health benefit plan, other than a hospital confinement indemnity policy, unless prior to a large customer's initial purchase of the health benefit plan the producer discloses in writing to the large customer that the producer will receive compensation from the insurer or third party administrator for the placement of insurance, including the amount or type of compensation known to the producer at the time of the disclosure.~~]

[~~(c) A producer shall:~~]

[~~(i) obtain the large customer's signed acknowledgment that the disclosure under Subsection (4)(b) was made to the large customer; or~~]

[~~(ii)~~

~~(A) sign a statement that the disclosure required by Subsection (4)(b) was made to the large customer; and~~]

[~~(B) keep the signed statement on file in the producer's office while the health benefit plan placed with the large customer is in force.~~]

[~~(d) A licensee who collects or receives any part of the compensation from an insurer or third party administrator in a manner that facilitates an audit shall, while the health benefit plan placed with the large customer is in force, maintain a copy of:~~]

[~~(i) the signed acknowledgment described in Subsection (4)(c)(i); or~~]

[~~(ii) the signed statement described in Subsection (4)(c)(ii).~~]

[~~(e) Subsection (4)(c) does not apply to:~~]

[~~(i) a person licensed as a producer who acts only as an intermediary between an insurer and the customer's producer, including a managing general agent; or~~]

[~~(ii) the placement of insurance in a secondary or residual market.~~]

[~~(f)~~

~~(i) A producer shall provide to a large customer listed in this Subsection (4)(f) an annual accounting, as defined by rule made by the department in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, of all amounts the producer receives in commission compensation from an insurer or third party administrator as a result of the sale or placement of a health benefit plan to a large customer that is:~~]

[~~(A) the state;~~]

[~~(B) a political subdivision or instrumentality of the state or a combination thereof primarily engaged in educational activities or the administration or servicing of educational activities, including the State Board of Education and its instrumentalities, an institution of higher education and its branches, a school district and its instrumentalities, a vocational and technical school, and an entity arising out of a consolidation agreement between entities described under this Subsection (4)(f)(i)(B);~~]

[~~(C) a county, city, town, special district under Title 17B, Limited Purpose Local Government Entities - Special Districts, special service district under Title 17D, Chapter 1, Special Service District Act, an entity created by an interlocal cooperation agreement under Title 11, Chapter 13, Interlocal Cooperation Act, or any other governmental entity designated in statute as a political subdivision of the state; or~~]

[~~(D) a quasi-public corporation, that has the same meaning as defined in Section 63E-1-102.~~]

[~~(ii) The department shall pattern the annual accounting required by this Subsection (4)(f) on the insurance related information on Internal Revenue Service Form 5500 and its relevant attachments.~~]

[~~(g) At the request of the department, a producer shall provide the department a copy of:~~]

[~~(i) a disclosure required by this Subsection (4); or~~]

[~~(ii) an Internal Revenue Service Form 5500 and its relevant attachments.~~]

[~~(5)~~] (4) This section does not alter the right of any licensee to recover from an insured the amount of any premium due for insurance effected by or through that licensee or to charge a reasonable rate of interest upon past-due accounts.

[~~(6)~~] (5) This section does not apply to bail bond producers or bail enforcement agents as defined in Section 31A-35-102.

[~~(7)~~] (6) A licensee may not receive noncommission compensation from an insurer, insured, or enrollee for providing a service or engaging in an act that is required to be provided or performed in order

to receive commission compensation, except for the surplus lines transactions that do not receive commissions.

Section 52. Section **31A-26-301** is amended to read:

31A-26-301. Timely payment of claims.

(1)

(a) Unless otherwise provided by law, an insurer shall timely pay every valid insurance claim made by an insured.

(b) By rule the commissioner may prescribe:

(i) the kinds of notice and proof of loss that will establish validity;

(ii) the manner in which an insurer may make a bona fide denial of a claim;

(iii) the periods of time within which payment is required to be made to be timely; and

(iv) the reasonable interest rates to be charged upon late claim payments.

(2)

(a) Notwithstanding Subsection (1) and subject to Subsection (2)(b), the payment of a claim is not overdue during any period in which:

(i) the insurer is unable to pay the claim because there is no recipient legally able to give a valid release for the payment; or

(ii) the insurer is unable to determine who is entitled to receive the payment.

(b) Subsection (2)(a) applies only if the insurer:

(i) promptly notifies the claimant of the inability to pay the claim; and

(ii) offers in good faith to pay the claim promptly when the inability to pay the claim is removed.

(3) This section applies only to a claim for first party benefits made by a person who is:

(a) named or defined as an insured under the terms of an insurance policy;

(b) described as a covered person under the terms of a policy of health care insurance as defined in Section 31A-1-301; or

(c) named, defined, or described:

(i) as:

(A) an insured;

(B) a beneficiary;

(C) a policyholder; or

(D) otherwise covered person; and

(ii) under the terms of:

(A) a life insurance policy; or

(B) an annuity.

(4)

(a) A dental insurer that pays a claim with a tangible check shall send the tangible check to the address designated by the provider.

(b) If a tangible check described in Subsection (4)(a) is returned to the dental insurer or has not been deposited or cashed after 180 days after the day on which the tangible check is issued, the dental insurer shall make a reasonable attempt to notify the provider by phone, mail, and email.

(c) A dental insurer that complies with Subsection (4)(b) is not obligated to pay a claim if:

(i) at least 365 days after the day on which the tangible check was issued have passed;

(ii) the dental insurer has documented the dental insurer's attempts to notify the provider of the returned payment; and

(iii) the provider has not:

(A) attempted to collect the payment; or

(B) contacted the dental insurer about the payment.

(5) If a dental insurer does not pay a claim to a provider after the dental insurer complies with Subsection (4), the provider may not seek payment from the insured.

Section 53. Section **31A-26-301.6** is amended to read:

31A-26-301.6. Health care claims practices.

(1) As used in this section:

(a) "Health care provider" means a person licensed to provide health care under:

(i) Title 26B, Chapter 2, Part 2, Health Care Facility Licensing and Inspection; or

(ii) Title 58, Occupations and Professions.

(b) "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~~] the third party administrator's own funds to pay claims that have not been funded by the entity for which the third party administrator is paying claims.

(c) "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) an accident and 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~~] that a provider or insured submits 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~~] If 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~~] If 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~~] an individual receiving benefits under the state Medicaid program as defined in Section 26B-3-101, unless required by the Department of Health and Human Services or federal law.

(8)

(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) The late fee described in Subsection (8)(a) 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) 0.033% daily interest rate.

(c) Any late fee paid or collected under this Subsection (8) shall be separately identified on the documentation used by the insurer to pay the claim.

(d) 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~~] In accordance with Chapter 2, Part 2, Duties and Powers of Commissioner, 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 provider may only seek recovery from the insurer for an amount the insurer improperly [~~paid by the insurer~~] pays within the same time frames [~~as Subsections~~] described in Subsection (14)(a)[~~ and (b)~~].

(16)

(a) An insurer may offer the remittance of payment through a credit card or other similar arrangement.

(b)

(i) A provider may elect not to receive remittance through a credit card or other similar arrangement.

(ii) An insurer:

(A) shall permit a provider's election described in Subsection (16)(b)(i) to apply to the provider's entire practice;

(B) may not require a provider's election described in Subsection (16)(b)(i) to be made on a patient-by-patient basis; and

(C) shall allow a provider to opt out of all credit card or other similar arrangements for every plan offered by the insurer through a single opt out process.

(iii) If a provider elects not to receive remittance through a credit card or other similar arrangement, that decision remains in effect until:

(A) the provider affirmatively elects to receive remittance through credit card or similar arrangement; or

(B) a new contract is issued.

(c) An insurer may not require a provider or insured to accept remittance through a credit card or other similar arrangement.

(d) An insurer shall allow a tangible check as a form of acceptable payment.

(e) Before July 1, 2028, a dental insurer may not impose a fee for paying with a tangible check.

Section 54. Section **31A-26-301.7** is amended to read:

31A-26-301.7. Dental claim transparency and practices.

(1) As used in this section:

(a) "Bundling" means the practice of combining distinct dental procedures into one procedure for billing purposes.

(b) "Dental plan" means the same as that term is defined in Section 31A-22-646.

(c) "Downcoding" means the adjustment of a claim submitted to a dental plan to a less complex or lower cost procedure code.

(d) "Covered services" means the same as that term is defined in Section 31A-22-646.

(e) "Material change" means a change to:

(i) a dental plan's rules, guidelines, policies, or procedures concerning payment for dental services;

(ii) the general policies of the dental plan that affect a reimbursement paid to providers; or

(iii) the manner by which a dental plan adjudicates and pays a claim for services.

(f) "Procedure code" means the Current Dental Terminology code maintained by the American Dental Association.

(g) "Professionally accepted treatment" means a dental service, medication, material, technology, or procedure that meets generally accepted practice standards to complete a procedure code.

(h) "Unbundling" means the systematic separate billing of distinct dental procedures by a dental provider that results in transparent documentation of actual services rendered.

(2) An insurer that contracts or renews a contract with a dental provider shall:

(a) make a copy of the insurer's current dental plan policies available online; and

(b) if requested by a provider, send a copy of the policies to the provider through mail or electronic mail.

(3) Dental policies described in Subsection (2) shall include:

(a) a summary of all material changes made to a dental plan since the policies were last updated;

(b) the downcoding and bundling policies that the insurer reasonably expects to be applied to the dental provider or provider's services as a matter of policy; and

(c) a description of the dental plan's utilization review procedures, including:

(i) a procedure for an enrollee of the dental plan to obtain review of an adverse determination in accordance with Section 31A-22-629; and

(ii) a statement of a provider's rights and responsibilities regarding the procedures described in Subsection (3)(c)(i).

(4) An insurer may not maintain a dental plan that:

(a) based on the provider's contracted fee for covered services, uses downcoding in a manner that prevents a dental provider from collecting the contracted fee for the actual service performed from either the plan or the patient;

(b) uses bundling in a manner where a procedure code is labeled as nonbillable to the patient unless, under generally accepted practice standards, the procedure code is for a procedure that may be provided in conjunction with another procedure;

(c) does not allow a dental provider to seek payment of the contracted fee for a covered service from the patient when the insurer denies payment for the service, unless under generally accepted practice standards, the service performed should not be billed; or

(d) beginning January 1, 2026, automatically recoups an overpayment unless:

(i) the recoupment occurs more than 60 days from the day the insurer sends a notice of the overpayment; or

(ii) the dental provider affirmatively elects to have recoupment occur earlier than 60 days from the day the insurer sends a notice of the overpayment.

