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S.B. 100
1st Sub. (Green)

Senator L. Steven Poulton proposes to substitute the following bill:

1 # INSURANCE LAW AMENDMENTS

2 2001 GENERAL SESSION

3 STATE OF UTAH

4 **Sponsor: L. Steven Poulton**

5 **This act modifies the Insurance Code and related provisions by addressing issues related to**
6 **the insurance business in general, health insurance, life insurance, and property insurance.**
7 **The act standardizes definition of terms and makes other technical changes. The act changes**
8 **terminology from "disability insurance" to "accident and health insurance." The act defines**
9 **the scope and applicability of certain provisions included in this act. The act imposes certain**
10 **requirements on health organizations that are imposed on insurers. The act addresses the**
11 **conditions governing the issuance and renewal of certificates of authority, including allowing**
12 **the commissioner to enter into interstate compacts. The act addresses the form of and**
13 **information required in statements filed with the department including permitting the**
14 **department to accept documents complying with National Association of Insurance**
15 **Commissioners requirements instead of statutory requirements. The act addresses the**
16 **requirements of minimum capital and permanent surplus as well as the amount of the**
17 **deposit each authorized organization shall maintain with the commissioner. The act**
18 **addresses issues related to formation, cancellation, and required provisions of insurance**
19 **contracts. The act redefines the qualified assets that may be used in determining the**
20 **financial condition of an insurer. The act changes the requirements for title insurance**
21 **reserves. The act requires that all documents and agreements that constitute a life insurance**
22 **policy shall be defined and attached to the policy. The act creates notification requirements**
23 **for termination of a group or blanket life insurance policy. The act modifies the**
24 **responsibilities of the Health Benefit Plan Committee. The act expands the commissioner's**
25 **rulemaking responsibilities for Medicare supplemental policies. The act requires a policy**

26 **summary or illustration to be delivered with a life insurance policy. The act requires, in**
27 **certain circumstances, monthly reports on an accident and health rider or supplemental**
28 **benefit. The act addresses maternity benefits required in a conversion policy. The act**
29 **changes the requirements and restrictions on long-term care insurance policies. The act**
30 **modifies the licensing, continuing education, and examination requirements for agents,**
31 **brokers, consultants, third party administrators, and independent or public adjusters. The**
32 **act also addresses the termination of licenses for agents, brokers, consultants, third party**
33 **administrators, and independent or public adjusters. The act expands the list of activities**
34 **that qualify as unfair marketing practices. The act addresses the handling of escrow funds**
35 **by title insurance agents. The act requires title insurance agents to make disclosures to loan**
36 **applicants purchasing title insurance. The act requires a financial institution to maintain**
37 **customer privacy by ensuring confidentiality of insurance information. The act addresses**
38 **sharing commissions for referrals of potential customers. The act addresses continuance of**
39 **coverage by health maintenance organizations.**
40 This act affects sections of Utah Code Annotated 1953 as follows:
41 AMENDS:
42 **7-9-5**, as last amended by Chapter 329, Laws of Utah 1999
43 **26-19-2**, as last amended by Chapters 39 and 145, Laws of Utah 1998
44 **26-40-104**, as enacted by Chapter 360, Laws of Utah 1998
45 **31A-1-103**, as last amended by Chapter 4, Laws of Utah 1993
46 **31A-1-301**, as last amended by Chapters 130 and 131, Laws of Utah 1999
47 **31A-2-214**, as last amended by Chapter 12, Laws of Utah 1987, First Special Session
48 **31A-4-103**, as enacted by Chapter 242, Laws of Utah 1985
49 **31A-4-113**, as last amended by Chapter 258, Laws of Utah 1992
50 **31A-5-211**, as last amended by Chapter 9, Laws of Utah 1996, Second Special Session
51 **31A-5-418**, as last amended by Chapter 9, Laws of Utah 1996, Second Special Session
52 **31A-5-703**, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session
53 **31A-6a-102**, as enacted by Chapter 203, Laws of Utah 1992
54 **31A-6a-110**, as enacted by Chapter 203, Laws of Utah 1992
55 **31A-8-101**, as last amended by Chapter 261, Laws of Utah 1989
56 **31A-8-103 (Effective 04/30/01)**, as last amended by Chapter 300, Laws of Utah 2000

