1 # INSURANCE LAW AMENDMENTS
2 2000 GENERAL SESSION
3 STATE OF UTAH
4 **Sponsor: L. Steven Poulton**

5 AN ACT RELATING TO INSURANCE; GRANTING RULEMAKING AUTHORITY;
6 ESTABLISHING A PROCESS FOR REQUIRING CERTAIN COVERAGE OR BENEFITS BY
7 RULE; CLARIFYING LANGUAGE ADDRESSING PENALTIES FOR CERTAIN IMPROPER
8 TRANSACTIONS OR PENALTIES; ADDRESSING INCORPORATION BY REFERENCE;
9 ADDRESSING RESCINDING POLICIES; INCLUDING APPLICATIONS UNDER CERTAIN
10 FORM REQUIREMENTS; AMENDING GRACE PERIOD REQUIREMENTS; ADDRESSING
11 LIFE INSURANCE BENEFITS IN THE CASE OF SUICIDE; ADDRESSING MATERNITY
12 BENEFITS; ADDRESSING REQUIRED DISCLOSURES OF DISABILITY INSURERS;
13 ADDRESSING MASTECTOMY COVERAGE; ADDRESSING MENTAL HEALTH PARITY;
14 ADDRESSING SIGNATURE REQUIREMENT FOR FORMS LISTING AGENTS; AMENDING
15 PROVISIONS RELATED TO THE COMPREHENSIVE HEALTH INSURANCE POOL ACT;
16 ADDRESSING SETTING RATES FOR THE POOL; ADDRESSING PREEXISTING
17 CONDITIONS; AND MAKING TECHNICAL CORRECTIONS.
18 This act affects sections of Utah Code Annotated 1953 as follows:
19 AMENDS:
20 **31A-4-115**, as enacted by Chapter 329, Laws of Utah 1998
21 **31A-16-111**, as last amended by Chapter 131, Laws of Utah 1999
22 **31A-18-106**, as last amended by Chapter 131, Laws of Utah 1999
23 **31A-21-105**, as last amended by Chapter 204, Laws of Utah 1986
24 **31A-21-106**, as last amended by Chapter 153, Laws of Utah 1996
25 **31A-21-201**, as last amended by Chapter 230, Laws of Utah 1992
26 **31A-22-402**, as enacted by Chapter 242, Laws of Utah 1985
27 **31A-22-404**, as enacted by Chapter 242, Laws of Utah 1985

28 **31A-22-513**, as enacted by Chapter 242, Laws of Utah 1985
29 **31A-22-613.5**, as last amended by Chapter 13, Laws of Utah 1998
30 **31A-23-219**, as last amended by Chapter 293, Laws of Utah 1998
31 **31A-25-205**, as enacted by Chapter 242, Laws of Utah 1985
32 **31A-29-111**, as last amended by Chapter 329, Laws of Utah 1998
33 **31A-29-117**, as last amended by Chapter 265, Laws of Utah 1997
34 **31A-30-107**, as last amended by Chapter 329, Laws of Utah 1998
35 ENACTS:
36 **31A-2-201.1**, Utah Code Annotated 1953
37 **31A-2-217**, Utah Code Annotated 1953
38 **31A-22-610.2**, Utah Code Annotated 1953
39 **31A-22-625**, Utah Code Annotated 1953
40 **31A-22-719**, Utah Code Annotated 1953
41 **31A-22-720**, Utah Code Annotated 1953
42 *Be it enacted by the Legislature of the state of Utah:*
43 Section 1. Section **31A-2-201.1** is enacted to read:
44 **31A-2-201.1. General filing requirements.**
45 Except as otherwise provided in this title, the commissioner may set by rule made in
46 accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, specific
47 requirements for filing any of the following required by this title:
48 (1) a form;
49 (2) a rate; or
50 (3) a report.
51 Section 2. Section **31A-2-217** is enacted to read:
52 **31A-2-217. Disability insurance coverage and benefits required by rule.**
53 (1) The commissioner may by rule require that all admitted disability insurers develop and
54 offer a specific disability insurance coverage or benefit in Utah if:
55 (a) the commissioner determines that the coverage or benefit is not available in the market
56 in Utah; and
57 (b) consumer demand and need for the coverage or benefit exists on such a scale that is
58 reasonable to offer it in Utah.

59 (2) In making the determination under Subsection (1), the commissioner shall consider:
60 (a) consumer demand in the market for the coverage or benefit;
61 (b) the extent to which the coverage or benefit is currently offered in the market;
62 (c) whether or not the pricing for the coverage or benefit will foster its availability
63 generally in the market;
64 (d) the public interest in having the coverage or benefit available;
65 (e) consumer need for the coverage or benefit to be adequate and readily accessible;
66 (f) any alternative methods for providing the coverage or benefit;
67 (g) any inherent limitations in providing the coverage or benefit;
68 (h) the reasonableness of underwriting the coverage or benefit;
69 (i) the impact the coverage or benefit has on competition in the market; and
70 (j) the extent to which consumer's choice of coverages and benefits in the market will be
71 maintained.
72 (3) If the commissioner determines under this section that a disability coverage or benefit
73 is to be offered in the market, all admitted disability insurers shall offer the coverage or benefit in
74 Utah.
75 (4) (a) If a consumer is unable to obtain a disability coverage or benefit because it is not
76 available in the market in Utah, the consumer may file a written request with the commissioner
77 that:
78 (i) identifies the coverage or benefit that is not available; and
79 (ii) requests that the commissioner make a determination under this section.
80 (b) On receipt of a written request under Subsection (4)(a), the commissioner shall begin
81 the process of making a determination in accordance with Subsection (2).
82 (5) The commissioner may issue rules related to:
83 (a) a disability coverage or benefit required under Subsection (1); and
84 (b) the process for making a determination under this section.
85 (6) The commissioner may require any interested party to a determination under this
86 section to provide information or data related to:
87 (a) a request made under Subsection (4); or
88 (b) a determination made under this section.
89 Section 3. Section **31A-4-115** is amended to read:

90 **31A-4-115. Plan of orderly withdrawal.**
91 (1) When an insurer intends to withdraw from writing a line of insurance in this state or
92 to reduce its total annual premium volume by 75% or more, it shall file with the commissioner a
93 plan of orderly withdrawal.
94 (2) An insurer's plan of orderly withdrawal shall:
95 (a) indicate the date the insurer intends to begin and complete its withdrawal plan; and
96 (b) include provisions for:
97 (i) meeting the insurer's contractual obligations;
98 (ii) providing services to its Utah policyholders and claimants; and
99 (iii) meeting any applicable statutory obligations.
100 (3) The commissioner shall approve a plan of orderly withdrawal if it adequately
101 demonstrates that the insurer will:
102 (a) protect the interests of the people of the state;
103 (b) meet its contractual obligations;
104 (c) provide service to its Utah policyholders and claimants; and
105 (d) meet any applicable statutory obligations.
106 (4) [~~The provisions of~~] Section 31A-2-302 [~~govern~~] <u>governs</u> the commissioner's approval
107 or disapproval of a plan for orderly withdrawal.
108 (5) The commissioner may require an insurer to increase the deposit maintained in
109 accordance with Section 31A-4-105 or Section 31A-4-105.5 and place the deposit in trust in the
110 name of the commissioner upon finding, after an adjudicative proceeding that:
111 (a) there is reasonable cause to conclude that the interests of the people of the state are best
112 served by such action; and
113 (b) the insurer:
114 (i) has filed a plan of orderly withdrawal; or
115 (ii) intends to<u>:</u>
116 <u>(A)</u> withdraw from writing a line of insurance in this state<u>;</u> or [~~to~~]
117 <u>(B)</u> reduce its total annual premium volume by 75% or more.
118 (6) An insurer that withdraws from writing insurance in this state or that reduces its total
119 annual premium volume by 75% or more in any year without having submitted a plan or receiving
120 the commissioner's approval is subject to the civil penalties under Section 31A-2-308.