[~~(5)~~

~~(a) An insurer shall ensure that an explanation of benefits for a dental plan includes the reason for any downcoding or bundling result.~~]

[~~(b) A dental provider who receives an overpayment from a dental plan shall return the amount of the overpayment through check or other means to the dental plan within 60 days from the day the insurer sends a notice of the overpayment.~~]

[~~(c) A dental provider shall make reasonable efforts to inform patients of services that may not be covered by the patient's dental plan if the dental provider will perform a service that may not be covered.~~]

Section 55. Section **55** is enacted to read:

31A-26-301.8. Non-covered dental services and claims documentation.

(1) Terms defined in Section 31A-26-301.7 apply to this section.

(2) An insurer may not require a dental provider to submit the dental provider's full fee-for-service charges on a claim form as a condition of payment or processing if:

(a) the dental provider disclosed the dental provider's full fee schedule during credentialing, contract negotiation, or renewal; and

(b) the contract includes a contracted fee schedule for covered services.

(3)

(a) If an insurer requires submission of a claim form, a dental provider may report:

(i) the contracted fee; or

(ii) the dental provider's fee for service.

(b) An insurer may not penalize a dental provider because of the dental provider's choice under Subsection (3)(a).

(4) If an insurer determines that a provided dental service is not a covered service, the insurer shall issue an explanation of benefits to the dental provider and patient that:

(a) clearly states that the procedure code is not covered under the dental plan; and

(b) does not describe the unreimbursed amount as a required contractual adjustment or mandatory write-off.

(5)

(a) An insurer shall ensure that an explanation of benefits for a dental plan includes the reason for any downcoding or bundling result.

(b) A dental provider who receives an overpayment from a dental plan shall return the amount of the overpayment through check or other means to the dental plan within 60 days from the day the insurer sends a notice of the overpayment.

(6) An insurer's failure to comply with Subsection (4) does not prevent a dental provider from billing and collecting payment from a patient for a non-covered service.

Section 56. Section **31A-26-401** is amended to read:

31A-26-401. Required contracts.

(1)

(a) A public adjuster may not, directly or indirectly, act within this state as a public adjuster without having first entered into a contract, in writing, on a form [~~filed~~] a public adjuster files with the department in accordance with Section 31A-21-201, [~~executed in duplicate by~~] that the public adjuster and the insured or the insured's duly authorized representative executes in duplicate.[~~A public adjuster may not use a form of contract that is not filed with the department.~~]

(b) A public adjuster shall provide a signed copy of the contract to the insured at the time of signing.

(c) A public adjuster may not use a form of contract that the public adjuster has not filed with the department.

(d) A public adjuster may not redact a compensation provision from a contract form the public adjuster files with the department.

(2)

(a) [~~A~~] An insured may rescind a contract described in Subsection (1) [~~is subject to recision~~]in accordance with Section 31A-26-311.

(b) If an insured rescinds a contract, the public adjuster shall return to the insured anything of value the insured gives to the public adjuster under the terms of the contract within 15 business days after the day on which the public adjuster receives the notice of rescission.

[~~(3)~~

~~(a) A contract described in Subsection (1) shall include a prominently displayed notice in 12-point boldface type that states "WE REPRESENT THE INSURED ONLY."~~]

[~~(b) The commissioner by rule, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, may require additional prominently displayed notice requirements in the contract as the commissioner considers necessary.~~]

(3) A contract described in Subsection (1):

(a) shall include each notice and statement that the commissioner:

(i) deems necessary; and

(ii) requires by rule in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and

(b) may not include a term that:

(i) allows a public adjuster to collect the public adjuster's percentage fee when money is due from an insurance company but the insurance company has not paid;

(ii) allows a public adjuster to collect the entire fee from the first check an insurance company issues instead of a percentage of each check the insurance company issues;

(iii) requires an insured to authorize an insurance company to issue a check only in the name of the public adjuster;

(iv) imposes a collection cost or a late fee; or

(v) prevents an insured from pursuing a civil remedy.

(4)

(a) A public adjuster shall provide to the insurer a notification letter, that the insured signs, authorizing the public adjuster to represent the insured's interest.

(b) After receiving the letter described in Subsection (4)(a), an insurer shall verify with the department that the public adjuster holds a valid license.

[~~(4) A public adjuster shall keep at the public adjuster's principal place of business a copy of each contract entered into in this state for the current year plus three years, and each contract shall be available at all times for inspection, without notice, by the commissioner or the commissioner's authorized representative.~~]

(5) A public adjuster may not enter into a contract with an insured and collect compensation as provided in the contract without actually performing the services a licensed public adjuster customarily [~~provided by a licensed public adjuster for~~] provides the insured.

Section 57. Section **31A-26-402** is amended to read:

31A-26-402. Compensation.

(1) Except as provided by [~~Subsection (2)~~] Subsection (4), a public adjuster may receive compensation for service [~~provided~~] a public adjuster provides under this chapter consisting of:[~~-~~]

(a) an hourly fee[~~,~~] ;

(b) [~~-~~]a flat rate[~~,~~] ;

(c) [~~-~~]a percentage of the total amount [~~paid by~~]an insurer pays to resolve a claim[~~,~~] ; or

(d) [-]another method of compensation.

(2)

(a) If a person compensates a public adjuster at an hourly rate, the contract between the person and public adjuster shall state:

(i) the hourly rate; and

(ii) how the hourly rate applies to the hours of service the public adjuster provides to calculate the amount payable to the public adjuster.

(b) If a person compensates a public adjuster on a flat fee basis, the contract between the person and public adjuster shall state the amount payable to the public adjuster.

(c) If a person compensates a public adjuster on a percentage basis, the contract between the person and the public adjuster shall state the exact percentage that applies to the settlement of a claim to calculate the amount payable to the public adjuster.

(d) If a person uses a method of calculation not described in Subsections (2)(a) through (c) to determine a public adjuster's compensation, the contract between the person and the public adjuster shall include a detailed explanation of how the person determines the amount payable to the public adjuster based on the service the public adjuster provides.

(3)

(a) A contract between an insured and a public adjuster for compensation under this section shall state the type of initial expenses, with dollar estimates, that the insured approves to reimburse the public adjuster from the proceeds of the claim payment.

(b) A public adjuster shall provide an itemized invoice of each expense the public adjuster incurs during the process of resolving a claim to the insured at the conclusion of a claim.

[~~(2)~~] (4)

(a) A public adjuster may not receive a compensation consisting of a percentage of the total amount [~~paid by~~]an insurer pays to resolve a claim on a claim on which the insurer, not later than 72 hours after the [~~date~~] day on which the loss is reported to the insurer, either pays or commits in writing to pay to the insured the policy limit of the insurance policy.

(b) [~~A~~] Subject to Subsection (6), a public adjuster is entitled to reasonable compensation from the insured for services [~~provided by~~]the public adjuster provides on behalf of the insured, based on the time spent on a claim that is subject to this [~~Subsection (2)~~] Subsection (4) and expenses [~~incurred~~

~~by~~]the public adjuster incurs, until the claim is paid or the insured receives a written commitment to pay from the insurer.

[~~(3)~~] (5) Except for the payment of compensation by the insured, a person paying proceeds of a policy of insurance or making a payment affecting an insured's rights under a policy of insurance shall:

(a) include the insured as a payee on the payment draft or check; and

(b) require the written signature and endorsement of the insured on the payment draft or check.

[~~(4)~~] (6) A public adjuster may not:

(a) [~~-~~]accept [~~any~~] a payment that violates this section notwithstanding [~~whether~~] a written authorization that the insured gives [~~authorization~~]to the public adjuster[~~.~~] ;

(b) [~~A public adjuster may not~~]sign and endorse [~~any~~] a payment draft or check on behalf of an insured[~~.~~] ;

(c) charge, agree to, or accept as compensation or reimbursement, a payment, commission, fee, or another thing of value equal to more than:

(i) 10% for a catastrophic insurance claim settlement; or

(ii) 20% for a non-catastrophic insurance claim settlement; or

(d) require, demand, or accept a fee, retainer, compensation, deposit, or other thing of value before the settlement of a claim.

Section 58. Section **58** is enacted to read:

31A-26-403.1. Assignment of property insurance policy rights and benefits.

(1) A property insurance policy may prohibit the assignment of a right or benefit under the property insurance policy to a property repair contractor, roofing company, disaster clean up company, appraiser, inspector, or other person hired to remedy the damage that is the subject of an insured's claim.

(2) A person may not circumvent the prohibition described in Subsection (1) by obtaining a power of attorney from an insured.

(3) A property insurance policy may not prohibit the assignment of a right or benefit under the policy to a policy adjuster.

Section 59. Section **59** is enacted to read:

31A-26-404. Funds that a public adjuster holds.

A public adjuster that receives, accepts, or holds funds on behalf of an insured shall deposit the funds into a trust account within a federally insured depository institution that:

(1)

(a) has a branch in this state, if the public adjuster depositing the money is a resident licensee;

(b) has a branch in the public adjuster's home state, if the public adjuster is a nonresident licensee; or

(c) has a branch where the loss occurred; and

(2) the depository institution's primary regulator authorizes to engage in trust business.

Section 60. Section **60** is enacted to read:

31A-26-405. Public adjuster standards of conduct.

A public adjuster may not:

(1) solicit or attempt to solicit an insured during the progress of a loss-producing occurrence;

(2) advertise or infer damage unless an inspection of the property has been completed;

(3) offer to pay an insured's deductible, or claim that the public adjuster will waive the insured's deductible, as an inducement for the insured to use the public adjuster's services;

(4) offer to conduct a free inspection of property other than property that is the subject of an insured's claim;

(5) participate directly, indirectly, or through an affiliate, in the reconstruction, repair, or restoration of property that is the subject of the public adjuster's contract with an insured;

(6) solicit, accept compensation from, or have an interest in a business that provides a product or service in connection with a claim that the public adjuster has a contract to adjust;

(7) have a financial interest in, directly, indirectly, or through an affiliate, an aspect of an insured's claim except for:

(a) a salary;

(b) a fee;

(c) a commission; or

(d) other compensation established in the written contract with the insured;

(8) collect compensation as provided in a contract without actually performing the service a licensed public adjuster customarily provides for the insured;

(9) acquire an interest in a salvage of property except as authorized in a contract with the insured;

(10) recommend or direct that the insured obtain a repair or service in connection with a loss from a person:

(a) in whom the public adjuster has a financial interest; or

(b) from whom the public adjuster may receive direct or indirect compensation for the referral;

(11) accept, sign, or endorse a check or payment draft:

(a) that does not name the insured as a payee; or

(b) on behalf of the insured;

(12) adjust a claim if the terms and conditions of the insurance coverage exceed the public adjuster's competence, knowledge, or expertise;

(13) represent or act as a company adjuster or independent adjuster on the same claim;

(14) enter into a contract or accept a power of attorney that vests in the public adjuster the authority to choose the persons that will perform repair work;

(15) agree to a loss settlement without the insured's knowledge or consent; or

(16) allow the following to obtain an insured's signature on the public adjuster's contract:

(a) a home repair contractor;

(b) a roofing company;

(c) a disaster clean up company;

(d) an appraiser;

(e) an inspector; or

(f) any other person hired to remedy the damage that is the subject of the insured's claim.