57 **31A-8-205**, as enacted by Chapter 204, Laws of Utah 1986
58 **31A-8-209**, as enacted by Chapter 204, Laws of Utah 1986
59 **31A-8-211**, as last amended by Chapter 30, Laws of Utah 1992
60 **31A-8-213**, as enacted by Chapter 204, Laws of Utah 1986
61 **31A-8-402**, as last amended by Chapter 327, Laws of Utah 1990
62 **31A-8-407**, as enacted by Chapter 261, Laws of Utah 1989
63 **31A-8-408**, as last amended by Chapter 344, Laws of Utah 1995
64 **31A-9-212 (Effective 04/30/01)**, as last amended by Chapter 300, Laws of Utah 2000
65 **31A-11-102**, as last amended by Chapter 10, Laws of Utah 1988, Second Special Session
66 **31A-14-201**, as last amended by Chapter 204, Laws of Utah 1986
67 **31A-14-212**, as enacted by Chapter 242, Laws of Utah 1985
68 **31A-15-103**, as last amended by Chapter 55, Laws of Utah 1999
69 **31A-15-106**, as last amended by Chapter 204, Laws of Utah 1986
70 **31A-17-201**, as last amended by Chapter 131, Laws of Utah 1999
71 **31A-17-401**, as last amended by Chapter 9, Laws of Utah 1996, Second Special Session
72 **31A-17-402**, as last amended by Chapter 305, Laws of Utah 1993
73 **31A-17-408**, as enacted by Chapter 242, Laws of Utah 1985
74 **31A-17-504**, as enacted by Chapter 305, Laws of Utah 1993
75 **31A-17-505**, as enacted by Chapter 305, Laws of Utah 1993
76 **31A-17-507**, as enacted by Chapter 305, Laws of Utah 1993
77 **31A-17-508**, as enacted by Chapter 305, Laws of Utah 1993
78 **31A-17-509**, as enacted by Chapter 305, Laws of Utah 1993
79 **31A-17-513**, as enacted by Chapter 305, Laws of Utah 1993
80 **31A-17-601**, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session
81 **31A-17-602**, as last amended by Chapter 185, Laws of Utah 1997
82 **31A-17-603**, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session
83 **31A-17-604**, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session
84 **31A-17-605**, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session
85 **31A-17-606**, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session
86 **31A-17-607**, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session
87 **31A-17-608**, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session

88 **31A-17-609**, as last amended by Chapter 131, Laws of Utah 1999
89 **31A-17-610**, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session
90 **31A-17-613**, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session
91 **31A-18-105**, as last amended by Chapter 9, Laws of Utah 1996, Second Special Session
92 **31A-19a-101**, as renumbered and amended by Chapter 130, Laws of Utah 1999
93 **31A-21-103**, as last amended by Chapter 204, Laws of Utah 1986
94 **31A-21-104**, as last amended by Chapter 190, Laws of Utah 1996
95 **31A-21-201**, as last amended by Chapter 114, Laws of Utah 2000
96 **31A-21-301**, as last amended by Chapter 230, Laws of Utah 1992
97 **31A-21-303**, as last amended by Chapter 203, Laws of Utah 1999
98 **31A-21-307**, as last amended by Chapter 68, Laws of Utah 1989
99 **31A-21-401**, as enacted by Chapter 204, Laws of Utah 1986
100 **31A-21-402**, as enacted by Chapter 204, Laws of Utah 1986
101 **31A-21-403**, as enacted by Chapter 204, Laws of Utah 1986
102 **31A-21-404**, as enacted by Chapter 204, Laws of Utah 1986
103 **31A-21-501**, as last amended by Chapter 302, Laws of Utah 1999
104 **31A-21-502**, as enacted by Chapter 132, Laws of Utah 1997
105 **31A-21-503**, as enacted by Chapter 132, Laws of Utah 1997
106 **31A-21-505**, as enacted by Chapter 132, Laws of Utah 1997
107 **31A-22-307**, as last amended by Chapter 71, Laws of Utah 1994
108 **31A-22-403**, as enacted by Chapter 242, Laws of Utah 1985
109 **31A-22-404**, as last amended by Chapter 114, Laws of Utah 2000
110 **31A-22-415**, as last amended by Chapter 39, Laws of Utah 1998
111 **31A-22-423**, as last amended by Chapter 329, Laws of Utah 1998
112 **31A-22-510**, as last amended by Chapter 91, Laws of Utah 1987
113 **31A-22-517**, as enacted by Chapter 242, Laws of Utah 1985
114 **31A-22-518**, as enacted by Chapter 242, Laws of Utah 1985
115 **31A-22-520**, as enacted by Chapter 242, Laws of Utah 1985
116 **31A-22-600**, as enacted by Chapter 242, Laws of Utah 1985
117 **31A-22-601**, as enacted by Chapter 242, Laws of Utah 1985
118 **31A-22-602**, as enacted by Chapter 242, Laws of Utah 1985