121 (7) An insurer that withdraws from writing all lines of insurance in this state may not
122 resume writing insurance in this state for five years without:
123 (a) the approval of the commissioner; and
124 (b) complying with Subsection [31A-30-109] 31A-30-108(5), if applicable.
125 (8) The commissioner shall adopt rules necessary to implement the provisions of this
126 section.
127 Section 4. Section **31A-16-111** is amended to read:
128 **31A-16-111. Required sale of improperly acquired stock -- Penalties.**
129 (1) If the commissioner finds that the acquiring person has not substantially complied with
130 the requirements of this chapter in acquiring control of a domestic insurer, the commissioner may
131 require the acquiring person to sell the acquiring person's stock of the domestic insurer in the
132 manner specified in Subsection (2).
133 (2) (a) The commissioner shall effect the sale required by Subsection (1) in the manner
134 which, under the particular circumstances, appears most likely to result in the payment of the full
135 market value for the stock by persons who have the collective competence, experience, financial
136 resources, and integrity to obtain approval under Subsection 31A-16-103(8).
137 (b) Sales made under this section are subject to approval by the Third Judicial District
138 Court for Salt Lake County, which court has the authority to effect the terms of the sale.
139 (3) The proceeds from sales made under this section shall be distributed first to the person
140 required by this section to sell the stock, but only up to the amount originally paid by the person
141 for the securities. Additional sale proceeds shall be paid to the General Fund.
142 (4) The person required to sell and persons related to or affiliated with the seller may not
143 purchase the stock at the sale conducted under this section.
144 (5) (a) [Every] A director or officer of an insurance holding company system [who]
145 violates this chapter if the director or officer knowingly [violates,]:
146 (i) participates in[,] or assents to[, or who knowingly permits any of the officers or agents
147 of the insurer to engage in transactions] a transaction or [make investments] investment that
148 [have]:
149 (A) has not been properly reported or submitted pursuant to:
150 (I) Subsections 31A-16-105 (1) and (2)[,]; or
151 (II) Subsection 31A-16-106 (1)(b)[,]; or [which]

152 (B) otherwise [violate] violates this chapter[,]; or
153 (ii) permits any of the officers or agents of the insurer to engage in a transaction or
154 investment described in Subsection (5)(a)(i).
155 (b) A director or officer in violation of Subsection (5)(a) shall pay, in [their] the director's
156 or officer's individual capacity, a civil penalty of not more than $20,000 per violation[,]:
157 (i) upon a finding by the commissioner of a violation[,]; and
158 (ii) after notice and hearing before the commissioner.
159 [(b)] (c) In determining the amount of the civil penalty under Subsection (5)[(a)](b), the
160 commissioner shall take into account:
161 (i) the appropriateness of the penalty with respect to the gravity of the violation;
162 (ii) the history of previous violations; and
163 (iii) any other matters that justice requires.
164 (6) (a) When it appears to the commissioner that any insurer or any director, officer,
165 employee, or agent of the insurer, has committed a willful violation of this chapter, the
166 commissioner may cause criminal proceedings to be instituted:
167 (i) (A) in the district court for the county in this state in which the principal office of the
168 insurer is located[,]; or
169 (B) if the insurer has no principal office in this state, [then] in the Third District Court for
170 Salt Lake County; and
171 (ii) against the insurer or the responsible director, officer, employee, or agent of the
172 insurer.
173 (b) (i) An insurer that willfully violates this chapter may be fined not more than $20,000.
174 (ii) Any individual who willfully violates this chapter is guilty of a third degree felony, and
175 upon conviction may be:
176 [(i)] (A) fined in that person's individual capacity not more than $5,000;
177 [(ii)] (B) imprisoned; or
178 [(iii)] (C) both fined and imprisoned.
179 (7) This section does not limit the other sanctions applicable to violations of this title under
180 Section 31A-2-308.
181 Section 5. Section **31A-18-106** is amended to read:
182 **31A-18-106. Investment limitations generally applicable.**

183 (1) The investment limitations listed in Subsections (1)(a) through (l) apply to each insurer.
184 (a) (i) Except as provided in Subsection (1)(a)(ii), for investments authorized under
185 Subsection 31A-18-105(1) that are not amortizable under applicable valuation rules, the limitation
186 is 5% of assets.
187 (ii) The limitation of Subsection (1)(a)(i) and the limitation of Subsection (2) do not apply
188 to demand deposits and certificates of deposit in solvent banks and savings and loan institutions
189 to the extent they are insured by a federal deposit insurance agency.
190 (b) For investments authorized under Subsection 31A-18-105(2), the limitation is 10% of
191 assets.
192 (c) For investments authorized under Subsection 31A-18-105(3), the limitation is 50% of
193 assets.
194 (d) For investments authorized under Subsection 31A-18-105(4), that are considered to
195 be investments in kinds of securities or evidences of debt pledged, those investments are subject
196 to the class limitations applicable to the pledged securities or evidences of debt.
197 (e) For investments authorized under Subsection 31A-18-105(5), the limitation is 35% of
198 assets.
199 (f) For investments authorized under Subsection 31A-18-105(6), the limitation is:
200 (i) 20% of assets for life insurers; and
201 (ii) 50% of assets for nonlife insurers.
202 (g) For investments authorized under Subsection 31A-18-105(7), the limitation is 5% of
203 assets, except as to insurers organized and operating under Chapter 7, in which case the limitation
204 is 25% of assets.
205 (h) For investments authorized under Subsection 31A-18-105(8), the limitation is 20% of
206 assets inclusive of home office and branch office properties, except as to insurers organized and
207 operating under Chapter 7, in which case the limitation is 35% of assets, inclusive of home office
208 and branch office properties.
209 (i) For investments authorized under Subsection 31A-18-105(10), the limitation is 1% of
210 assets.
211 (j) For investments authorized under Subsection 31A-18-105(11), the limitation is the
212 greater of that permitted or required for compliance with Section 31A-18-103.
213 (k) Except as provided in Subsection (1)(l), an insurer's investments in subsidiaries is