Section 61. Section **61** is enacted to read:

31A-26-406. Record retention requirements.

(1) A public adjuster shall keep at the public adjuster's address that the public adjuster registers with the commissioner a record of each investigation, adjustment, or transaction the public adjuster undertakes or completes under the public adjuster's license.

(2) For each investigation, adjustment, or transaction, a record described in Subsection (1) shall include:

(a) the name of the insured;

(b) the date, location, and amount of the loss the insured incurs;

(c) a copy of the contract between the public adjuster and the insured;

(d) for each policy an insured carries that relates to the loss the insured incurs:

(i) the name of the insurer;

(ii) the amount of the policy;

(iii) the expiration date of the policy; and

(iv) the number of the policy;

(e) an itemized statement of each of the insured's recoveries;

(f) an itemized statement of all compensation the public adjuster receives in connection with the investigation, adjustment, or transaction;

(g) a register of all money the public adjuster receives, deposits, disburses, or withdraws in connection with a transaction with an insured, including:

(i) a fee transfer;

(ii) a disbursement from a trust account; or

(iii) a transaction that involves an interest-bearing account;

(h) the name of the public adjuster that executed the contract;

(i) the name of the attorney that represents the insured, if applicable;

(j) the name of the insurance company's claims representative; and

(k) documentation that the public adjuster meets all applicable statutory financial responsibility requirements.

Section 62. Section **31A-26-407** is renumbered and amended to read:

~~[31A-26-403]~~ 31A-26-407. Rulemaking.

The commissioner may make rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act:

(1) addressing the forms required by this part;

(2) providing for notice requirements in contracts; and

(3) establishing the scope of a contract a public adjuster enters into with an insured that the public adjuster represents.

Section 63. Section **31A-28-203** is amended to read:

Part 2. Utah Property and Casualty Insurance Guaranty Association Act

31A-28-203. Definitions.

As used in this part:

(1) "Affiliate" [~~is as defined~~] means the same as that term is defined in Section 31A-1-301.

(2) "Association account" means the Utah Property and Casualty Insurance Guaranty Association Account created by Section 31A-28-205.

(3)

(a) "Claimant" means:

(i) an insured making a first-party claim; or

(ii) a person instituting a liability claim.

(b) A person who is an affiliate of the insolvent insurer may not be a claimant.

(4)

(a) "Covered claim" means an unpaid claim, including an unpaid claim under a personal lines policy for unearned premiums [~~submitted by~~]a claimant submits, if:

(i) the claim arises out of the coverage;

(ii) the claim is within the coverage;

(iii) the claim is not in excess of the applicable limits of an insurance policy to which this part applies;

(iv) the insurer who issued the policy becomes an insolvent insurer; and

(v)

(A) the claimant or insured is a resident of this state at the time of the insured event; or

(B) the claim is a first-party claim for damage to property that is permanently located in this state.

(b) "Covered claim" does not include:

(i) [~~any~~] an amount awarded as punitive or exemplary damages or [~~any~~] an amount due any reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise[~~,~~] ;

(ii) [~~nor does it include any~~] a supplementary payment obligation, including adjustment fees and expenses, attorneys' fees and expenses, court costs, interest, and bond premiums, [~~prior to~~] before the appointment of a liquidator;

[~~(ii)~~] (iii) [~~any~~] an amount sought as a return of premium under a retrospective rating plan;

[~~(iii)~~] (iv) [~~any~~] a first-party claim by an insured if:

(A) the insured's net worth exceeds $25,000,000 on December 31 of the year [~~preceding the date~~] before the day on which the insurer becomes an insolvent insurer; and

(B) the insured's net worth includes the aggregate net worth of the insured and all of [~~its~~] the insured's subsidiaries as calculated on a consolidated basis;[~~or~~]

[~~(iv)~~] (v) any first-party claims by an insured that is an affiliate of the insolvent insurer[~~.~~] ; or

(vi) a claim by or against an insured of an insolvent insurer, if the insured has a net worth of more than $25,000,000 on the day on which the insurer becomes:

(A) insolvent; or

(B) subject to an order of liquidation.

(5) "Insolvent insurer" means a member insurer that is placed under an order of liquidation by a court [~~of competent~~] with jurisdiction [~~with~~] that makes a finding of insolvency.

(6) "Member insurer" means [~~any~~] a person [~~who~~] that:

(a) writes any kind of insurance to which this part applies under Section 31A-28-202, including the exchange of reciprocal or inter-insurance contracts; and

(b) is licensed to transact insurance in this state.

(7)

(a) "Net direct written premiums" means direct gross premiums written in this state on insurance policies that this part applies to, less return premiums and dividends paid or credited to policyholders on the direct business.

(b) "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers.

(8) "Personal lines policy" means an insurance policy issued to an individual that:

(a) insures a motor vehicle used for personal purposes and not used in trade or business; or

(b) insures a residential dwelling.

(9) "Residence" means, for [~~entities~~] an entity other than a natural person, the state where the principal place of business of a claimant, insured, or policyholder is located at the time of the insured event.

Section 64. Section **31A-35-103** is amended to read:

31A-35-103. Exemption from other provisions of this title.

Bail bond agencies are exempted from:

(1) Chapter 3, Department Funding, Fees, and Taxes, except Section 31A-3-103;

(2) Chapter 4, Insurers in General, except Sections 31A-4-102, 31A-4-103, 31A-4-104, and 31A-4-107;

(3) Chapter 5, Domestic Stock and Mutual Insurance Corporations, except Section 31A-5-103;

(4) Chapter 6a, Service Contracts;

(5) Chapter 6b, Guaranteed Asset Protection Waiver Act;

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

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

(8) Chapter 8a, Health Discount Program Consumer Protection Act;

(9) Chapter 9, Insurance Fraternals;

(10) Chapter 10, Annuities;

(11) Chapter 11, Motor Clubs;

(12) Chapter 12, State Risk Management Fund;

(13) Chapter 14, Foreign Insurers;

(14) Chapter 15, Unauthorized Insurers, Surplus Lines, and Risk Retention Groups;

(15) Chapter 16, Insurance Holding Companies;

(16) Chapter 17, Determination of Financial Condition;

(17) Chapter 18, Investments;

(18) Chapter 19a, Utah Rate Regulation Act;

(19) Chapter 20, Underwriting Restrictions;

(20) Chapter 23b, Navigator License Act;

(21) Chapter 25, Third Party Administrators;

(22) Chapter 26, Insurance Adjusters;

(23) [~~Chapter 27, Delinquency Administrative Action Provisions~~] Chapter 27, Administrative Supervision of Insurers;

(24) Chapter 27a, Insurer Receivership Act;

(25) Chapter 28, Guaranty Associations;

(26) Chapter 30, Individual, Small Employer, and Group Health Insurance Act;

(27) Chapter 31, Insurance Fraud Act;

(28) Chapter 32a, Medical Care Savings Account Act;

(29) Chapter 36, Life Settlements Act;

(30) Chapter 37, Captive Insurance Companies Act;

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

(32) Chapter 38, Federal Health Care Tax Credit Program Act;

(33) Chapter 39, Interstate Insurance Product Regulation Compact;

(34) Chapter 40, Professional Employer Organization Licensing Act;

(35) Chapter 41, Title Insurance Recovery, Education, and Research Fund Act; and

(36) Chapter 43, Small Employer Stop-Loss Insurance Act.

Section 65. Section **31A-37-102** is amended to read:

31A-37-102. Definitions.

As used in this chapter:

(1)

(a) "Affiliated company" means a business entity that because of common ownership, control, operation, or management is in the same corporate or limited liability company system as:

(i) a parent;

(ii) an industrial insured; or

(iii) a member organization.

(b) "Affiliated company" does not include a business entity for which the commissioner issues an order finding that the business entity is not an affiliated company.

(2) "Agency captive" means a captive insurer that:

(a) is owned by one or more business entities that are licensed in any state as insurance producers or managing general agents; and

(b) only insures risks on policies placed through the captive insurer's owners.

(3) "Alien captive insurance company" means an insurer:

(a) formed to write insurance business for a parent or affiliate of the insurer; and

(b) licensed [~~pursuant to~~] in accordance with the laws of an alien or foreign jurisdiction that imposes statutory or regulatory standards:

(i) on a business entity transacting the business of insurance in the alien or foreign jurisdiction; and

(ii) in a form acceptable to the commissioner.

(4) "Applicant captive insurance company" means an entity that has submitted an application for a certificate of authority for a captive insurance company, unless the application has been denied or withdrawn.

(5) "Association" means a legal association of two or more persons that meets the following requirements:

(a) the persons are exposed to similar or related liability because of related, similar, or common business trade, products, services, premises, or operations; and

(b)

(i) the association or the association's member organizations:

(A) own, control, or hold power to vote all of the outstanding voting securities of an association captive insurance company incorporated as a stock insurer;

(B) have complete voting control over an association captive insurance company incorporated as a mutual insurer; or

(C) have complete voting control over an association captive insurance company formed as a limited liability company; or

(ii) the association's member organizations collectively constitute all of the subscribers of an association captive insurance company formed as a reciprocal insurer.

(6) "Association captive insurance company" means a business entity that insures risks of:

(a) a member organization of the association;

(b) an affiliate of a member organization of the association; and

(c) the association.

(7) "Branch business" means an insurance business transacted by a branch captive insurance company in this state.

(8) "Branch captive insurance company" means an alien captive insurance company that has a certificate of authority from the commissioner to transact the business of insurance in this state through a captive insurance company that is domiciled outside of this state.

(9) "Branch operation" means a business operation of a branch captive insurance company in this state.

(10)

(a) "Captive insurance company" means the same as that term is defined in Section 31A-1-301.