119 **31A-22-603**, as enacted by Chapter 242, Laws of Utah 1985
120 **31A-22-604**, as last amended by Chapter 1, Laws of Utah 2000
121 **31A-22-605**, as last amended by Chapter 224, Laws of Utah 1992
122 **31A-22-606**, as last amended by Chapter 316, Laws of Utah 1994
123 **31A-22-607**, as enacted by Chapter 242, Laws of Utah 1985
124 **31A-22-608**, as last amended by Chapter 91, Laws of Utah 1987
125 **31A-22-609**, as enacted by Chapter 242, Laws of Utah 1985
126 **31A-22-610**, as last amended by Chapter 206, Laws of Utah 1996
127 **31A-22-610.2**, as enacted by Chapter 114, Laws of Utah 2000
128 **31A-22-610.5**, as last amended by Chapters 102 and 137, Laws of Utah 1995
129 **31A-22-611**, as enacted by Chapter 242, Laws of Utah 1985
130 **31A-22-612**, as last amended by Chapter 204, Laws of Utah 1986
131 **31A-22-613**, as last amended by Chapter 160, Laws of Utah 2000
132 **31A-22-613.5**, as last amended by Chapter 114, Laws of Utah 2000
133 **31A-22-614**, as enacted by Chapter 242, Laws of Utah 1985
134 **31A-22-617**, as last amended by Chapter 267, Laws of Utah 2000
135 **31A-22-619**, as last amended by Chapter 316, Laws of Utah 1994
136 **31A-22-620**, as last amended by Chapter 185, Laws of Utah 1997
137 **31A-22-623**, as enacted by Chapter 6, Laws of Utah 1998
138 **31A-22-624**, as enacted by Chapter 357, Laws of Utah 1998
139 **31A-22-626**, as enacted by Chapter 248, Laws of Utah 2000
140 **31A-22-630**, as enacted by Chapter 114, Laws of Utah 2000
141 **31A-22-701**, as last amended by Chapter 143, Laws of Utah 1996
142 **31A-22-702**, as enacted by Chapter 242, Laws of Utah 1985
143 **31A-22-703**, as last amended by Chapter 329, Laws of Utah 1998
144 **31A-22-704**, as last amended by Chapter 321, Laws of Utah 1995
145 **31A-22-705**, as last amended by Chapter 261, Laws of Utah 1989
146 **31A-22-715**, as last amended by Chapter 12, Laws of Utah 1994
147 **31A-22-716**, as enacted by Chapter 327, Laws of Utah 1990
148 **31A-22-717**, as enacted by Chapter 253, Laws of Utah 1991
149 **31A-22-720**, as enacted by Chapter 114, Laws of Utah 2000

150 **31A-22-801**, as enacted by Chapter 242, Laws of Utah 1985
151 **31A-22-802**, as enacted by Chapter 242, Laws of Utah 1985
152 **31A-22-803**, as enacted by Chapter 242, Laws of Utah 1985
153 **31A-22-804**, as enacted by Chapter 242, Laws of Utah 1985
154 **31A-22-805**, as enacted by Chapter 242, Laws of Utah 1985
155 **31A-22-806**, as last amended by Chapter 204, Laws of Utah 1986
156 **31A-22-807**, as last amended by Chapter 230, Laws of Utah 1992
157 **31A-22-808**, as enacted by Chapter 242, Laws of Utah 1985
158 **31A-22-809**, as enacted by Chapter 242, Laws of Utah 1985
159 **31A-22-1002**, as last amended by Chapter 375, Laws of Utah 1997
160 **31A-22-1101**, as enacted by Chapter 242, Laws of Utah 1985
161 **31A-22-1401**, as enacted by Chapter 243, Laws of Utah 1991
162 **31A-22-1402**, as enacted by Chapter 243, Laws of Utah 1991
163 **31A-22-1407**, as last amended by Chapter 344, Laws of Utah 1995
164 **31A-22-1409**, as enacted by Chapter 243, Laws of Utah 1991
165 **31A-22-1411**, as enacted by Chapter 344, Laws of Utah 1995
166 **31A-22-1412**, as enacted by Chapter 344, Laws of Utah 1995
167 **31A-23-101**, as enacted by Chapter 242, Laws of Utah 1985
168 **31A-23-102**, as last amended by Chapter 1, Laws of Utah 2000
169 **31A-23-201**, as last amended by Chapter 344, Laws of Utah 1995
170 **31A-23-202**, as last amended by Chapter 232, Laws of Utah 1997
171 **31A-23-203**, as last amended by Chapter 131, Laws of Utah 1999
172 **31A-23-204**, as last amended by Chapter 131, Laws of Utah 1999
173 **31A-23-206**, as last amended by Chapter 131, Laws of Utah 1999
174 **31A-23-207**, as last amended by Chapter 316, Laws of Utah 1994
175 **31A-23-209**, as last amended by Chapter 204, Laws of Utah 1986
176 **31A-23-211.7**, as enacted by Chapter 131, Laws of Utah 1999
177 **31A-23-212**, as last amended by Chapter 131, Laws of Utah 1999
178 **31A-23-216**, as last amended by Chapter 232, Laws of Utah 1997
179 **31A-23-218**, as enacted by Chapter 242, Laws of Utah 1985
180 **31A-23-302**, as last amended by Chapter 344, Laws of Utah 1995