214 limited to 50% of the insurer's total adjusted [~~capitol~~] capital. Investments by an insurer in its
215 subsidiaries includes:
216 (i) the insurer's loans, advances, and contributions to its subsidiaries; and
217 (ii) the insurer's holding of bonds, notes, and stocks of its subsidiaries are included.
218 (l) Under a plan of merger approved by the commissioner, the commissioner may allow
219 an insurer any portion of its assets invested in an insurance subsidiary. The approved plan of
220 merger shall require the acquiring insurer to conform its accounting for investments in subsidiaries
221 to Subsection (1)(k) within a specified period that may not exceed five years.
222 (2) The limits on investments listed in Subsections (2)(a) through (e) apply to each insurer.
223 (a) For all investments in a single entity, its affiliates, and subsidiaries, the limitation is
224 10% of assets, except that the limit imposed by this Subsection (2)(a) does not apply to:
225 (i) investments in the government of the United States or its agencies;
226 (ii) investments guaranteed by the government of the United States; or
227 (iii) investments in the insurer's insurance subsidiaries.
228 (b) Investments authorized by Subsection 31A-18-105(3) shall comply with the
229 requirements listed in this Subsection (2)(b).
230 (i) (A) Except as provided in Subsection (2)(b)(i), the amount of any loan secured by a
231 mortgage or deed of trust may not exceed 80% of the value of the real estate interest mortgaged,
232 unless the excess over 80%:
233 (I) is insured or guaranteed by the United States, any state of the United States, any
234 instrumentality, agency, or political subdivision of the United States, any of its states, or a
235 combination of any of these; or
236 (II) insured by an insurer approved by the commissioner and qualified to insure that type
237 of risk in this state.
238 (B) Mortgage loans representing purchase money mortgages acquired from the sale of real
239 estate are not subject to the limitation of Subsection (2)(b)(i)(A).
240 (ii) Subject to Subsection (2)(b)(v), loans or evidences of debt secured by real estate may
241 only be secured by unencumbered real property, or an unencumbered interest in real property that
242 is located in the United States.
243 (iii) Evidence of debt secured by first mortgages or deeds of trust upon leasehold estates
244 shall require that:

245 (A) the leasehold estate exceed the maturity of the loan by not less than 10% of the lease
246 term;
247 (B) the real estate not be otherwise encumbered; and
248 (C) the mortgagee is entitled to be subrogated to all rights under the leasehold.
249 (iv) Subject to Subsection (2)(b)(v):
250 (A) participation in any mortgage loan must:
251 (I) be senior to other participants; and
252 (II) give the holder substantially the rights of a first mortgagee; or
253 (B) the interest of the insurer in the evidence of indebtedness must be of equal priority, to
254 the extent of the interest, with other interests in the real property.
255 (v) A fee simple or leasehold real estate or any interest in either of them is not considered
256 to be encumbered within the meaning of this chapter by reason of any prior mortgage or trust deed
257 held or assumed by the insurer as a lien on the property, if:
258 (A) the total of the mortgages or trust deeds held does not exceed 70% of the value of the
259 property; and
260 (B) the security created by the prior mortgage or trust deed is a first lien.
261 (c) Loans permitted under Subsection 31A-18-105(4) may not exceed 75% of the market
262 value of the collateral pledged, except that loans upon the pledge of United States government
263 bonds may be equal to the market values of the pledge.
264 (d) For an equity interest in a single real estate property authorized under Subsection
265 31A-18-105(8), the limitation is 5% of assets.
266 (e) Investments authorized under Subsection 31A-18-105(10) shall be in connection with
267 potential changes in the value of specifically identified:
268 (i) assets which the insurer owns; or
269 (ii) liabilities which the insurer has incurred.
270 (3) The restrictions on investments listed in Subsections (3)(a) and (b) apply to each
271 insurer.
272 (a) Except for financial futures contracts and real property acquired and occupied by the
273 insurer for home and branch office purposes, a security or other investment is not eligible for
274 purchase or acquisition under this chapter unless it is:
275 (i) interest bearing or income paying; and

276 (ii) not then in default.
277 (b) A security is not eligible for purchase at a price above its market value.
278 (4) Computation of percentage limitations under this section:
279 (a) is based only upon the insurer's total qualified invested assets described in Section
280 31A-18-105 and this section, as these assets are valued under Section 31A-17-401; and
281 (b) excludes investments permitted under Section 31A-18-108 and Subsections
282 31A-17-203(2) and (3).
283 (5) An insurer may not make an investment that, because the investment does not conform
284 to Section 31A-18-105 and this section, has the result of rendering the insurer, under Chapter 17,
285 Part VI, Risk-Based Capital, subject to proceedings under Chapter 27.
286 (6) A pattern of persistent deviation from the investment diversification standards set forth
287 in Section 31A-18-105 and this section may be grounds for a finding that the person or persons
288 with authority to make the insurer's investment decisions are "incompetent" as used in Subsection
289 31A-5-410(3).
290 (7) Section 77r-1 of the Secondary Mortgage Market Enhancement Act of 1984 does not
291 apply to the purchase, holding, investment, or valuation limitations of assets of insurance
292 companies subject to this chapter.
293 Section 6. Section **31A-21-105** is amended to read:
294 **31A-21-105. Representations, warranties, and conditions.**
295 (1) (a) No statement, representation, or warranty made by any person representing the
296 insurer in the negotiation for an individual or franchise insurance contract affects the insurer's
297 obligations under the policy unless it is stated in the policy or in a written application signed by
298 the applicant. No person, except the applicant or another by his written consent, may alter the
299 application, except for administrative purposes in a way which is clearly not ascribable to the
300 applicant.
301 (b) No statement, representation, or warranty made by or on behalf of a particular
302 certificate holder under a group policy affects the insurer's obligations under the certificate unless
303 it is stated in the certificate or in a written document signed by the certificate holder, and a copy
304 of it is supplied to the certificate holder.
305 (c) The policyholder, his assignee, the loss payee or mortgagee or lienholder under
306 property insurance, and any person whose life or health is insured under a policy may request, in

307 writing, from the company a copy of the application, if he did not receive the policy or a copy of
308 it, or if the policy has been reinstated or renewed without the attachment of a copy of the original
309 application. If the insurer does not deliver or mail a copy as requested within 30 days after receipt
310 of the request by the insurer or its agent, or in the case of a group policy certificate holder, does
311 not inform that person within the same period how he may inspect the policy or a copy of it and
312 application or enrollment card or a copy of it during normal business hours at a place reasonably
313 convenient to the certificate holder, nothing in the application or enrollment card affects the
314 insurer's obligations under the policy to the person making the request. Each person whose life
315 or health is insured under a group policy has the same right to request a copy of any document
316 under Subsection (1) (b).
317 (2) Except as provided in Subsection (5), no misrepresentation or breach of an affirmative
318 warranty affects the insurer's obligations under the policy unless:
319 (a) the insurer relies on it and it is either material or is made with intent to deceive; or
320 (b) the fact misrepresented or falsely warranted contributes to the loss.
321 (3) No failure of a condition prior to the loss and no breach of a promissory warranty
322 affects the insurer's obligations under the policy unless it exists at the time of the loss and either
323 increases the risk at the time of the loss or contributes to the loss. This Subsection (3) does not
324 apply to failure to tender payment of premium.
325 (4) Nondisclosure of information not requested by the insurer is not a defense to an action
326 against the insurer. Failure to correct within a reasonable time any representation that becomes
327 incorrect because of changes in circumstances is misrepresentation, not nondisclosure.
328 (5) If after issuance of a policy the insurer acquires knowledge of sufficient facts to
329 constitute a general defense to all claims under the policy, the defense is only available if the
330 insurer notifies the insured within 60 days after acquiring the knowledge of its intention to defend
331 against a claim if one should arise, or within 120 days if the insurer considers it necessary to secure
332 additional medical information and is actively seeking the information at the end of the 60 days.
333 The insurer and insured may mutually agree to a policy rider in order to continue the policy in
334 force with exceptions or modifications. For purposes of this Subsection (5), an insurer has
335 acquired knowledge only if the information alleged to give rise to the knowledge was disclosed
336 to the insurer or its agent in connection with communications or investigations associated with the
337 insurance policy under which the subject claim arises.