(b) "Captive insurance company" includes any of the following formed or holding a certificate of authority under this chapter:

(i) an agency captive insurance company;

(ii) [~~a branch~~] an association captive insurance company;

(iii) a [~~pooling~~] branch captive insurance company;

(iv) [~~a pure~~] an industrial insured captive insurance company;

(v) [~~an association~~] a pooling captive insurance company;

(vi) a [~~sponsored~~] pure captive insurance company;

(vii) [~~an industrial insured captive insurance company, including an industrial insured captive insurance company formed as~~]a risk retention group [~~captive in this state pursuant to the provisions of the Federal Liability Risk Retention Act of 1986;~~] formed in this state as a corporation or other limited liability entity under the Liability Risk Retention Act of 1986, 15 U.S.C. Sec. 3901 et seq.;

(viii) a [~~special purpose~~] sponsored captive insurance company;[~~ or~~]

(ix) a special purpose [~~financial~~]captive insurance company[~~.~~] ; or

(x) a special purpose financial captive insurance company.

(11)

(a) "Cell" means a separate account for one or more participants formed and operating under the authority of a sponsored captive insurance company to write insurance coverage as described in this title.

(b) "Cell" includes an account formed as either:

(i) an incorporated cell; or

(ii) a protected cell.

(12) "Commissioner" means Utah's Insurance Commissioner or the commissioner's designee.

(13) "Common ownership and control" means that two or more captive insurance companies are owned or controlled by the same person or group of persons as follows:

(a) in the case of a captive insurance company that is a stock corporation, the direct or indirect ownership of 80% or more of the outstanding voting stock of the stock corporation;

(b) in the case of a captive insurance company that is a mutual corporation, the direct or indirect ownership of 80% or more of the surplus and the voting power of the mutual corporation;

(c) in the case of a captive insurance company that is a limited liability company, the direct or indirect ownership by the same member or members of 80% or more of the membership interests in the limited liability company; or

(d) in the case of a sponsored captive insurance company, a cell is a separate captive insurance company owned and controlled by the cell's participant, only if:

(i) the participant is the only participant with respect to the cell; and

(ii) the participant is the sponsor or is affiliated with the sponsor of the sponsored captive insurance company through common ownership and control.

(14) "Consolidated debt to total capital ratio" means the ratio of Subsection (14)(a) to (b).

(a) This Subsection (14)(a) is an amount equal to the sum of all debts and hybrid capital instruments including:

(i) all borrowings from depository institutions;

(ii) all senior debt;

(iii) all subordinated debts;

(iv) all trust preferred shares; and

(v) all other hybrid capital instruments that are not included in the determination of consolidated GAAP net worth issued and outstanding.

(b) This Subsection (14)(b) is an amount equal to the sum of:

(i) total capital consisting of all debts and hybrid capital instruments as described in Subsection (14)(a); and

(ii) shareholders' equity determined in accordance with generally accepted accounting principles for reporting to the United States Securities and Exchange Commission.

(15) "Consolidated GAAP net worth" means the consolidated shareholders' or members' equity determined in accordance with generally accepted accounting principles for reporting to the United States Securities and Exchange Commission.

(16) "Controlled unaffiliated business" means a business entity:

(a)

(i) in the case of a [~~pure~~]captive insurance company, other than a risk retention group, that is not in the corporate or limited liability company system of a parent or the parent's affiliate; or

(ii) in the case of an industrial insured captive insurance company, that is not in the corporate or limited liability company system of an industrial insured or an affiliated company of the industrial insured;

(b)

(i) in the case of a [~~pure~~]captive insurance company, other than a risk retention group, that has a contractual relationship with a parent or affiliate; or

(ii) in the case of an industrial insured captive insurance company, that has a contractual relationship with an industrial insured or an affiliated company of the industrial insured; and

(c) whose risks that are or will be insured by a [~~pure~~]captive insurance company, [~~an industrial insured captive insurance company, or both~~] other than a risk retention group, are managed in accordance with Subsection 31A-37-106(1)(j) by:

(i)

(A) a [~~pure~~]captive insurance company; or

(B) an industrial insured captive insurance company; or

(ii) a parent or affiliate of:

(A) a [~~pure~~]captive insurance company; or

(B) an industrial insured captive insurance company.

(17) "Criminal act" means an act for which a person receives a verdict or finding of guilt after a criminal trial or a plea of guilty or nolo contendere to a criminal charge.

(18) "Establisher" means a person who establishes a business entity or a trust.

(19) "Governing body" means the persons who hold the ultimate authority to direct and manage the affairs of an entity.

(20) "Incorporated cell" means a separate account:

(a) established and maintained by a sponsored captive insurance company for a participant; and

(b) that has been organized as a corporation, a limited liability company, or a not-for-profit organization.

(21) "Industrial insured" means an insured:

(a) that produces insurance:

(i) by the services of a full-time employee acting as a risk manager or insurance manager; or

(ii) using the services of a regularly and continuously qualified insurance consultant;

(b) whose aggregate annual premiums for insurance on all risks total at least $25,000; and

(c) that has at least 25 full-time employees.

(22) "Industrial insured captive insurance company" means a business entity that:

(a) insures risks of the industrial insureds that comprise the industrial insured group; and

(b) may insure the risks of:

(i) an affiliated company of an industrial insured; or

(ii) a controlled unaffiliated business of:

(A) an industrial insured; or

(B) an affiliated company of an industrial insured.

(23) "Industrial insured group" means:

(a) a group of industrial insureds that collectively:

(i) own, control, or hold with power to vote all of the outstanding voting securities of an industrial insured captive insurance company incorporated or organized as a limited liability company as a stock insurer; or

(ii) have complete voting control over an industrial insured captive insurance company incorporated or organized as a limited liability company as a mutual insurer; or

[~~(b) a group that is:~~]

[~~(i) created under the Product Liability Risk Retention Act of 1981, 15 U.S.C. Sec. 3901 et seq., as amended, as a corporation or other limited liability association; and~~]

[~~(ii) taxable under this title as a:~~]

[~~(A) stock corporation; or~~]

[~~(B) mutual insurer; or~~]

[~~(c)~~] (b) a group that has complete voting control over an industrial captive insurance company formed as a limited liability company.

(24) "Member organization" means a person that belongs to an association.

(25) "Parent" means a person that directly or indirectly owns, controls, or holds with power to vote more than 50% of the outstanding securities of an organization.

(26) "Participant" means an entity that is insured by a sponsored captive insurance company:

(a) if the losses of the participant are limited through a participant contract to the assets of a protected cell; and

(b)

(i) the entity is permitted to be a participant under Section 31A-37-403; or

(ii) the entity is an affiliate of an entity permitted to be a participant under Section 31A-37-403.

(27) "Participant contract" means a contract by which a sponsored captive insurance company:

(a) insures the risks of a participant; and

(b) limits the losses of the participant to the assets of a protected cell.

(28) "Pooling captive" means a captive insurer organized for the purpose of establishing a risk-sharing arrangement between other captive insurers.

(29) "Protected cell" means a separate account:

(a) established and maintained by a sponsored captive insurance company for a participant; and

(b) that has not been organized as an entity including a corporation, a limited liability company, or a not-for-profit organization.

(30) "Pure captive insurance company" means a business entity that insures risks of a parent, affiliate, or controlled unaffiliated business of the business entity.

(31) "Special purpose financial captive insurance company" means the same as that term is defined in Section 31A-37a-102.

(32) "Sponsor" means an entity that:

(a) meets the requirements of Section 31A-37-402; and

(b) is approved by the commissioner to:

(i) provide all or part of the capital and surplus in an amount:

(A) required by Section 31A-37-204; or

(B) greater than the amount required by Section 31A-37-204, if, by order, the commissioner deems the increase necessary; and

(ii) organize and operate a sponsored captive insurance company.

(33) "Sponsored captive insurance company" means a captive insurance company:

(a) in which the minimum capital and surplus required by applicable law is provided by one or more sponsors or participants;

(b) that is formed or holding a certificate of authority under this chapter;

(c) that insures the risks of a separate participant through the contract; and

(d) that segregates each participant's liability through one or more cells.

(34) "Treasury rates" means the United States Treasury strip asked yield as published in the Wall Street Journal as of a balance sheet date.

Section 66. Section **31A-37-103** is amended to read:

31A-37-103. Chapter exclusivity.

(1) Except as provided in Subsections (2) and (3) or otherwise provided in this chapter, a provision of this title other than this chapter does not apply to a captive insurance company.

(2) To the extent that a provision of the following does not contradict this chapter, the provision applies to a captive insurance company that receives a certificate of authority under this chapter:

(a) Chapter 1, General Provisions;

(b) Chapter 2, Administration of the Insurance Laws;

(c) Chapter 4, Insurers in General;

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

(e) Chapter 14, Foreign Insurers;

(f) Chapter 16, Insurance Holding Companies;

(g) Chapter 17, Determination of Financial Condition;

(h) Chapter 18, Investments;

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

(j) [~~Chapter 27, Delinquency Administrative Action Provisions~~] Chapter 27, Administrative Supervision of Insurers; and

(k) Chapter 27a, Insurer Receivership Act.

(3) In addition to this chapter, and subject to Section 31A-37a-103:

(a) Chapter 37a, Special Purpose Financial Captive Insurance Company Act, applies to a special purpose financial captive insurance company; and

(b) for purposes of a special purpose financial captive insurance company, a reference in this chapter to "this chapter" includes a reference to Chapter 37a, Special Purpose Financial Captive Insurance Company Act.

(4) In addition to this chapter, [~~an industrial group captive insurance company formed as~~]a risk retention group [~~captive~~]is subject to Chapter 15, Part 2, Risk Retention Groups Act, to the extent that this chapter is silent regarding regulation of risk retention groups conducting business in the state.

Section 67. Section **31A-37-201** is amended to read:

31A-37-201. Certificate of authority.

(1) The commissioner may issue a certificate of authority to act as an insurer in this state to a captive insurance company that meets the requirements of this chapter.

(2) To conduct insurance business in this state, a captive insurance company shall:

(a) obtain from the commissioner a certificate of authority authorizing the captive insurance company to conduct insurance business in this state;

(b)

(i) hold a meeting of the governing body:

(A) at least once each year;

(B) at which a quorum is present;

(C) in the state; and

(D) at which at least one out-of-state individual is physically present; or

(ii) become a member of the Utah Captive Insurance Association at the highest level of membership;

(c) maintain in this state:

(i) the principal place of business of the captive insurance company; or

(ii) in the case of a branch captive insurance company, the principal place of business for the branch operations of the branch captive insurance company; and

(d) except as provided in Subsection (3), appoint a resident registered agent to accept service of process and to otherwise act on behalf of the captive insurance company in the state.

(3) In the case of a captive insurance company formed as a corporation, if the registered agent cannot with reasonable diligence be found at the registered office of the captive insurance company, the commissioner is the agent of the captive insurance company upon whom process, notice, or demand may be served.

(4)

(a) Before receiving a certificate of authority, an applicant captive insurance company shall file with the commissioner:

(i) a certified copy of the captive insurance company's organizational charter;

(ii) a statement under oath of the captive insurance company's president and secretary or their equivalents showing the captive insurance company's financial condition; and

(iii) any other statement or document required by the commissioner under Section 31A-37-106.