181 **31A-23-303**, as last amended by Chapter 204, Laws of Utah 1986
182 **31A-23-307**, as last amended by Chapter 185, Laws of Utah 1997
183 **31A-23-310**, as last amended by Chapter 344, Laws of Utah 1995
184 **31A-23-312**, as last amended by Chapter 230, Laws of Utah 1992
185 **31A-23-404**, as last amended by Chapter 293, Laws of Utah 1998
186 **31A-23-503**, as last amended by Chapter 1, Laws of Utah 2000
187 **31A-23-601**, as last amended by Chapter 1, Laws of Utah 2000
188 **31A-23-702**, as enacted by Chapter 258, Laws of Utah 1992
189 **31A-23-705**, as enacted by Chapter 258, Laws of Utah 1992
190 **31A-25-102**, as enacted by Chapter 242, Laws of Utah 1985
191 **31A-25-202**, as enacted by Chapter 242, Laws of Utah 1985
192 **31A-25-203**, as enacted by Chapter 242, Laws of Utah 1985
193 **31A-25-205**, as last amended by Chapters 1 and 114, Laws of Utah 2000
194 **31A-25-206**, as enacted by Chapter 242, Laws of Utah 1985
195 **31A-25-207**, as enacted by Chapter 242, Laws of Utah 1985
196 **31A-25-208**, as enacted by Chapter 242, Laws of Utah 1985
197 **31A-26-101**, as last amended by Chapter 30, Laws of Utah 1992
198 **31A-26-202**, as last amended by Chapter 232, Laws of Utah 1997
199 **31A-26-203**, as last amended by Chapter 9, Laws of Utah 1996, Second Special Session
200 **31A-26-204**, as last amended by Chapter 131, Laws of Utah 1999
201 **31A-26-206**, as last amended by Chapter 131, Laws of Utah 1999
202 **31A-26-207**, as last amended by Chapter 204, Laws of Utah 1986
203 **31A-26-208**, as last amended by Chapter 204, Laws of Utah 1986
204 **31A-26-209**, as last amended by Chapter 204, Laws of Utah 1986
205 **31A-26-213**, as last amended by Chapter 232, Laws of Utah 1997
206 **31A-26-302**, as enacted by Chapter 242, Laws of Utah 1985
207 **31A-28-102**, as last amended by Chapter 316, Laws of Utah 1994
208 **31A-28-103**, as last amended by Chapter 316, Laws of Utah 1994
209 **31A-28-106**, as repealed and reenacted by Chapter 211, Laws of Utah 1991
210 **31A-28-108**, as last amended by Chapter 344, Laws of Utah 1995
211 **31A-28-109**, as repealed and reenacted by Chapter 211, Laws of Utah 1991

212 **31A-28-202**, as last amended by Chapter 97, Laws of Utah 1988
213 **31A-29-103**, as enacted by Chapter 232, Laws of Utah 1990
214 **31A-29-117**, as last amended by Chapter 114, Laws of Utah 2000
215 **31A-30-103**, as last amended by Chapter 265, Laws of Utah 1997
216 **31A-30-104**, as last amended by Chapter 131, Laws of Utah 1999
217 **31A-30-106**, as last amended by Chapter 267, Laws of Utah 2000
218 **31A-30-106.5**, as enacted by Chapter 321, Laws of Utah 1995
219 **31A-30-107**, as last amended by Chapters 114 and 315, Laws of Utah 2000
220 **31A-32a-102**, as enacted by Chapter 131, Laws of Utah 1999
221 **31A-33-103.5**, as last amended by Chapter 107, Laws of Utah 1998
222 **31A-33-113**, as last amended by Chapter 375, Laws of Utah 1997
223 **34A-2-103**, as last amended by Chapters 55 and 199, Laws of Utah 1999
224 **58-67-501**, as last amended by Chapter 227, Laws of Utah 1997
225 **58-68-501**, as last amended by Chapter 227, Laws of Utah 1997
226 **59-10-114**, as last amended by Chapter 257, Laws of Utah 2000
227 **62A-11-326.1**, as last amended by Chapter 145, Laws of Utah 1998
228 **62A-11-326.2**, as last amended by Chapter 145, Laws of Utah 1998
229 **63-25a-413**, as renumbered and amended by Chapter 242, Laws of Utah 1996
230 **63-55-231**, as last amended by Chapters 52 and 267, Laws of Utah 2000
231 **67-22-1**, as last amended by Chapter 117, Laws of Utah 2000
232 **67-22-2**, as last amended by Chapter 117, Laws of Utah 2000
233 **78-14-4.5**, as last amended by Chapters 30 and 240, Laws of Utah 1992
234 **78-45-7.5**, as last amended by Chapter 161, Laws of Utah 2000
235 ENACTS:
236 **31A-2-217**, Utah Code Annotated 1953
237 **31A-22-424**, Utah Code Annotated 1953
238 **31A-22-522**, Utah Code Annotated 1953
239 **31A-22-631**, Utah Code Annotated 1953
240 **31A-22-632**, Utah Code Annotated 1953
241 **31A-22-1413**, Utah Code Annotated 1953
242 **31A-22-1414**, Utah Code Annotated 1953

243 **31A-23-201.5**, Utah Code Annotated 1953
244 **31A-23-317**, Utah Code Annotated 1953
245 **31A-26-215**, Utah Code Annotated 1953
246 REPEALS AND REENACTS:
247 **31A-27-311.5**, as enacted by Chapter 170, Laws of Utah 1990
248 REPEALS:
249 **31A-8-210**, as last amended by Chapter 9, Laws of Utah 1996, Second Special Session
250 **31A-8-212**, as last amended by Chapter 327, Laws of Utah 1990
251 *Be it enacted by the Legislature of the state of Utah:*
252 Section 1. Section **7-9-5** is amended to read:
253 **7-9-5. Powers of credit unions.**
254 In addition to the powers specified elsewhere in this chapter, a credit union may:
255 (1) make contracts;
256 (2) sue and be sued;
257 (3) acquire, lease, or hold fixed assets, including real property, furniture, fixtures, and
258 equipment as the directors consider necessary or incidental to the operation and business of the
259 credit union, but the value of the real property may not exceed 7% of credit union assets, unless
260 approved by the commissioner;
261 (4) pledge, hypothecate, sell, or otherwise dispose of real or personal property, either in
262 whole or in part, necessary or incidental to its operation;
263 (5) incur and pay necessary and incidental operating expenses;
264 (6) require an entrance or membership fee;
265 (7) receive the funds of its members in payment for:
266 (a) shares;
267 (b) share certificates;
268 (c) deposits;
269 (d) deposit certificates;
270 (e) share drafts;
271 (f) NOW accounts; and
272 (g) other instruments;
273 (8) allow withdrawal of shares and deposits, as requested by a member orally to a third