338 (6) (a) An insurer that offers coverage to a small employer group as required by P.L.
339 104-91, 110 Stat. 1979, Sec. 2711(a), may not rescind a policy or individual certificate holder
340 based on application misrepresentation unless the insurer would not have been required to issue
341 the coverage in the absence of the misrepresentation.
342 (b) Subsection (6)(a) does not prevent an insurer from correcting rates if:
343 (i) in the absence of misrepresentation a different rate would have been required; and
344 (ii) the corrected rates are in compliance with Section 31A-30-106.
345 [(6)] (7) No trivial or transitory breach of or noncompliance with any provision of this
346 chapter is a basis for avoiding an insurance contract.
347 Section 7. Section **31A-21-106** is amended to read:
348 **31A-21-106. Incorporation by reference.**
349 (1) (a) Except as provided in Subsection (1)(b), an insurance policy may not contain any
350 agreement or incorporate any provision not fully set forth in the policy or in an application or other
351 document attached to and made a part of the policy at the time of its delivery, unless the policy,
352 application, or agreement accurately reflects the terms of the incorporated agreement, provision,
353 or attached document.
354 (b) (i) A policy may by reference incorporate rate schedules and classifications of risks and
355 short-rate tables filed with the commissioner.
356 (ii) By rule or order, the commissioner may authorize incorporation by reference of
357 provisions for administrative arrangements, premium schedules, and payment procedures for
358 complex contracts.
359 (c) (i) A policy of title insurance insuring the mortgage or deed of trust of an institutional
360 lender may, if requested by an institutional lender, incorporate by reference generally applicable
361 policy terms that are contained in a specifically identified policy that has been filed with the
362 commissioner.
363 (ii) As used in Subsection (1)(c)(i), "institutional lender" means a person that regularly
364 engages in the business of making loans secured by real estate.
365 (d) A policy may incorporate by reference the following by citing in the policy:
366 (i) a federal law or regulation;
367 (ii) a state law or rule; or
368 (iii) a public directive of a federal or state agency.

369 (2) Except as provided in Subsection (3) or (4), or as otherwise mandated by law, no
370 purported modification of a contract during the term of the policy affects the obligations of a party
371 to the contract unless the modification is in writing and agreed to by the party against whose
372 interest the modification operates.
373 (3) Subsection (2) does not prevent a change in coverage under group contracts resulting
374 from:
375 (a) provisions of an employer eligibility rule;
376 (b) the terms of a collective bargaining agreement; or
377 (c) provisions in federal Employee Retirement Income Security Act plan documents.
378 (4) Subsection (2) does not prevent a premium increase at any renewal date that is
379 applicable uniformly to all comparable persons.
380 Section 8. Section **31A-21-201** is amended to read:
381 **31A-21-201. Filing and approval of forms.**
382 (1) [~~No~~] (a) A form subject to Subsection 31A-21-101 (1), except as exempted under
383 Subsections 31A-21-101 (2) through [~~31A-21-101~~] (6), may not be used, sold, or offered for sale
384 unless it has been filed with the commissioner.
385 (b) A form is considered filed with the commissioner when [~~it has been received by~~] the
386 commissioner [~~with~~] receives:
387 (i) the form;
388 (ii) the applicable filing fee as prescribed under Section 31A-3-103 [~~together with~~]; and
389 (iii) the applicable transmittal forms as required by the commissioner.
390 (2) In filing a form for use in this state the insurer is responsible for assuring that the form
391 is in compliance with this title and rules adopted by the commissioner.
392 (3) (a) The commissioner may disapprove a form at any time upon a finding that:
393 (i) it is:
394 (A) inequitable[~~,~~];
395 (B) unfairly discriminatory[~~,~~];
396 (C) misleading[~~,~~];
397 (D) deceptive[~~,~~];
398 (E) obscure[~~,~~];
399 (F) unfair[~~,~~];

400 (G) encourages misrepresentation[,]; or [is]
401 (H) not in the public interest;
402 (ii) it provides benefits or contains other provisions that endanger the solidity of the
403 insurer;
404 (iii) in the case of the basic policy and the application for a basic policy, [though not
405 applicable to riders and endorsements,] it fails to provide the exact name of the insurer and its state
406 of domicile; [or]
407 (iv) it violates a statute or a rule adopted by the commissioner[,]; or
408 (v) it is otherwise contrary to law.
409 (b) Subsection (3)(a)(iii) does not apply to riders and endorsements to a basic policy.
410 [(b)] (c) (i) Whenever the commissioner disapproves a form under Subsection (3)(a), the
411 commissioner may order that, on or before a date not less than 15 days after the order, the use of
412 the form be discontinued.
413 (ii) Once a form has been disapproved, it may not be used unless appropriate changes are
414 filed with and approved by the commissioner. [The]
415 (iii) Whenever the commissioner disapproves a form under Subsection (3)(a), the
416 commissioner may [also] require the insurer to disclose contract deficiencies to existing
417 policyholders.
418 [(c)] (d) The commissioner's disapproval under this Subsection (3) shall be in writing and
419 constitutes an order. The order shall state the reasons for disapproval.
420 (4) (a) If, after a hearing, the commissioner determines that it is in the public interest, [he]
421 the commissioner may require by rule or order that certain forms be subject to the commissioner's
422 approval prior to their use.
423 (b) The rule or order described in Subsection (4)(a) shall prescribe the filing procedures
424 for [such] the forms if different than stated in this section.
425 (c) The types of forms [which] that may be addressed under Subsection (4)(a) include:
426 (i) forms for a particular class of insurance[,];
427 (ii) forms for a specific line of insurance[,];
428 (iii) a specific type of form[,]; or
429 (iv) forms for a specific market segment.
430 Section 9. Section **31A-22-402** is amended to read:

431 **31A-22-402. Grace period.**
432 (1) (a) Every life insurance policy other than a group policy shall contain a provision
433 entitling the policyholder to a grace period within which the payment of any premium may be
434 made after the first [may be made] payment of any premium.
435 (b) During the grace period described in Subsection (1)(a), the policy continues in full
436 force.
437 (2) The grace period required by Subsection (1) may not be less than [30]:
438 (a) 31 days[,]; or [less than]
439 (b) four weeks for policies whose premiums are payable more frequently than monthly.
440 (3) The insurer may impose an interest charge during the grace period not in excess of the
441 interest rate:
442 (a) set by the policy for policy loans[,]; or
443 (b) in the absence of [that] a provision described in Subsection (3)(a), a rate set by the
444 commissioner by rule. [The]
445 (4) If a claim arises under the policy during the grace period, an insurer may deduct from
446 the policy proceeds:
447 (a) the amount of any premium due or overdue[, together with];
448 (b) interest at the rate provided in this section[,]; and
449 (c) any deferred installment of the annual premium[, may be deducted from the policy
450 proceeds if a claim arises under the policy during the grace period].
451 Section 10. Section **31A-22-404** is amended to read:
452 **31A-22-404. Suicide.**
453 (1) (a) Suicide is not a defense to a claim under a life insurance policy that has been in
454 force as to a policyholder or certificate holder for two years from the date the coverage is effective,
455 whether:
456 (i) the suicide was voluntary or involuntary [and whether]; or
457 (ii) the insured was sane or insane. [However, if]
458 (b) If a suicide occurs within the two-year period described in Subsection (1)(a), the
459 insurer shall pay to the beneficiary an amount not less than the premium paid for the life insurance
460 policy.
461 (2) (a) If after a life insurance policy is in effect the policy allows the insured[, after the