(b) In addition to the information required under Subsection (4)(a), an applicant captive insurance company shall file with the commissioner evidence of:

(i) the amount and liquidity of the assets of the applicant captive insurance company relative to the risks to be assumed by the applicant captive insurance company;

(ii) the adequacy of the expertise, experience, and character of the person who will manage the applicant captive insurance company;

(iii) the overall soundness of the plan of operation of the applicant captive insurance company;

(iv) the adequacy of the loss prevention programs for the prospective insureds of the applicant captive insurance company as the commissioner deems necessary; and

(v) any other factor the commissioner:

(A) adopts by rule under Section 31A-37-106; and

(B) considers relevant in ascertaining whether the applicant captive insurance company will be able to meet the policy obligations of the applicant captive insurance company.

(c) In addition to the information required by Subsections (4)(a) and (b), an applicant sponsored captive insurance company shall file with the commissioner:

(i) a business plan at the level of detail required by the commissioner under Section 31A-37-106 demonstrating:

(A) the manner in which the applicant sponsored captive insurance company will account for the losses and expenses of each cell; and

(B) the manner in which the applicant sponsored captive insurance company will report to the commissioner the financial history, including losses and expenses, of each cell;

(ii) a statement acknowledging that the applicant sponsored captive insurance company will make all financial records of the applicant sponsored captive insurance company, including records pertaining to a cell, available for inspection or examination by the commissioner;

(iii) a contract or sample contract between the applicant sponsored captive insurance company and a participant; and

(iv) evidence that expenses will be allocated to each cell in an equitable manner.

(5)

(a) Information submitted in accordance with this section is classified as a protected record under Title 63G, Chapter 2, Government Records Access and Management Act.

(b) Notwithstanding Title 63G, Chapter 2, Government Records Access and Management Act, the commissioner may disclose information submitted in accordance with this section to a public official having jurisdiction over the regulation of insurance in another state if:

(i) the public official receiving the information agrees in writing to maintain the confidentiality of the information; and

(ii) the laws of the state in which the public official serves require the information to be confidential.

(c) This Subsection (5) does not apply to information [~~provided by an industrial insured captive insurance company insuring the risks of an industrial insured group~~] that a risk retention group formed or operating in this state provides.

(6)

(a) A captive insurance company shall pay to the department the following nonrefundable fees [~~established by~~]the department establishes under Sections 31A-3-103, 31A-3-304, and 63J-1-504:

(i) a fee for examining, investigating, and processing, by a department employee, of an application for a certificate of authority made by an applicant captive insurance company;

(ii) a fee for obtaining a certificate of authority for the year the captive insurance company is issued a certificate of authority by the department; and

(iii) a certificate of authority renewal fee, assessed annually.

(b) The commissioner may:

(i) assign a department employee or retain legal, financial, or examination services from outside the department to perform the services described in:

(A) Subsection (6)(a); and

(B) Section 31A-37-502; and

(ii) charge the reasonable cost of services described in Subsection (6)(b)(i) to the applicant captive insurance company.

(7) If the commissioner is satisfied that the documents and statements filed by the applicant captive insurance company comply with this chapter, the commissioner may grant a certificate of authority authorizing the company to do insurance business in this state.

(8) A certificate of authority granted under this section expires annually and shall be renewed by July 1 of each year.

Section 68. Section **31A-37-204** is amended to read:

31A-37-204. Paid-in capital -- Other capital.

(1) For purposes of this section, "marketable securities" means:

(a) a bond or other evidence of indebtedness of a governmental unit in the United States or Canada or any instrumentality of the United States or Canada; or

(b) securities:

(i) traded on one or more of the following exchanges in the United States:

(A) New York;

(B) American; or

(C) NASDAQ;

(ii) when no particular security, or a substantially related security, applied toward the required minimum capital and surplus requirement of Subsection (2) represents more than 50% of the minimum capital and surplus requirement; and

(iii) when no group of up to four particular securities, consolidating substantially related securities, applied toward the required minimum capital and surplus requirement of Subsection (2) represents more than 90% of the minimum capital and surplus requirement.

(2)

(a) The commissioner may not issue a certificate of authority to a captive insurance company [~~described in Subsection (2)(c)~~]unless the company possesses and maintains unimpaired paid-in capital and unimpaired paid-in surplus of:

(i) in the case of a pure captive insurance company:

(A) except as provided in Subsection (2)(a)(i)(B), not less than $250,000; or

(B) if the pure captive insurance company is not acting as a pool that facilitates risk distribution for other captive insurers, an amount that is the greater of:

(I) not less than 20% of the company's total aggregate risk; or

(II) $50,000;

(ii) in the case of an association captive insurance company, not less than $500,000;

(iii) in the case of an industrial insured captive insurance company [~~incorporated as a stock insurer~~] or a risk retention group, not less than $700,000;

(iv) in the case of a sponsored captive insurance company, not less than $250,000 of which a minimum of $50,000 is provided by the sponsor; or

(v) in the case of a special purpose captive insurance company, an amount determined by the commissioner after giving due consideration to the company's business plan, feasibility study, and pro-formas, including the nature of the risks to be insured.

(b) The paid-in capital and surplus required under this Subsection (2) may be in the form of:

(i)

(A) cash; or

(B) cash equivalent;

(ii) an irrevocable letter of credit:

(A) issued by:

(I) a bank chartered by this state;

(II) a member bank of the Federal Reserve System; or

(III) a member bank of the Federal Deposit Insurance Corporation;

(B) [~~approved by~~] that the commissioner approves;

(iii) marketable securities as determined by Subsection (1); or

(iv) some other thing of value [~~approved by~~] that the commissioner approves, for a period not to exceed 45 days, to facilitate the formation of a captive insurance company in this state [~~pursuant to~~] in accordance with an approved plan of liquidation and reorganization of another captive insurance company or alien captive insurance company in another jurisdiction.

[~~(c) This Subsection (2) applies to:~~]

[~~(i) a pure captive insurance company;~~]

[~~(ii) a sponsored captive insurance company;~~]

[~~(iii) a special purpose captive insurance company;~~]

[~~(iv) an association captive insurance company; or~~]

[~~(v) an industrial insured captive insurance company.~~]

(3)

(a) The commissioner may, under Section 31A-37-106, [~~prescribe~~] require additional capital based on the type, volume, and nature of insurance business transacted.

(b) The capital [~~prescribed by~~] that the commissioner requires under this Subsection (3) may be in the form of:

(i) cash;

(ii) an irrevocable letter of credit issued by:

(A) a bank chartered by this state; or

(B) a member bank of the Federal Reserve System; or

(iii) marketable securities as determined by Subsection (1).

(4)

(a) Except as provided in Subsection (4)(c), a branch captive insurance company, as security for the payment of liabilities attributable to branch operations, shall, through the branch captive insurance company's branch operations, establish and maintain a trust fund:

(i) funded by an irrevocable letter of credit or other acceptable asset; and

(ii) in the United States for the benefit of:

(A) United States policyholders; and

(B) United States ceding insurers under:

(I) insurance policies issued; or

(II) reinsurance contracts issued or assumed.

(b) The amount of the security required under this Subsection (4) shall be no less than:

(i) the capital and surplus required by this chapter; and

(ii) the reserves on the insurance policies or reinsurance contracts, including:

(A) reserves for losses;

(B) allocated loss adjustment expenses;

(C) incurred but not reported losses; and

(D) unearned premiums with regard to business written through branch operations.

(c) Notwithstanding the other provisions of this Subsection (4):

(i) the commissioner may permit a branch captive insurance company that is required to post security for loss reserves on branch business by the branch captive insurance company's reinsurer to reduce the funds in the trust account required by this section by the same amount as the security posted if the security remains posted with the reinsurer; and

(ii) a branch captive insurance company that is the result of the licensure of an alien captive insurance company that is not formed in an alien jurisdiction is not subject to the requirements of this Subsection (4).

(5)

(a) A captive insurance company may not pay the following without the prior approval of the commissioner:

(i) a dividend out of capital or surplus; or

(ii) a distribution with respect to capital or surplus.

(b) The commissioner shall condition approval of an ongoing plan for the payment of dividends or other distributions on the retention, at the time of each payment, of capital or surplus.

(6) Notwithstanding Subsection (1), to protect the solvency and liquidity of a captive insurance company, the commissioner may reject the application of specific assets or amounts of specific assets to [~~satisfying~~] satisfy the requirement of Subsection (2).

Section 69. Section **31A-37-302** is amended to read:

31A-37-302. Investment requirements.

(1)

(a) Except as provided in Subsection (1)(b), a captive insurance company [~~and an industrial insured captive insurance company~~] and a risk retention group shall comply with the investment requirements contained in this title.

(b) Notwithstanding Subsection (1)(a) and any other provision of this title, the commissioner may approve the use of alternative reliable methods of valuation and rating under Section 31A-37-106 for a captive insurance company or [~~an industrial insured captive insurance company~~] a risk retention group.

(2)

(a) Except as provided in Subsection (2)(b), a [~~pure~~]captive insurance company, [~~or industrial insured captive insurance company~~] other than a risk retention group, is not subject to any restrictions on [~~allowable~~] authorized classes of investments described in Section [~~31A-18-108~~] 31A-18-110.

(b) Under Section 31A-37-106, the commissioner may prohibit or limit an investment that threatens the solvency or liquidity of a captive insurance company or [~~industrial insured captive insurance company~~] risk retention group.

(3)

(a)

(i) Except as provided in Subsection (3)(a)(ii), a captive insurance company may not make loans to:

(A) the parent company of the captive insurance company; or

(B) an affiliate of the captive insurance company.

(ii) A pure captive insurance company and an incorporated cell of a sponsored captive insurance company may make loans to:

(A) the parent company of the pure captive insurance company or incorporated cell of a sponsored captive insurance company; or

(B) an affiliate of the pure captive insurance company or incorporated cell of a sponsored captive insurance company.

(b) A loan under Subsection (3)(a):

(i) may be made only on the prior written approval of the commissioner and, when applicable, the sponsor for an incorporated cell; and

(ii) shall be evidenced by a note in a form approved by the commissioner and, when applicable, the sponsor for an incorporated cell.

(c) A pure captive insurance company may not make a loan from the paid-in capital required under Subsection 31A-37-204(2).

[~~(4) If a captive insurer has excess surplus above the minimum capital required by Section 31A-37-204, the captive insurer may invest the captive insurer's excess surplus in a manner inconsistent with the authorized classes of investments described in Section 31A-18-110.~~]

(4)

(a) For purposes of this chapter, the excess surplus of a captive insurance company, other than a risk retention group, is the amount of the company's assets that exceeds 120% of the company's minimum capital required by Section 31A-37-204 plus an actuarially determined reserve estimate.