274 party with prior authorization in writing, including, but not limited to, drafts drawn on the credit
275 union for payment to the member or any third party, in accordance with the procedures established
276 by the board of directors, including, but not limited to, drafts, third-party instruments, and other
277 transaction instruments, as provided in the bylaws;
278 (9) charge fees for its services;
279 (10) extend credit to its members, at rates established in accordance with the bylaws or by
280 the board of directors;
281 (11) extend credit secured by real estate;
282 (12) make loan participation arrangements with other credit unions, credit union
283 organizations, or financial organizations in accordance with written policies of the board of
284 directors, if the credit union that originates a loan for which participation arrangements are made
285 retains an interest of at least 10% of the loan;
286 (13) sell and pledge eligible obligations in accordance with written policies of the board
287 of directors;
288 (14) engage in activities and programs of the federal government or this state or any
289 agency or political subdivision of the state, when approved by the board of directors and not
290 inconsistent with this chapter;
291 (15) act as fiscal agent for and receive payments on shares and deposits from the federal
292 government, this state, or its agencies or political subdivisions not inconsistent with the laws of
293 this state;
294 (16) borrow money and issue evidence of indebtedness for a loan or loans for temporary
295 purposes in the usual course of its operations;
296 (17) discount and sell notes and obligations;
297 (18) sell all or any portion of its assets to another credit union or purchase all or any
298 portion of the assets of another credit union;
299 (19) invest funds as provided in this title and in its bylaws;
300 (20) maintain deposits in insured depository institutions as provided in this title and in its
301 bylaws;
302 (21) (a) hold membership in corporate credit unions organized under this chapter or under
303 other state or federal statutes; and
304 (b) hold membership or equity interest in associations and organizations of credit unions,

305 including credit union service organizations;
306 (22) declare and pay dividends on shares, contract for and pay interest on deposits, and pay
307 refunds of interest on loans as provided in this title and in its bylaws;
308 (23) collect, receive, and disburse funds in connection with the sale of negotiable or
309 nonnegotiable instruments and for other purposes that provide benefits or convenience to its
310 members, as provided in this title and in its bylaws;
311 (24) make donations for the members' welfare or for civic, charitable, scientific, or
312 educational purposes as authorized by the board of directors or provided in its bylaws;
313 (25) act as trustee of funds permitted by federal law to be deposited in a credit union as
314 a deferred compensation or tax deferred device, including, but not limited to, individual retirement
315 accounts as defined by Section 408, Internal Revenue Code;
316 (26) purchase reasonable [~~disability~~] accident and health insurance, including accidental
317 death benefits, for directors and committee members through insurance companies licensed in this
318 state as provided in its bylaws;
319 (27) provide reasonable protection through insurance or other means to protect board
320 members, committee members, and employees from liability arising out of consumer legislation
321 such as, but not limited to, truth-in-lending and equal credit laws and as provided in its bylaws;
322 (28) reimburse directors and committee members for reasonable and necessary expenses
323 incurred in the performance of their duties;
324 (29) participate in systems which allow the transfer, withdrawal, or deposit of funds of
325 credit unions or credit union members by automated or electronic means and hold membership in
326 entities established to promote and effectuate these systems, if:
327 (a) the participation is not inconsistent with the law and rules of the department; and
328 (b) any credit union participating in any system notifies the department as provided by law;
329 (30) issue credit cards and debit cards to allow members to obtain access to their shares,
330 deposits, and extensions of credit;
331 (31) provide any act necessary to obtain and maintain membership in the credit union;
332 (32) exercise incidental powers necessary to carry out the purpose for which a credit union
333 is organized;
334 (33) undertake other activities relating to its purpose as its bylaws may provide;
335 (34) engage in other activities, exercise other powers, and enjoy other rights, privileges,

336 benefits, and immunities authorized by rules of the commissioner;
337 (35) act as trustee, custodian, or administrator for Keogh plans, individual retirement
338 accounts, credit union employee pension plans, and other employee benefit programs; and
339 (36) advertise to the general public the products and services offered by the credit union
340 if the advertisement prominently discloses that to use the products or services of the credit union
341 a person is required to:
342 (a) be eligible for membership in the credit union; and
343 (b) become a member of the credit union.
344 Section 2. Section **26-19-2** is amended to read:
345 **26-19-2. Definitions.**
346 As used in this chapter:
347 (1) "Employee welfare benefit plan" means a medical insurance plan developed by an
348 employer under 29 U.S.C. Section 1001, et seq., the Employee Retirement Income Security Act
349 of 1974 as amended.
350 (2) "Estate" means, regarding a deceased recipient, all real and personal property or other
351 assets included within a decedent's estate as defined in Section 75-1-201 and a decedent's
352 augmented estate as defined in Section 75-2-203.
353 (3) "Insurer" includes:
354 (a) a group health plan as defined in Subsection 607(1) of the federal Employee Retirement
355 Income Security Act of 1974;
356 (b) a health maintenance organization; and
357 (c) any entity offering a health service benefit plan.
358 (4) "Medical assistance" means:
359 (a) all funds expended for the benefit of a recipient under Title 26, Chapter 18, Medical
360 Assistance Act, or under Titles XVIII and XIX, federal Social Security Act; and
361 (b) any other services provided for the benefit of a recipient by a prepaid health care
362 delivery system under contract with the department.
363 (5) "Provider" means a person or entity who provides services to a recipient.
364 (6) "Recipient" means:
365 (a) a person who has applied for or received medical assistance from the state;
366 (b) the guardian, conservator, or other personal representative of a person under Subsection