462 policy's issuance and for an additional premium,] to obtain a death benefit [which] that is larger
463 than when the policy was originally [issued, then] effective for an additional premium, the payment
464 of the additional increment of benefit may be [denied on the ground of suicide, if the policy so
465 provides, until two years after the incremental increase of benefits is in effect] limited in the event
466 of a suicide within a two-year period beginning on the date the increment increase takes effect.
467 (b) If a suicide occurs within the two-year period described in Subsection (2)(a), the
468 insurer shall pay to the beneficiary an amount not less than the additional premium paid for the
469 additional increment of benefit.
470 (3) This section does not apply to:
471 (a) policies insuring against death by accident only[, nor to]; or
472 (b) the accident or double indemnity provisions of an insurance policy.
473 Section 11. Section **31A-22-513** is amended to read:
474 **31A-22-513. Grace period.**
475 (1) (a) Every group life insurance policy shall contain a provision that the policyholder is
476 entitled to a grace period of not less than [30] 31 days for the payment of any premium due except
477 the first payment of premium.
478 (b) During the grace period described in Subsection (1)(a) the death benefit coverage
479 continues in force, unless the policyholder gives the insurer written notice of discontinuance:
480 (i) in advance of the date of discontinuance; and
481 (ii) in accordance with the policy terms.
482 (2) The policy may require the policyholder to pay the pro rata premium for the time the
483 policy is in force during the grace period.
484 Section 12. Section **31A-22-610.2** is enacted to read:
485 **31A-22-610.2. Maternity stay minimum limits.**
486 (1) (a) If an insured has coverage for maternity benefits, the policy may not be limited to
487 a less than a 48-hour benefit for both mother and newborn with a normal vaginal delivery.
488 (b) If an insured has coverage for maternity benefits, the policy may not be limited to a less
489 than 96-hour benefit for both mother and newborn with a caesarean section delivery.
490 (2) Subsection (1) applies to a disability insurer who offers maternity coverage.
491 (3) (a) This section does not prevent a disability insurer from imposing cost-sharing
492 measures for health benefits relating to hospital stays in connection with a delivery if the

493 cost-sharing measures are not greater than those imposed on a hospital stay relating to childbirth
494 prior to the actual delivery.
495 (b) For purposes of Subsection (3)(a), cost-sharing measures include imposing a deductible
496 or coinsurance requirement.
497 Section 13. Section **31A-22-613.5** is amended to read:
498 **31A-22-613.5. Price and value comparisons of health insurance.**
499 (1) This section applies generally to all health insurance policies and health maintenance
500 organization contracts.
501 (2) (a) Immediately after the effective date of this section, the commissioner shall appoint
502 a Health Benefit Plan Committee.
503 (b) The committee shall be composed of representatives of carriers, employers, employees,
504 health care providers, consumers, and producers[,].
505 (c) A member of the committee shall be appointed to a four-year [terms] term.
506 [(c)] (d) Notwithstanding the requirements of Subsection (2)[(b)](c), the commissioner
507 shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the
508 terms of committee members are staggered so that approximately half of the committee is
509 appointed every two years.
510 (3) When a vacancy occurs in the membership for any reason, the replacement shall be
511 appointed for the unexpired term.
512 (4) (a) Members shall receive no compensation or benefits for their services, but may
513 receive per diem and expenses incurred in the performance of the member's official duties at the
514 rates established by the Division of Finance under Sections 63A-3-106 and 63A-3-107.
515 (b) Members may decline to receive per diem and expenses for their service.
516 (5) (a) The committee shall:
517 (i) serve as an advisory committee to the commissioner; and [shall]
518 (ii) recommend [services to be covered, copays, deductibles, levels of coinsurance, annual
519 out-of-pocket maximums, exclusions, and limitations] for two or more designated health care plans
520 to be marketed in the state[.]:
521 (A) services to be covered;
522 (B) copays;
523 (C) deductibles;

524 (D) levels of coinsurance;
525 (E) annual out-of-pocket maximums;
526 (F) exclusions; and
527 (G) limitations.
528 [(a)] (b) The plans recommended by the committee may include reasonable benefit
529 differentials applicable to participating and nonparticipating providers.
530 [(b)] (c) The plans recommended by the committee [shall] may not prohibit the use of the
531 following cost management techniques by an insurer:
532 (i) preauthorization of health care services;
533 (ii) concurrent review of health care services;
534 (iii) case management of health care services;
535 (iv) retrospective review of medical appropriateness;
536 (v) selective contracting with hospitals, physicians, and other health care providers to the
537 extent permitted by law; and
538 (vi) other reasonable techniques intended to manage health care costs.
539 [(c)] (d) The committee shall submit the plans to the commissioner within 180 days after
540 the appointment of the committee in accordance with this section.
541 [(d)] (e) The commissioner shall adopt two or more health benefit plans within 60 days
542 after the committee submits recommendations.
543 [(e)] (f) (i) If the committee fails to submit recommendations to the commissioner within
544 180 days after appointment, the commissioner shall, within 90 days, develop two or more
545 designated health benefit plans.
546 (ii) The commissioner shall, after notice and hearing, adopt two or more designated health
547 benefit plans.
548 (iii) The commissioner shall provide incentives for personal management of health care
549 expenses by adopting:
550 (A) one plan that applies deductibles in the amount of $1,500; and
551 (B) another plan that applies deductibles in the amount of $2,500. [These]
552 (iv) The plans described in Subsection (5)(f)(iii) may include:
553 (A) illustrations and explanations showing the premium savings generated by the high
554 deductibles being applied to a medical savings account for the insured [which] that can be used