(b) A captive insurer may only invest excess surplus in a manner inconsistent with the authorized classes of investments described in Section 31A-18-110 with prior written approval of the commissioner.

(5) Nothing in this section empowers a captive insurer to make an investment that is illegal or otherwise prohibited by this title.

Section 70. Section **31A-37-501** is amended to read:

31A-37-501. Reports to commissioner.

(1) A captive insurance company is not required to make a report except those provided in this chapter.

(2)

(a) Before March 1 of each year, a captive insurance company shall submit to the commissioner a report of the financial condition of the captive insurance company, verified by oath of at least two individuals who are executive officers of the captive insurance company.

(b) Except as provided in Section 31A-37-204, a captive insurance company shall report:

(i) using generally accepted accounting principles, except to the extent that the commissioner requires, approves, or accepts the use of a statutory accounting principle;

(ii) using a useful or necessary modification or adaptation to an accounting principle that is required, approved, or accepted by the commissioner for the type of insurance and kind of insurer to be reported upon; and

(iii) supplemental or additional information required by the commissioner.

(c) Except as otherwise provided:

(i) a licensed captive insurance company shall file the report required by Section 31A-4-113; and

(ii) [~~an industrial insured~~] a risk retention group shall comply with Section 31A-4-113.5.

(3)

(a) A pure captive insurance company may make written application to file the required report on a fiscal year end that is consistent with the fiscal year of the parent company of the pure captive insurance company.

(b) If the commissioner grants an alternative reporting date for a [~~pure~~]captive insurance company requested under Subsection (3)(a)[~~,~~] :

(i) [-]the annual report is due 60 days after the day on which the fiscal year [~~end.~~] ends; and

(ii) the annual audit is due six months after the day on which the fiscal year ends.

(4)

(a) Sixty days after the fiscal year end, a branch captive insurance company shall file with the commissioner a copy of the reports and statements required to be filed under the laws of the jurisdiction in which the alien captive insurance company is formed, verified by oath by two of the alien captive insurance company's executive officers.

(b) If the commissioner is satisfied that the annual report filed by the alien captive insurance company in the jurisdiction in which the alien captive insurance company is formed provides adequate information concerning the financial condition of the alien captive insurance company, the commissioner may waive the requirement for completion of the annual statement required for a

captive insurance company under this section with respect to business written in the alien or foreign jurisdiction.

(c) A waiver by the commissioner under Subsection (4)(b):

(i) shall be in writing; and

(ii) is subject to public inspection.

(5) Before March 1 of each year, a sponsored captive insurance company shall submit to the commissioner a consolidated report of the financial condition of each cell, including a financial statement for each cell.

(6)

(a) A captive insurance company shall notify the commissioner in writing if there is:

(i) a material change to the captive insurance company's most recently filed report of financial condition; or

(ii) an adverse material change in the financial condition of a captive insurance company since the captive insurance company's most recently filed report of financial condition.

(b) A captive insurance company shall submit a notification described in this subsection within 20 days after the day on which the captive insurance company learns of the material change.

Section 71. Section **31A-37-505** is amended to read:

31A-37-505. Suspension or revocation -- Grounds.

(1) The commissioner may suspend or revoke the certificate of authority of a captive insurance company to conduct an insurance business in this state for:

(a) insolvency or impairment of capital or surplus;

(b) failure to meet the requirements [~~of Section 31A-37-204~~] of Part 2, Certificate of Authority;

(c) refusal or failure to submit:

(i) an annual report required by Section 31A-37-501; or

(ii) any other report or statement required by law or by lawful order of the commissioner;

(d) failure to comply with the charter, bylaws, or other organizational document of the captive insurance company;

(e) failure to submit to:

(i) an examination under Section 31A-37-502; or

(ii) any legal obligation relative to an examination under Section 31A-37-502;

(f) refusal or failure to pay:

(i) an annual fee described in Section 31A-3-304;

(ii) the cost of examination described in Section 31A-37-502; or

(iii) any other fee prescribed by this title;

(g) use of methods that, although not otherwise specifically prohibited by law, render:

(i) the operation of the captive insurance company detrimental to the public or the policyholders of the captive insurance company; or

(ii) the condition of the captive insurance company unsound with respect to the public or to the policyholders of the captive insurance company; or

(h) failure otherwise to comply with laws of this state.

(2) Notwithstanding any other provision of this title, if the commissioner finds, upon examination, hearing, or other evidence, that a captive insurance company has committed [~~any of the acts specified in~~] an act described in Subsection (1), the commissioner may suspend or revoke the certificate of authority of the captive insurance company if the commissioner considers [~~it~~] that the revocation or suspension is in the best interest of the public and the policyholders of the captive insurance company[~~ to revoke the certificate of authority~~].

Section 72. 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 [~~an industrial insured captive insurance company~~] a risk retention group or a cell of a sponsored captive insurance company, is eligible for a certificate of dormancy if the 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 (4), 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[~~:~~] at least 10% of the minimum capital required in Section 31A-37-204; and

[~~(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 $50,000, of which the sponsor provides at least $20,000; 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.

Section 73. Section **31A-41-202** is amended to read:

31A-41-202. Assessments.

(1) An agency title insurance producer licensed under this title shall pay an annual assessment determined by the commission by rule made in accordance with Section 31A-2-404, except that the annual assessment:

(a) may not exceed $1,000; and

(b) shall be determined on the basis of title insurance premium volume.

(2) An individual who applies for a license or renewal of a license as an individual title insurance producer, shall pay in addition to any other fee required by this title, an assessment not to exceed $20, as determined by the commission by rule made in accordance with Section 31A-2-404, except

that if the individual holds more than one license, the total of all assessments under this Subsection (2) may not exceed $20 in a fiscal year.

(3)

(a) To be licensed as an agency title insurance producer, a person shall pay to the department an assessment of $1,000 before the day on which the person is licensed as a title insurance agency.

(b)

(i) The department shall assess on a licensed agency title insurance producer an amount equal to the greater of:

(A) $1,000; or

(B) subject to Subsection (3)(b)(ii), 2% of the balance in the agency title insurance producer's reserve account described in Subsection [~~31A-23a-204(3)~~] 31A-23a-204(4).

(ii) The department may assess on an agency title insurance producer an amount less than 2% of the balance described in Subsection (3)(b)(i)(B) if:

(A) before issuing the assessments under this Subsection (3)(b) the department determines that the total of all assessments under Subsection (3)(b)(i) will exceed $250,000;

(B) the amount assessed on the agency title insurance producer is not less than $1,000; and

(C) the department reduces the assessment in a proportionate amount for agency title insurance producers assessed on the basis of the 2% of the balance described in Subsection (3)(b)(i)(B).

(iii) An agency title insurance producer assessed under this Subsection (3)(b) shall pay the assessment by no later than August [~~1~~] 31.

(4) The department may not assess a title insurance licensee an assessment for purposes of the fund if that assessment is not expressly provided for in this section.

Section 74. Section **63G-2-305** is amended to read:

63G-2-305. Protected records.

The following records are protected if properly classified by a governmental entity:

(1) trade secrets as defined in Section 13-24-2 if the person submitting the trade secret has provided the governmental entity with the information specified in Section 63G-2-309;

(2) commercial information or nonindividual financial information obtained from a person if:

(a) disclosure of the information could reasonably be expected to result in unfair competitive injury to the person submitting the information or would impair the ability of the governmental entity to obtain necessary information in the future;

(b) the person submitting the information has a greater interest in prohibiting access than the public in obtaining access; and

(c) the person submitting the information has provided the governmental entity with the information specified in Section 63G-2-309;

(3) commercial or financial information acquired or prepared by a governmental entity to the extent that disclosure would lead to financial speculations in currencies, securities, or commodities that will interfere with a planned transaction by the governmental entity or cause substantial financial injury to the governmental entity or state economy;

(4) records, the disclosure of which could cause commercial injury to, or confer a competitive advantage upon a potential or actual competitor of, a commercial project entity as defined in Subsection 11-13-103(4);

(5) test questions and answers to be used in future license, certification, registration, employment, or academic examinations;

(6) records, the disclosure of which would impair governmental procurement proceedings or give an unfair advantage to any person proposing to enter into a contract or agreement with a governmental entity, except, subject to Subsections (1) and (2), that this Subsection (6) does not restrict the right of a person to have access to, after the contract or grant has been awarded and signed by all parties:

(a) a bid, proposal, application, or other information submitted to or by a governmental entity in response to:

(i) an invitation for bids;

(ii) a request for proposals;

(iii) a request for quotes;

(iv) a grant; or

(v) other similar document; or

(b) an unsolicited proposal, as defined in Section 63G-6a-712;

(7) information submitted to or by a governmental entity in response to a request for information, except, subject to Subsections (1) and (2), that this Subsection (7) does not restrict the right of a person to have access to the information, after:

(a) a contract directly relating to the subject of the request for information has been awarded and signed by all parties; or

(b)

(i) a final determination is made not to enter into a contract that relates to the subject of the request for information; and

(ii) at least two years have passed after the day on which the request for information is issued;

(8) records that would identify real property or the appraisal or estimated value of real or personal property, including intellectual property, under consideration for public acquisition before any rights to the property are acquired unless:

(a) public interest in obtaining access to the information is greater than or equal to the governmental entity's need to acquire the property on the best terms possible;

(b) the information has already been disclosed to persons not employed by or under a duty of confidentiality to the entity;

(c) in the case of records that would identify property, potential sellers of the described property have already learned of the governmental entity's plans to acquire the property;

(d) in the case of records that would identify the appraisal or estimated value of property, the potential sellers have already learned of the governmental entity's estimated value of the property; or

(e) the property under consideration for public acquisition is a single family residence and the governmental entity seeking to acquire the property has initiated negotiations to acquire the property as required under Section 78B-6-505;

(9) records prepared in contemplation of sale, exchange, lease, rental, or other compensated transaction of real or personal property including intellectual property, which, if disclosed prior to completion of the transaction, would reveal the appraisal or estimated value of the subject property, unless:

(a) the public interest in access is greater than or equal to the interests in restricting access, including the governmental entity's interest in maximizing the financial benefit of the transaction; or

(b) when prepared by or on behalf of a governmental entity, appraisals or estimates of the value of the subject property have already been disclosed to persons not employed by or under a duty of confidentiality to the entity;

(10) records created or maintained for civil, criminal, or administrative enforcement purposes or audit purposes, or for discipline, licensing, certification, or registration purposes, if release of the records:

(a) reasonably could be expected to interfere with investigations undertaken for enforcement, discipline, licensing, certification, or registration purposes;

(b) reasonably could be expected to interfere with audits, disciplinary, or enforcement proceedings;

(c) would create a danger of depriving a person of a right to a fair trial or impartial hearing;

(d) reasonably could be expected to disclose the identity of a source who is not generally known outside of government and, in the case of a record compiled in the course of an investigation, disclose information furnished by a source not generally known outside of government if disclosure would compromise the source; or

(e) reasonably could be expected to disclose investigative or audit techniques, procedures, policies, or orders not generally known outside of government if disclosure would interfere with enforcement or audit efforts;

(11) records the disclosure of which would jeopardize the life or safety of an individual;

(12) records the disclosure of which would jeopardize the security of governmental property, governmental programs, or governmental recordkeeping systems from damage, theft, or other appropriation or use contrary to law or public policy;

(13) records that, if disclosed, would jeopardize the security or safety of a correctional facility, or records relating to incarceration, treatment, probation, or parole, that would interfere with the control and supervision of an offender's incarceration, treatment, probation, or parole;

(14) records that, if disclosed, would reveal recommendations made to the Board of Pardons and Parole by an employee of or contractor for the Department of Corrections, the Board of Pardons and Parole, or the Department of Health and Human Services that are based on the employee's or contractor's supervision, diagnosis, or treatment of any person within the board's jurisdiction;

(15) records and audit workpapers that identify audit, collection, and operational procedures and methods used by the State Tax Commission, if disclosure would interfere with audits or collections;

(16) records of a governmental audit agency relating to an ongoing or planned audit until the final audit is released;

(17) records that are subject to the attorney client privilege;

(18) records prepared for or by an attorney, consultant, surety, indemnitor, insurer, employee, or agent of a governmental entity for, or in anticipation of, litigation or a judicial, quasi-judicial, or administrative proceeding;

(19)

(a)

(i) personal files of a state legislator, including personal correspondence to or from a member of the Legislature; and

(ii) notwithstanding Subsection (19)(a)(i), correspondence that gives notice of legislative action or policy may not be classified as protected under this section; and

(b)

(i) an internal communication that is part of the deliberative process in connection with the preparation of legislation between:

(A) members of a legislative body;

(B) a member of a legislative body and a member of the legislative body's staff; or

(C) members of a legislative body's staff; and

(ii) notwithstanding Subsection (19)(b)(i), a communication that gives notice of legislative action or policy may not be classified as protected under this section;

(20)

(a) records in the custody or control of the Office of Legislative Research and General Counsel, that, if disclosed, would reveal a particular legislator's contemplated legislation or contemplated course of action before the legislator has elected to support the legislation or course of action, or made the legislation or course of action public; and

(b) notwithstanding Subsection (20)(a), the form to request legislation submitted to the Office of Legislative Research and General Counsel is a public document unless a legislator asks that the records requesting the legislation be maintained as protected records until such time as the legislator elects to make the legislation or course of action public;

(21) a research request from a legislator to a legislative staff member and research findings prepared in response to the request;

(22) drafts, unless otherwise classified as public;

(23) records concerning a governmental entity's strategy about:

(a) collective bargaining; or

(b) imminent or pending litigation;

(24) records of investigations of loss occurrences and analyses of loss occurrences that may be covered by the Risk Management Fund, the Employers' Reinsurance Fund, the Uninsured Employers' Fund, or similar divisions in other governmental entities;

(25) records, other than personnel evaluations, that contain a personal recommendation concerning an individual if disclosure would constitute a clearly unwarranted invasion of personal privacy, or disclosure is not in the public interest;

(26) records that reveal the location of historic, prehistoric, paleontological, or biological resources that if known would jeopardize the security of those resources or of valuable historic, scientific, educational, or cultural information;

(27) records of independent state agencies if the disclosure of the records would conflict with the fiduciary obligations of the agency;

(28) records of an institution of higher education defined in Section 53H-1-101 regarding tenure evaluations, appointments, applications for admissions, retention decisions, and promotions, which could be properly discussed in a meeting closed in accordance with Title 52, Chapter 4, Open and Public Meetings Act, provided that records of the final decisions about tenure, appointments, retention, promotions, or those students admitted, may not be classified as protected under this section;

(29) records of the governor's office, including budget recommendations, legislative proposals, and policy statements, that if disclosed would reveal the governor's contemplated policies or contemplated courses of action before the governor has implemented or rejected those policies or courses of action or made them public;

(30) records of the Office of the Legislative Fiscal Analyst relating to budget analysis, revenue estimates, and fiscal notes of proposed legislation before issuance of the final recommendations in these areas;

(31) records provided by the United States or by a government entity outside the state that are given to the governmental entity with a requirement that they be managed as protected records if the providing entity certifies that the record would not be subject to public disclosure if retained by it;

(32) transcripts, minutes, recordings, or reports of the closed portion of a meeting of a public body except as provided in Section 52-4-206;

(33) records that would reveal the contents of settlement negotiations but not including final settlements or empirical data to the extent that they are not otherwise exempt from disclosure;

(34) memoranda prepared by staff and used in the decision-making process by an administrative law judge, a member of the Board of Pardons and Parole, or a member of any other body charged by law with performing a quasi-judicial function;

(35) records that would reveal negotiations regarding assistance or incentives offered by or requested from a governmental entity for the purpose of encouraging a person to expand or locate a business in Utah, but only if disclosure would result in actual economic harm to the person or place the

governmental entity at a competitive disadvantage, but this section may not be used to restrict access to a record evidencing a final contract;

(36) materials to which access must be limited for purposes of securing or maintaining the governmental entity's proprietary protection of intellectual property rights including patents, copyrights, and trade secrets;

(37) the name of a donor or a prospective donor to a governmental entity, including an institution of higher education defined in Section 53H-1-101, and other information concerning the donation that could reasonably be expected to reveal the identity of the donor, provided that:

(a) the donor requests anonymity in writing;

(b) any terms, conditions, restrictions, or privileges relating to the donation may not be classified protected by the governmental entity under this Subsection (37); and

(c) except for an institution of higher education defined in Section 53H-1-101, the governmental unit to which the donation is made is primarily engaged in educational, charitable, or artistic endeavors, and has no regulatory or legislative authority over the donor, a member of the donor's immediate family, or any entity owned or controlled by the donor or the donor's immediate family;

(38) accident reports, except as provided in Sections 41-6a-404, 41-12a-202, and 73-18-13;

(39) a notification of workers' compensation insurance coverage described in Section 34A-2-205;

(40) subject to Subsections (40)(g) and (h), the following records of an institution[-] of higher education defined in Section 53H-1-101, which have been developed, discovered, disclosed to, or received by or on behalf of faculty, staff, employees, or students of the institution:

(a) unpublished lecture notes;

(b) unpublished notes, data, and information:

(i) relating to research; and

(ii) of:

(A) the institution of higher education defined in Section 53H-1-101; or

(B) a sponsor of sponsored research;

(c) unpublished manuscripts;

(d) creative works in process;

(e) scholarly correspondence; and

(f) confidential information contained in research proposals;

(g) this Subsection (40) may not be construed to prohibit disclosure of public information required [~~pursuant to~~] in accordance with Subsection 53H-14-202(2)(a) or (b); and

(h) this Subsection (40) may not be construed to affect the ownership of a record;

(41)

(a) records in the custody or control of the Office of the Legislative Auditor General that would reveal the name of a particular legislator who requests a legislative audit prior to the date that audit is completed and made public; and

(b) notwithstanding Subsection (41)(a), a request for a legislative audit submitted to the Office of the Legislative Auditor General is a public document unless the legislator asks that the records in the custody or control of the Office of the Legislative Auditor General that would reveal the name of a particular legislator who requests a legislative audit be maintained as protected records until the audit is completed and made public;

(42) records that provide detail as to the location of an explosive, including a map or other document that indicates the location of:

(a) a production facility; or

(b) a magazine;

(43) information contained in the statewide database of the Division of Aging and Adult Services created by Section 26B-6-210;

(44) information contained in the Licensing Information System described in Title 80, Chapter 2, Child Welfare Services;

(45) information regarding National Guard operations or activities in support of the National Guard's federal mission;

(46) records provided by any pawn or secondhand business to a law enforcement agency or to the central database in compliance with Title 13, Chapter 32a, Pawnshop, Secondhand Merchandise, and Catalytic Converter Transaction Information Act;

(47) information regarding food security, risk, and vulnerability assessments performed by the Department of Agriculture and Food;

(48) except to the extent that the record is exempt from this chapter [~~pursuant to~~] in accordance with Section 63G-2-106, records related to an emergency plan or program, a copy of which is provided to or prepared or maintained by the Division of Emergency Management, and the disclosure of which would jeopardize:

(a) the safety of the general public; or

(b) the security of:

(i) governmental property;

(ii) governmental programs; or

(iii) the property of a private person who provides the Division of Emergency Management information;

(49) records of the Department of Agriculture and Food that provides for the identification, tracing, or control of livestock diseases, including any program established under Title 4, Chapter 24, Utah Livestock Brand and Anti-Theft Act, or Title 4, Chapter 31, Control of Animal Disease;

(50) as provided in Section 26B-2-709:

(a) information or records held by the Department of Health and Human Services related to a complaint regarding a provider, program, or facility which the department is unable to substantiate; and

(b) information or records related to a complaint received by the Department of Health and Human Services from an anonymous complainant regarding a provider, program, or facility;

(51) unless otherwise classified as public under Section 63G-2-301 and except as provided under Section 41-1a-116, an individual's home address, home telephone number, or personal mobile phone number, if:

(a) the individual is required to provide the information in order to comply with a law, ordinance, rule, or order of a government entity; and

(b) the subject of the record has a reasonable expectation that this information will be kept confidential due to:

(i) the nature of the law, ordinance, rule, or order; and

(ii) the individual complying with the law, ordinance, rule, or order;

(52) the portion of the following documents that contains a candidate's residential or mailing address, if the candidate provides to the filing officer another address or phone number where the candidate may be contacted:

(a) a declaration of candidacy, a nomination petition, or a certificate of nomination, described in Section 20A-9-201, 20A-9-202, 20A-9-203, 20A-9-404, 20A-9-405, 20A-9-408, 20A-9-408.5, 20A-9-502, or 20A-9-601;

(b) an affidavit of impecuniosity, described in Section 20A-9-201; or

(c) a notice of intent to gather signatures for candidacy, described in Section 20A-9-408;

(53) the name, home address, work addresses, and telephone numbers of an individual that is engaged in, or that provides goods or services for, medical or scientific research that is:

(a) conducted within the state system of higher education, as described in Section 53H-1-102; and

(b) conducted using animals;