367 (6)(a) if the person is a minor or an incapacitated person; or
368 (c) the estate and survivors of a person under Subsection (6)(a) if the person is deceased.
369 (7) "State plan" means the state Medicaid program as enacted in accordance with Title
370 XIX, federal Social Security Act.
371 (8) "Third party" includes:
372 (a) an individual, institution, corporation, public or private agency, trust, estate, insurance
373 carrier, employee welfare benefit plan, health maintenance organization, health service
374 organization, preferred provider organization, governmental program such as Medicare,
375 CHAMPUS, and workers' compensation, which may be obligated to pay all or part of the medical
376 costs of injury, disease, or disability of a recipient, unless any of these are excluded by department
377 rule; and
378 (b) a spouse or a parent who:
379 (i) may be obligated to pay all or part of the medical costs of a recipient under law or by
380 court or administrative order; or
381 (ii) has been ordered to maintain health, dental, or [~~disability~~] accident and health
382 insurance to cover medical expenses of a spouse or dependent child by court or administrative
383 order.
384 Section 3. Section **26-40-104** is amended to read:
385 **26-40-104. Advisory Council.**
386 (1) There is created a Utah Children's Health Insurance Program Advisory Council
387 consisting of at least eight and no more than eleven members appointed by the executive director
388 of the department. The term of each appointment shall be three years. The appointments shall be
389 staggered at one-year intervals to ensure continuity of the advisory council.
390 (2) The advisory council shall meet at least quarterly.
391 (3) The membership of the advisory council shall include at least one representative from
392 each of the following groups:
393 (a) child health care providers;
394 (b) parents and guardians of children enrolled in the program;
395 (c) ethnic populations other than American Indians;
396 (d) American Indians;
397 (e) the Health Policy Commission;

398 (f) the Utah Association of Health Care Providers;
399 (g) health and [disability] accident and health insurance providers; and
400 (h) the general public.
401 (4) The advisory council shall advise the department on:
402 (a) benefits design;
403 (b) eligibility criteria;
404 (c) outreach;
405 (d) evaluation; and
406 (e) special strategies for under-served populations.
407 (5) (a) (i) Members who are not government employees may not receive compensation or
408 benefits for their services, but may receive per diem and expenses incurred in the performance of
409 the member's official duties at the rates established by the Division of Finance under Sections
410 63A-3-106 and 63A-3-107.
411 (ii) Members may decline to receive per diem and expenses for their service.
412 (b) (i) State government officer and employee members who do not receive salary, per
413 diem, or expenses from their agency for their service may receive per diem and expenses incurred
414 in the performance of their official duties from the council at the rates established by the Division
415 of Finance under Sections 63A-3-106 and 63A-3-107.
416 (ii) State government officer and employee members may decline to receive per diem and
417 expenses for their service.
418 Section 4. Section **31A-1-103** is amended to read:
419 **31A-1-103. Scope and applicability of title.**
420 (1) This title does not apply to:
421 (a) retainer contracts made by attorneys-at-law with individual clients with fees based on
422 estimates of the nature and amount of services to be provided to the specific client, and similar
423 contracts made with a group of clients involved in the same or closely related legal matters;
424 (b) arrangements for providing benefits that do not exceed a limited amount of
425 consultations, advice on simple legal matters, either alone or in combination with referral services,
426 or the promise of fee discounts for handling other legal matters;
427 (c) limited legal assistance on an informal basis involving neither an express contractual
428 obligation nor reasonable expectations, in the context of an employment, membership, educational,

429 or similar relationship; or

430 (d) legal assistance by employee organizations to their members in matters relating to

431 employment.

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

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

434 law.

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

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

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

438 (b) ocean marine insurance;

439 (c) death and [~~disability~~] accident and health benefits provided by an organization where

440 the principal purpose is to achieve charitable, educational, social, or religious objectives rather than

441 to provide death and [~~disability~~] accident and health benefits, if the organization does not incur a

442 legal obligation to pay a specified amount and does not create reasonable expectations of receiving

443 a specified amount on the part of an insured person;

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

445 transaction of such business in this state does not require regulation for the protection of the

446 interests of the residents of this state or on a finding that it would be impracticable to require

447 compliance with this title;

448 (e) (i) transactions independently procured through negotiations under Section

449 31A-15-104;

450 (ii) however, the transactions described in Subsection (3)(e)(i) are subject to taxation under

451 Section 31A-3-301;

452 (f) self-insurance;

453 (g) reinsurance;

454 (h) subject to Subsection (4), employee and labor union group or blanket insurance

455 covering risks in this state if:

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

457 (ii) the policyholder is not a resident of this state or a domestic corporation or does not

458 have its principal office in this state;

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

460 (iv) on request of the commissioner, the insurer files with the department a copy of the
461 policy and a copy of each form or certificate; and
462 (v) the insurer agrees to pay premium taxes on the Utah portion of its business, as if it were
463 authorized to do business in this state, and if the insurer provides the commissioner with the
464 security the commissioner considers necessary for the payment of premium taxes under Title 59,
465 Chapter 9, Taxation of Admitted Insurers; or
466 (i) to the extent provided in Subsection (5):
467 (A) a manufacturer's [warranties issued in the ordinary course of sale;] warranty; and
468 [(j) manufacturer's warranties or service contracts paid for with separate or additional
469 consideration; or]
470 [(k) service contracts paid for with separate or additional consideration, issued in the
471 ordinary course of sale, that are for the repair or maintenance of goods, other than motor vehicles,
472 having a purchase price of $3,000 or less]
473 (B) a manufacturer's service contract.
474 (4) (a) After a hearing, the commissioner may order an insurer of certain group or blanket
475 contracts to transfer the Utah portion of the business otherwise exempted under Subsection (3)(h)
476 to an authorized insurer if the contracts have been written by an unauthorized insurer.
477 (b) If the commissioner finds that the conditions required for the exemption of a group or
478 blanket insurer are not satisfied or that adequate protection to residents of this state is not provided,
479 [he] the commissioner may require:
480 (i) the insurer to be authorized to do business in this state; or [require]
481 (ii) that any of the insurer's transactions be subject to this title.
482 (5) (a) As used in Subsection (3)(i) and this Subsection (5):
483 (i) "manufacturer's service contract" means a service contract:
484 (A) made available by a manufacturer of a product:
485 (I) on one specific product; or
486 (II) on products that are components of a system; and
487 (B) under which the manufacturer is liable for services to be provided under the service
488 contract including, if the manufacturer's service contract designates, providing parts and labor;
489 (ii) "manufacturer's warranty" means the guaranty of the manufacturer of a product:
490 (A) (I) on one specific product; or

491 (II) on products that are components of a system; and
492 (B) under which the manufacturer is liable for services to be provided under the warranty,
493 including, if the manufacturer's warranty designates, providing parts and labor; and
494 (iii) "service contract" is as defined in Section 31A-6a-101.
495 (b) A manufacturer's warranty may be designated as:
496 (i) a warranty;
497 (ii) a guaranty; or
498 (iii) a term similar to a term described in Subsection (5)(b)(i) or (ii).
499 (c) This title does not apply to:
500 (i) a manufacturer's warranty;
501 (ii) a manufacturer's service contract paid for with consideration that is in addition to the
502 consideration paid for the product itself; and
503 (iii) a service contract that is not a manufacturer's warranty or manufacturer's service
504 contract if:
505 (A) the service contract is paid for with consideration that is in addition to the
506 consideration paid for the product itself; and
507 (B) the service contract is for the repair or maintenance of goods;
508 (C) the cost of the product is equal to an amount determined in accordance with
509 Subsection (5)(e); and
510 (D) the product is not a motor vehicle.
511 (d) This title does not apply to a manufacturer's warranty or service contract paid for with
512 consideration that is in addition to the consideration paid for for the product itself regardless of
513 whether the manufacturer's warranty or service contract is sold:
514 (i) at the time of the purchase of the product; or
515 (ii) at a time other than the time of the purchase of the product.
516 (e) (i) For fiscal year 2001-02, the amount described in Subsection (5)(c)(iii)(C) shall be
517 equal to $3,700 or less.
518 (ii) For each fiscal year after fiscal year 2001-02, the commissioner shall annually
519 determine whether the amount described in Subsection (5)(c)(iii)(C) should be adjusted in
520 accordance with changes in the Consumer Price Index published by the United States Bureau of
521 Labor Statistics selected by the commissioner by rule, between:

522 (A) the Consumer Price Index for the February immediately preceding the adjustment; and
523 (B) the Consumer Price Index for February 2001.
524 (iii) If under Subsection (5)(e)(ii) the commissioner determines that an adjustment should
525 be made, the commission shall make the adjustment by rule.
526 Section 5. Section **31A-1-301** is amended to read:
527 **31A-1-301. Definitions.**
528 As used in this title, unless otherwise specified:
529 (1) (a) "Accident and health insurance" means insurance to provide protection against
530 economic losses resulting from:
531 (i) a medical condition including:
532 (A) medical care expenses; or
533 (B) the risk of disability;
534 (ii) accident; or
535 (iii) sickness.
536 (b) "Accident and health insurance":
537 (i) includes a contract with disability contingencies including:
538 (A) an income replacement contract;
539 (B) a health care contract;
540 (C) an expense reimbursement contract;
541 (D) a credit accident and health contract;
542 (E) a continuing care contract; and
543 (F) long-term care contracts; and
544 (ii) may provide:
545 (A) hospital coverage;
546 (B) surgical coverage;
547 (C) medical coverage; or
548 (D) loss of income coverage.
549 (c) "Accident and health insurance" does not include workers' compensation insurance.
550 [~~(1)~~] (2) "Administrator" is defined in Subsection [~~(90)~~] (111).
551 [~~(2)~~] (3) "Adult" means a natural person who has attained the age of at least 18 years.
552 [~~(3)~~] (4) "Affiliate" means any person who controls, is controlled by, or is under common