555 to pay:
556 (I) medical expenses up to the plan deductible [~~and/or~~];
557 (II) any other medical expenses not covered by the insurance[~~,~~]; or
558 (III) both the medical expenses described in Subsection (5)(f)(iv)(A)(I) and (II); and
559 (B) an explanation that any funds in the savings account belong to the insured.
560 [~~(f)~~] (g) The commissioner may reconvene a Health Benefit Plan Committee in accordance
561 with Subsections (2) and (5) to recommend revisions to the designated benefit plans adopted by
562 the commissioner.
563 (6) (a) Within 180 days after the adoption of the designated benefit plans by the
564 commissioner, or any changes in the designated plans, an insurer offering health insurance policies
565 for sale in this state shall, at the request of a potential buyer, offer the current designated plans at
566 a premium based on factors such as that buyer's previous claims experience, group size,
567 demographic characteristics, and health status.
568 (b) This section does not prohibit an insurer from refusing to insure, under any plan, a
569 person or group. However, if the insurer offers any policy or contract to that person or group, the
570 insurer [~~must~~] shall offer the designated plans.
571 (7) The designated benefit plans, described in Subsection (5) are intended to facilitate price
572 and value comparisons by consumers. The designated benefit plans are not minimum standards
573 for health insurance policies. An insurer offering the designated benefit plans may offer policies
574 that provide more or less coverage than the designated benefit plans.
575 (8) (a) The commissioner shall convene or reconvene a Health Benefit Plan Committee
576 for the purpose of developing a Basic Health Care Plan to be offered under the open enrollment
577 provisions of Chapter 30.
578 (b) The commissioner shall adopt a Basic Health Care Plan within 60 days after the
579 committee submits recommendations, or if the committee fails to submit recommendations to the
580 commissioner within 180 days after appointment, the commissioner shall, within 90 days, adopt
581 a Basic Health Care Plan.
582 (c) (i) Before adoption of a plan under Subsection (8)(b), the commissioner shall submit
583 the proposed Basic Health Care Plan to the Health and Human Services Interim Committee for
584 review and recommendations.
585 (ii) After the commissioner adopts the Basic Health Care Plan, the Health and Human

586 Services Interim Committee:
587 (A) shall provide legislative oversight of the Basic Health Care Plan; and
588 (B) may recommend legislation to modify the Basic Health Care Plan adopted by the
589 commissioner.
590 (d) The committee's recommendations for the Basic Health Care Plan shall be advisory
591 to the commissioner.
592 (9) (a) The commissioner shall promote informed consumer behavior and responsible
593 health insurance and health plans by requiring an insurer issuing health insurance policies or health
594 maintenance organization contracts to provide to all enrollees, prior to enrollment in the health
595 benefit plan or health insurance policy, written disclosure of:
596 (i) restrictions or limitations on prescription drugs and biologics including the use of a
597 formulary and generic substitution[. If a formulary is used, the drugs included and the patented
598 drugs not included, and any conditions which exist as a precedent to coverage shall be made
599 readily available to prospective enrollees and evidence of the fact of that disclosure shall be
600 maintained by the insurer]; and
601 (ii) coverage limits under the plan.
602 (b) [An] In addition to the requirements of Subsections (9)(a) and (d), an insurer described
603 in Subsection (9)(a) shall [also] submit the written disclosure required by this Subsection (9) to
604 the commissioner:
605 (i) annually[,]; and
606 (ii) anytime [thereafter when] the insurer amends any of the following described in
607 Subsection (9)(a):
608 (A) treatment policies[,];
609 (B) practice standards[, or];
610 (C) restrictions [described in Subsection (8)(a)]; or
611 (D) coverage limits of the insurer's health benefit plan or health insurance policy.
612 (c) The commissioner may adopt rules to implement the disclosure requirements of this
613 Subsection (9), taking into account:
614 (i) business confidentiality of the insurer[,];
615 (ii) definitions of terms[,]; and
616 (iii) the method of disclosure to enrollees.

617 (d) If under Subsection (9)(a)(i) a formulary is used, the insurer shall make available to
618 prospective enrollees and maintain evidence of the fact of the disclosure of:
619 (i) the drugs included;
620 (ii) the patented drugs not included; and
621 (iii) any conditions that exist as a precedent to coverage.
622 (10) (a) The commissioner shall annually publish a table comparing the rates charged by
623 insurers for the designated health plans and other health insurance plans in this state.
624 (b) The comparison required by Subsection (10)(a) shall list:
625 (i) the top 20 insurers writing the greatest volume by premium dollar per calendar year;
626 and
627 (ii) others requesting inclusion in the comparison.
628 (c) In conjunction with the rate comparison described in this Subsection (10), the
629 commissioner shall publish for each of the listed health insurers a table comparing the complaints
630 filed and the combined loss and expense ratio as described in Subsections 31A-2-208.5(2) and (3).
631 Section 14. Section **31A-22-625** is enacted to read:
632 **31A-22-625. Mastectomy coverage.**
633 (1) If an insured has coverage that provides medical and surgical benefits with respect to
634 a mastectomy, it shall provide coverage, with consultation of the attending physician and the
635 patient, for:
636 (a) reconstruction of the breast on which the mastectomy has been performed;
637 (b) surgery and reconstruction of the breast on which the mastectomy was not performed
638 to produce symmetrical appearance; and
639 (c) prostheses and physical complications with regards to all stages of mastectomy,
640 including lymphedemas.
641 (2) (a) This section does not prevent a disability insurer from imposing cost-sharing
642 measures for health benefits relating to this coverage, if cost-sharing measures are not greater than
643 those imposed on any other medical condition.
644 (b) For purposes of this Subsection (2), cost-sharing measures include imposing a
645 deductible or coinsurance requirement.
646 (3) Written notice of the availability of the coverage described in Subsection (1) shall be
647 delivered to the participant:

648 (a) upon enrollment; and
649 (b) annually after the enrollment.
650 Section 15. Section **31A-22-719** is enacted to read:
651 **31A-22-719. Mastectomy coverage.**
652 (1) A group policy subject to Section 31A-22-625 may not deny a person's eligibility or
653 continued eligibility to enroll or renew coverage under the terms of the group policy plan solely
654 for the purpose of avoiding the requirements of this section or Section 31A-22-625.
655 (2) A group policy subject to Section 31A-22-625 may not do any of the following to
656 induce a provider to provide care to an insured in a manner inconsistent with this section or
657 Section 31A-22-625:
658 (a) penalize or otherwise reduce or limit the reimbursement of an attending provider; or
659 (b) provide incentives to an attending provider whether or not the incentives are monetary.
660 Section 16. Section **31A-22-720** is enacted to read:
661 **31A-22-720. Mental health parity.**
662 (1) (a) A group disability plan offered by an insurer shall comply with Subsection (1)(b)
663 if the group disability plan:
664 (i) applies an aggregate lifetime limit to plan payments for medical or surgical services
665 covered by the group disability plan; and
666 (ii) provides a mental health benefit.
667 (b) A group disability plan described in Subsection (1)(a) shall:
668 (i) include in the aggregate lifetime limit for medical or surgical services covered by the
669 group disability plan the payments made under the plan for mental health services; or
670 (ii) establish a separate aggregate lifetime limit to plan payments for mental health services
671 covered by the group disability plan, but only if the dollar amount of the aggregate lifetime limit
672 for mental health services covered by that plan is equal to or greater than the dollar amount of the
673 aggregate lifetime limit for medical or surgical services covered by that plan.
674 (2) (a) A group disability plan offered by an insurer shall comply with Subsection (2)(b)
675 if the group disability plan:
676 (i) applies an annual limit to plan payments for medical or surgical services covered by the
677 group disability plan; and
678 (ii) provides a mental health benefit.