(54) in accordance with Section 78A-12-203, any record of the Judicial Performance Evaluation Commission concerning an individual commissioner's vote, in relation to whether a judge meets or exceeds minimum performance standards under Subsection 78A-12-203(4), and information disclosed under Subsection 78A-12-203(5)(e);

(55) information collected and a report prepared by the Judicial Performance Evaluation Commission concerning a judge, unless Section 20A-7-702 or Title 78A, Chapter 12, Judicial Performance Evaluation Commission Act, requires disclosure of, or makes public, the information or report;

(56) records provided or received by the Public Lands Policy Coordinating Office in furtherance of any contract or other agreement made in accordance with Section 63L-11-202;

(57) information requested by and provided to the 911 Division under Section 63H-7a-302;

(58) in accordance with Section 73-10-33:

(a) a management plan for a water conveyance facility in the possession of the Division of Water Resources or the Board of Water Resources; or

(b) an outline of an emergency response plan in possession of the state or a county or municipality;

(59) the following records in the custody or control of the Office of Inspector General of Medicaid Services, created in Section 63A-13-201:

(a) records that would disclose information relating to allegations of personal misconduct, gross mismanagement, or illegal activity of a person if the information or allegation cannot be corroborated by the Office of Inspector General of Medicaid Services through other documents or evidence, and the records relating to the allegation are not relied upon by the Office of Inspector General of Medicaid Services in preparing a final investigation report or final audit report;

(b) records and audit workpapers to the extent they would disclose the identity of a person who, during the course of an investigation or audit, communicated the existence of any Medicaid fraud, waste, or abuse, or a violation or suspected violation of a law, rule, or regulation adopted under the laws of this state, a political subdivision of the state, or any recognized entity of the United States, if the information was disclosed on the condition that the identity of the person be protected;

(c) before the time that an investigation or audit is completed and the final investigation or final audit report is released, records or drafts circulated to a person who is not an employee or head of a governmental entity for the person's response or information;

(d) records that would disclose an outline or part of any investigation, audit survey plan, or audit program; or

(e) requests for an investigation or audit, if disclosure would risk circumvention of an investigation or audit;

(60) records that reveal methods used by the Office of Inspector General of Medicaid Services, the fraud unit, or the Department of Health and Human Services, to discover Medicaid fraud, waste, or abuse;

(61) information provided to the Department of Health and Human Services or the Division of Professional Licensing under Subsections 58-67-304(3) and (4) and Subsections 58-68-304(3) and (4);

(62) a record described in Section 63G-12-210;

(63) captured plate data that is obtained through an automatic license plate reader system used by a governmental entity as authorized in Section 41-6a-2003;

(64) an audio or video recording created by a body-worn camera, as that term is defined in Section 77-7a-103, that records sound or images inside a hospital or health care facility as those terms are defined in Section 78B-3-403, inside a clinic of a health care provider, as that term is defined in Section 78B-3-403, or inside a human service program as that term is defined in Section 26B-2-101, except for recordings that:

(a) depict the commission of an alleged crime;

(b) record any encounter between a law enforcement officer and a person that results in death or bodily injury, or includes an instance when an officer fires a weapon;

(c) record any encounter that is the subject of a complaint or a legal proceeding against a law enforcement officer or law enforcement agency;

(d) contain an officer involved critical incident as defined in Subsection 76-2-408(1)(f); or

(e) have been requested for reclassification as a public record by a subject or authorized agent of a subject featured in the recording;

(65) a record pertaining to the search process for a president of an institution of higher education described in Section 53H-3-302;

(66) an audio recording that is:

(a) produced by an audio recording device that is used in conjunction with a device or piece of equipment designed or intended for resuscitating an individual or for treating an individual with a life-threatening condition;

(b) produced during an emergency event when an individual employed to provide law enforcement, fire protection, paramedic, emergency medical, or other first responder service:

(i) is responding to an individual needing resuscitation or with a life-threatening condition; and

(ii) uses a device or piece of equipment designed or intended for resuscitating an individual or for treating an individual with a life-threatening condition; and

(c) intended and used for purposes of training emergency responders how to improve their response to an emergency situation;

(67) records submitted by or prepared in relation to an applicant seeking a recommendation by the Research and General Counsel Subcommittee, the Budget Subcommittee, or the Legislative Audit Subcommittee, established under Section 36-12-8, for an employment position with the Legislature;

(68) work papers as defined in Section 31A-2-204;

(69) a record made available to Adult Protective Services or a law enforcement agency under Section 61-1-206;

(70) a record submitted to the Insurance Department in accordance with Section 31A-37-201;

(71) a record described in Section 31A-37-503;

(72) any record created by the Division of Professional Licensing as a result of Subsection 58-37f-304(5) or 58-37f-702(2)(a)(ii);

(73) a record described in Section 72-16-306 that relates to the reporting of an injury involving an amusement ride;

(74) except as provided in Subsection 63G-2-305.5(1), the signature of an individual on a political petition, or on a request to withdraw a signature from a political petition, including a petition or request described in the following titles:

(a) Title 10, Utah Municipal Code;

(b) Title 17, Counties;

(c) Title 17B, Limited Purpose Local Government Entities - Special Districts;

(d) Title 17D, Limited Purpose Local Government Entities - Other Entities; and

(e) Title 20A, Election Code;

(75) except as provided in Subsection 63G-2-305.5(2), the signature of an individual in a voter registration record;

(76) except as provided in Subsection 63G-2-305.5(3), any signature, other than a signature described in Subsection (74) or (75), in the custody of the lieutenant governor or a local political subdivision collected or held under, or in relation to, Title 20A, Election Code;

(77) a Form I-918 Supplement B certification as described in Title 77, Chapter 38, Part 5, Victims Guidelines for Prosecutors Act;

(78) a record submitted to the Insurance Department under Section 31A-48-103;

(79) personal information, as defined in Section 63G-26-102, to the extent disclosure is prohibited under Section 63G-26-103;

(80) an image taken of an individual during the process of booking the individual into jail, unless:

(a) the individual is convicted of a criminal offense based upon the conduct for which the individual was incarcerated at the time the image was taken;

(b) a law enforcement agency releases or disseminates the image:

(i) after determining that the individual is a fugitive or an imminent threat to an individual or to public safety and releasing or disseminating the image will assist in apprehending the individual or reducing or eliminating the threat; or

(ii) to a potential witness or other individual with direct knowledge of events relevant to a criminal investigation or criminal proceeding for the purpose of identifying or locating an individual in connection with the criminal investigation or criminal proceeding;

(c) a judge orders the release or dissemination of the image based on a finding that the release or dissemination is in furtherance of a legitimate law enforcement interest; or

(d) the image is displayed to a person who is permitted to view the image under Section 17-72-802;

(81) a record:

(a) concerning an interstate claim to the use of waters in the Colorado River system;

(b) relating to a judicial proceeding, administrative proceeding, or negotiation with a representative from another state or the federal government as provided in Section 63M-14-205; and

(c) the disclosure of which would:

(i) reveal a legal strategy relating to the state's claim to the use of the water in the Colorado River system;

(ii) harm the ability of the Colorado River Authority of Utah or river commissioner to negotiate the best terms and conditions regarding the use of water in the Colorado River system; or

(iii) give an advantage to another state or to the federal government in negotiations regarding the use of water in the Colorado River system;

(82) any part of an application described in Section 63N-16-201 that the Governor's Office of Economic Opportunity determines is nonpublic, confidential information that if disclosed would result in actual economic harm to the applicant, but this Subsection (82) may not be used to restrict access to a record evidencing a final contract or approval decision;

(83) the following records of a drinking water or wastewater facility:

(a) an engineering or architectural drawing of the drinking water or wastewater facility; and

(b) except as provided in Section 63G-2-106, a record detailing tools or processes the drinking water or wastewater facility uses to secure, or prohibit access to, the records described in Subsection (83)(a);

(84) a statement that an employee of a governmental entity provides to the governmental entity as part of the governmental entity's personnel or administrative investigation into potential misconduct involving the employee if the governmental entity:

(a) requires the statement under threat of employment disciplinary action, including possible termination of employment, for the employee's refusal to provide the statement; and

(b) provides the employee assurance that the statement cannot be used against the employee in any criminal proceeding;

(85) any part of an application for a Utah Fits All Scholarship account described in Section 53F-6-402 or other information identifying a scholarship student as defined in Section 53F-6-401;

(86) a record:

(a) concerning a claim to the use of waters in the Great Salt Lake;

(b) relating to a judicial proceeding, administrative proceeding, or negotiation with a person concerning the claim, including a representative from another state or the federal government; and

(c) the disclosure of which would:

(i) reveal a legal strategy relating to the state's claim to the use of the water in the Great Salt Lake;

(ii) harm the ability of the Great Salt Lake commissioner to negotiate the best terms and conditions regarding the use of water in the Great Salt Lake; or

(iii) give an advantage to another person including another state or to the federal government in negotiations regarding the use of water in the Great Salt Lake;

(87) a consumer complaint described in Section 13-2-11, unless the consumer complaint is reclassified as public as described in Subsection 13-2-11(4);

(88) a record of the Utah water agent, appointed under Section 73-10g-702:

(a) concerning a claim to the use of waters;

(b) relating to a judicial proceeding, administrative proceeding, or negotiation with a representative from another state, a tribe, the federal government, or other government entity as provided in Title 73, Chapter 10g, Part 7, Utah Water Agent; and

(c) the disclosure of which would:

(i) reveal a legal strategy relating to the state's claim to the use of the water;

(ii) harm the ability of the Utah water agent to negotiate the best terms and conditions regarding the use of water; or

(iii) give an advantage to another state, a tribe, the federal government, or other government entity in negotiations regarding the use of water;[~~and~~]

(89) a record created or maintained for an investigation of the Prosecutor Conduct Commission, created in Section 63M-7-1102, that contains any personal identifying information of a prosecuting attorney, including:

(a) a complaint, or a document that is submitted or created for a complaint, received by the Prosecutor Conduct Commission; or

(b) a finding by the Prosecutor Conduct Commission[~~.~~] ; and

(90) the identity of an agency title insurance producer that makes a report to the Insurance Commissioner in accordance with Subsection 31A-23a-204(11)(a).

Section 75. **Repealer.**

This Bill Repeals:

This bill repeals:

Section **31A-20-109, Single risk limitation for title insurance.**

Section **31A-22-2001, Title.**

Section **31A-22-2003, Scope.**

Section **31A-22-2004, Disclosure and performance standards for limited long-term care insurance.**

Section **31A-22-2005, Nonforfeiture benefits.**

Section 76. **Effective date.**

Effective Date.

This bill takes effect on May 6, 2026.

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