679 (b) A group disability plan described in Subsection (2)(a) shall:
680 (i) include in the annual limit for medical or surgical services covered by the group
681 disability plan the payments made under the plan for mental health services; or
682 (ii) establish a separate annual limit to plan payments for mental health services covered
683 by the group disability plan, but only if the dollar amount of the annual limit for mental health
684 services covered by that plan is equal to or greater than the dollar amount of the annual limit for
685 medical or surgical services covered by that plan.
686 (3) This section does not prohibit a group disability plan offered by an insurer from:
687 (a) using other forms of cost containment not prohibited under Subsection (1); or
688 (b) applying requirements that make distinctions between acute care and chronic care.
689 (4) This section does not apply to:
690 (a) benefits for:
691 (i) substance abuse; or
692 (ii) chemical dependency; or
693 (b) disability benefits or plans paid under Title XVII or XIX of the Social Security Act.
694 (5) (a) This section does not apply to plans maintained by employers that employ less than
695 50 employees.
696 (b) For purposes of determining whether an employer is exempt under Subsection (5)(a):
697 (i) if the employer was not in existence throughout the preceding calendar year, the number
698 of employees of the employer is determined based on the average number of employees that the
699 employer is reasonably expected to employ on business days in the calendar year for which the
700 determination is made; and
701 (ii) as used in this Subsection (5), "employer" includes a predecessor of the employer.
702 Section 17. Section **31A-23-219** is amended to read:
703 **31A-23-219. Appointment and listing of insurance agents.**
704 (1) As used in this section, "insurer" includes a bail bond surety [~~companies~~] as defined
705 in Section 31A-35-102.
706 (2) (a) An insurer shall appoint a natural person or agency that has an insurance agent or
707 managing general agent license to act as an insurance agent on its behalf prior to any agent doing
708 business for the insurer in this state.
709 (b) All insurers shall report to the commissioner, at intervals and in the form the

710 commissioner establishes by rule, all new appointments and all terminations of appointments.
711 (c) All insurers shall submit to the commissioner on or before July 1 of each
712 odd-numbered year a list of all agent appointments then in force in this state.
713 (3) (a) An insurer shall report to the commissioner the cause of termination of an agent's
714 appointment. The information provided to the commissioner shall remain confidential.
715 (b) An insurer is immune from civil action, civil penalty, or damages if the insurer
716 complies in good faith with this Subsection (3) in reporting to the commissioner the cause of
717 termination of agents' appointments.
718 (c) Notwithstanding any other provision in this section, an insurer is not immune from any
719 action or resulting penalty imposed on the reporting insurer as a result of proceedings brought by
720 or on behalf of the department if the action is based on evidence other than the report submitted
721 in compliance with this Subsection (3).
722 (4) If an insurer appoints an agency as its agent, the insurer need not appoint, report, or pay
723 appointment reporting fees for natural person agents designated on the agency's agent's license
724 under Section 31A-23-212.
725 (5) (a) Each insurer shall maintain with the department[~~, on forms supplied by the~~
726 ~~department, and signed by the president and secretary of the insurer,~~] a list of natural persons with
727 authority to appoint and remove the company's agents in this state on forms:
728 (i) supplied by the department; and
729 (ii) signed by any officer of the insurer.
730 (b) The insurer shall submit the [~~reports~~] list required under Subsection (5)(a) to the
731 commissioner pursuant to Subsection (2).
732 (6) If an insurer lists a licensee as its agent in reports submitted under Subsection (2), there
733 is a rebuttable presumption that in placing a risk with the insurer the appointed licensee or any of
734 the licensee's licensed employees acted as the insurer's agent and not as a broker.
735 Section 18. Section **31A-25-205** is amended to read:
736 **31A-25-205. Financial responsibility.**
737 (1) Every person licensed under this chapter shall, while licensed and for one year after
738 that date, maintain an insurance policy or surety bond, issued by an authorized insurer, in an
739 amount specified under Subsection (2), on a policy or contract form which is acceptable under
740 Subsection (3).

741 (2) (a) Insurance policies or surety bonds satisfying the requirement of Subsection (1) shall
742 be in a face amount equal to at least 10% of the total funds handled by the administrator.
743 However, no policy or bond under this subsection may be in a face amount of less than $5,000 nor
744 more than $500,000.
745 (b) In fixing the policy or bond face amount under Subsection (2)(a), the total funds
746 handled is the greater of the premiums received or claims paid through the administrator during
747 the previous calendar year, or, if no funds were handled during the preceding year, the total funds
748 reasonably anticipated to be handled by the administrator during the current calendar year.
749 (c) This section does not prohibit any person dealing with the administrator from requiring,
750 by contract, insurance coverage in amounts greater than required under this section.
751 (3) Insurance policies or surety bonds issued to satisfy Subsection (1) shall be on forms
752 approved by the commissioner. The policies or bonds shall require the insurer to pay, up to the
753 policy or bond face amount, any judgment obtained by participants in or beneficiaries of plans
754 administered by the insured licensee which arise from the negligence or culpable acts of the
755 licensee or any employee or agent of the licensee in connection with the activities described under
756 [~~the first paragraph of Section 31A-25-101~~] Subsection 31A-1-301(90). The commissioner may
757 require that policies or bonds issued to satisfy the requirements of this section require the insurer
758 to give the commissioner 20 day prior notice of policy cancellation.
759 (4) The commissioner shall establish annual reporting requirements and forms to monitor
760 compliance with this section.
761 (5) This section may not be construed as limiting any cause of action an insured would
762 otherwise have against the insurer.
763 Section 19. Section **31A-29-111** is amended to read:
764 **31A-29-111. Eligibility -- Limitations.**
765 (1) (a) Except as provided in Subsection (1)(b), a person is eligible for pool coverage if:
766 (i) (A) the person pays the established premium; and
767 (B) is a resident of this state; or
768 (ii) is a dependent child 25 years of age or less of a person described in Subsection
769 (1)(a)(i).
770 (b) Notwithstanding Subsection (1)(a), a person is not eligible for pool coverage if one of
771 the following conditions apply:

772 (i) at the time of application, the person is eligible for health care benefits under Medicaid
773 or Medicare, except as provided in Section 31A-29-112;
774 (ii) the person has terminated coverage in the pool, unless:
775 (A) 12 months have elapsed since the termination date; or
776 (B) the person demonstrates that continuous other coverage has been involuntarily
777 terminated for any reason other than nonpayment of premium;
778 (iii) the pool has paid the maximum lifetime benefit to or on behalf of the person;
779 (iv) the person is an inmate of a public institution;
780 (v) the person is eligible for other public programs for which medical care is provided;
781 (vi) the person's health condition does not meet the criteria established under Subsection
782 (4);
783 (vii) the person is an eligible employee or a member of an employer group that offers
784 health insurance or a self-insurance arrangement to all its eligible employees or members; or
785 (viii) at the time of application, the person:
786 (A) is not eligible for coverage that is subject to the Health Insurance Portability and
787 Accountability Act, P.L. 104-91, 110 Stat. 1962; and
788 (B) has not resided in Utah for at least 12 consecutive months preceding the date of
789 application.
790 (2) (a) Notwithstanding Subsection (1)(b)(viii), if otherwise eligible under Subsection (1),
791 a person whose health insurance coverage from a state health risk pool with similar coverage is
792 terminated because of nonresidency in another state may apply for coverage under the pool subject
793 to the conditions of Subsections (1)(b)(i) through (vii).
794 (b) (i) [~~If the coverage is applied for~~] Coverage sought under Subsection (2)(a) shall be
795 applied for within [~~31~~] 63 days after the termination [~~and if~~] date of the previous risk pool
796 coverage.
797 (ii) If premiums are paid for the entire coverage period under the pool, the effective date
798 of the pool's coverage shall be the date of termination of previous coverage.
799 (iii) If premiums are not paid back to the previous termination date, then the effective date
800 will be determined by the pool administrator in accordance with the date of application.
801 (c) The waiting period of a person with a preexisting condition applying for coverage
802 under this chapter shall be waived if:

803 (i) the waiting period was satisfied under a similar plan from another state; and
804 (ii) the other state's benefit limitation was not reached.
805 (3) If an eligible person applies for pool coverage within 30 days of being denied coverage
806 by an individual carrier, the effective date for pool coverage shall be set at the first day of the
807 month following the submission of the completed insurance application to the carrier.
808 (4) (a) The board shall establish and adjust, as necessary, underwriting criteria based on:
809 (i) health condition; and
810 (ii) expected claims so that the expected claims are anticipated to remain within available
811 funding.
812 (b) The commissioner may contract with one or more providers under Title 63, Chapter
813 56, Utah Procurement Code, to develop underwriting criteria under Subsection (4)(a).
814 (c) If a person is denied coverage under the criteria established in Subsection (4)(a), the
815 pool shall issue a certificate to the applicant for coverage under Subsection 31A-30-108(3).
816 Section 20. Section **31A-29-117** is amended to read:
817 **31A-29-117. Premium rates.**
818 (1) (a) Premium charges for coverage under the pool may not be unreasonable in relation
819 to:
820 (i) the benefits provided[,];
821 (ii) the risk experience[,]; and
822 (iii) the reasonable expenses provided in the coverage.
823 (b) Separate schedules of premium rates based on age and other appropriate demographic
824 characteristics may apply for individual risks.
825 (2) A small employer carrier shall annually inform the commissioner by April 1 of the
826 carrier's small employer index premium rates as of March 1 of the current and preceding year.
827 (3) (a) Premium rates in effect as of January 1, 1997, shall be adjusted on July 1, 1997, and
828 each following July 1 [~~based on~~] may be adjusted by the board.
829 (b) In adjusting premium rates, the board shall:
830 (i) consider the average increase in small employer index rates for the five largest small
831 employer carriers submitted under Subsection (2)[.]; and
832 (ii) be subject to Subsection (1).
833 (4) The board may establish a premium scale based on income. The highest rate may not

834 exceed the expected claims and expenses for the individual.
835 (5) If a person is an eligible individual as defined in the Health Insurance Portability and
836 Accountability Act, P.L. 104-191, 110 Stat. 1979, Sec. 2741(b), the maximum premium rate for
837 that person may not exceed the amount permitted under P.L. 104-191, 110 Stat. 1986, Sec.
838 2744(c)(2)(B).
839 (6) All rates and rate schedules shall be submitted by the board to the commissioner for
840 approval.
841 Section 21. Section **31A-30-107** is amended to read:
842 **31A-30-107. Renewal -- Limitations -- Exclusions.**
843 (1) A health benefit plan subject to this chapter is renewable with respect to all covered
844 individuals at the option of the covered insured except in any of the following cases:
845 (a) nonpayment of the required premiums;
846 (b) fraud or misrepresentation of:
847 (i) the employer; or[,]
848 (ii) with respect to coverage of individual insureds, the insureds or their representatives;
849 (c) noncompliance with the covered carrier's minimum participation requirements;
850 (d) noncompliance with the covered carrier's employer contribution requirements;
851 (e) repeated misuse of a provider network provision; or
852 (f) an election by the covered carrier to nonrenew all of its health benefit plans issued to
853 covered insureds in this state, in which case the covered carrier shall:
854 (i) provide advanced notice of its decision under this Subsection (1) to the commissioner
855 in each state in which it is licensed; and
856 (ii) provide notice of the decision not to renew coverage to all affected covered insureds
857 and to the commissioner in each state in which an affected insured individual is known to reside
858 [~~at least 180 days prior to the nonrenewal of any health benefit plans by the covered carrier~~].
859 (2) Notice [~~to the commissioner~~] under [~~this~~] Subsection (1) shall be provided:
860 (a) to affected covered insureds at least 180 days prior to nonrenewal of any health benefit
861 plans by the covered carrier; and
862 (b) to the commissioner at least three working days prior to the notice to the affected
863 covered insureds.
864 [~~(2)~~] (3) A covered carrier that elects not to renew a health benefit plan under Subsection

865 (1)(f) is prohibited from writing new business subject to this chapter in this state for a period of
866 five years from the date of notice to the commissioner.
867 [(3)] (4) When a covered carrier is doing business subject to this chapter in one service
868 area of this state, Subsections (1) [and (2)] through (3) apply only to the covered carrier's
869 operations in that service area.
870 [(4)] (5) Health benefit plans covering covered insureds shall comply with [the following
871 provisions:] Subsections (5)(a) and (b).
872 (a) (i) A health benefit plan may not deny, exclude, or limit benefits for a covered
873 individual for losses incurred more than 12 months, or 18 months in the case of a late enrollee, as
874 defined in P.L. 104-191, 110 Stat. 1940, Sec. 101, following the effective date of the individual's
875 coverage due to a preexisting condition.
876 (ii) A health benefit plan may not define a preexisting condition more restrictively than:
877 (A) a condition for which medical advice, diagnosis, care, or treatment was recommended
878 or received during the six months immediately preceding the earlier of:
879 (I) the enrollment date; or
880 (II) the effective date of coverage; or
881 (B) for an individual insurance policy, a pregnancy existing on the effective date of
882 coverage.
883 (b) (i) A covered carrier shall waive any time period applicable to a preexisting condition
884 exclusion or limitation period with respect to particular services in a health benefit plan for the
885 period of time the individual was previously covered by public or private health insurance or by
886 any other health benefit arrangement that provided benefits with respect to such services, provided
887 that:
888 (A) the previous coverage was continuous to a date not more than [62] 63 days prior to the
889 effective date of the new coverage; and
890 (B) the insured provides notification of previous coverage to the covered carrier within 36
891 months of the coverage effective date if the insurer has previously requested such notification.
892 (ii) The period of continuous coverage under Subsection [(4)] (5)(b)(i)(A) [shall] may not
893 include any waiting period for the effective date of the new coverage applied by the employer or
894 the carrier. This Subsection (5)(b)(ii) does not preclude application of any waiting period
895 applicable to all new enrollees under [such] the plan.

Legislative Review Note
as of 2-3-00 2:36 PM

This legislation raises the following constitutional or statutory concerns:

This bill modifies an existing requirement that to participate in the Comprehensive Health Insurance Pool a person must be a resident of this state for 12 months unless that person was covered by a similar pool in another state. A 1999 United States Supreme Court case has found a durational residency requirement related to welfare benefits unconstitutional. *Saenz v. Roe*, 526 U.S. 489 (1999). However, in as much as this bill extends the period to transfer from another state's pool and clarifies the effective date of coverage, this bill may facilitate the insurance coverage of some persons that do not meet the existing 12-month residency requirement.

Office of Legislative Research and General Counsel