553 control with, another person. A corporation is an affiliate of another corporation, regardless of
554 ownership, if substantially the same group of natural persons manages the corporations.
555 [(4)] (5) "Alien insurer" means an insurer domiciled outside the United States.
556 (6) "Amendment" means an endorsement to an insurance policy or certificate.
557 [(5)] (7) "Annuity" means an agreement to make periodical payments for a period certain
558 or over the lifetime of one or more natural persons if the making or continuance of all or some of
559 the series of the payments, or the amount of the payment, is dependent upon the continuance of
560 human life.
561 (8) "Application" means a document:
562 (a) completed by an applicant to provide information about the risk to be insured; and
563 (b) that contains information that is used by the insurer to:
564 (i) evaluate risk; and
565 (ii) decide whether to:
566 (A) insure the risk under:
567 (I) the coverages as originally offered; or
568 (II) a modification of the coverage as originally offered; or
569 (B) decline to insure the risk.
570 [(6)] (9) "Articles" or "articles of incorporation" means the original articles, special laws,
571 charters, amendments, restated articles, articles of merger or consolidation, trust instruments, and
572 other constitutive documents for trusts and other entities that are not corporations, and
573 amendments to any of these.
574 [(7)] (10) "Bail bond insurance" means a guarantee that a person will attend court when
575 required, or will obey the orders or judgment of the court, as a condition to the release of that
576 person from confinement.
577 [(8)] (11) "Binder" is defined in Section 31A-21-102.
578 [(9)] (12) "Board," "board of trustees," or "board of directors" means the group of persons
579 with responsibility over, or management of, a corporation, however designated.
580 [(10)] (13) "Business of insurance" is defined in Subsection [(53)] (64).
581 [(11)] (14) "Business plan" means the information required to be supplied to the
582 commissioner under Subsections 31A-5-204(2)(i) and (j), including the information required when
583 these subsections are applicable by reference under:

584 (a) Section 31A-7-201;
585 (b) Section 31A-8-205; or
586 (c) Subsection 31A-9-205(2).
587 [(12)] (15) "Bylaws" means the rules adopted for the regulation or management of a
588 corporation's affairs, however designated and includes comparable rules for trusts and other entities
589 that are not corporations.
590 [(13)] (16) "Casualty insurance" means liability insurance as defined in Subsection [(59)]
591 (70).
592 [(14)] (17) "Certificate" means [the] evidence of insurance given to:
593 (a) an insured under a group insurance policy; or
594 (b) a third party.
595 [(15)] (18) "Certificate of authority" is included within the term "license."
596 [(16)] (19) "Claim," unless the context otherwise requires, means a request or demand on
597 an insurer for payment of benefits according to the terms of an insurance policy.
598 [(17)] (20) "Claims-made coverage" means an insurance contract or provision limiting
599 coverage under a policy insuring against legal liability to claims that are first made against the
600 insured while the policy is in force.
601 [(18)] (21) (a) "Commissioner" or "commissioner of insurance" means Utah's insurance
602 commissioner.
603 (b) When appropriate, the terms listed in Subsection [(18)] (21)(a) apply to the equivalent
604 supervisory official of another jurisdiction.
605 (22) (a) "Continuing care insurance" means insurance that:
606 (i) provides board and lodging;
607 (ii) provides one or more of the following services:
608 (A) personal services;
609 (B) nursing services;
610 (C) medical services; or
611 (D) other health-related services; and
612 (iii) provides the coverage described in Subsection (22)(a)(i) under an agreement effective:
613 (A) for the life of the insured; or
614 (B) for a period in excess of one year.

615 (b) Insurance is continuing care insurance regardless of whether or not the board and
616 lodging are provided at the same location as the services described in Subsection (22)(a)(ii).
617 [(19)] (23) (a) "Control," "controlling," "controlled," or "under common control" means
618 the direct or indirect possession of the power to direct or cause the direction of the management
619 and policies of a person. This control may be:
620 (i) by contract;
621 (ii) by common management;
622 (iii) through the ownership of voting securities; or
623 (iv) by a means other than those described in Subsections [(19)] (23)(a)(i) through (iii).
624 (b) There is no presumption that an individual holding an official position with another
625 person controls that person solely by reason of the position.
626 (c) A person having a contract or arrangement giving control is considered to have control
627 despite the illegality or invalidity of the contract or arrangement.
628 (d) There is a rebuttable presumption of control in a person who directly or indirectly
629 owns, controls, holds with the power to vote, or holds proxies to vote 10% or more of the voting
630 securities of another person.
631 [(20)] (24) (a) "Corporation" means insurance corporation, except when referring to:
632 (i) a corporation doing business as an insurance broker, consultant, or adjuster under:
633 (A) Chapter 23, Insurance Marketing - Licensing Agents, Brokers, Consultants, and
634 Reinsurance Intermediaries; and
635 (B) Chapter 26, Insurance Adjusters; or
636 (ii) a noninsurer that is part of a holding company system under Chapter 16, Insurance
637 Holding Companies.
638 (b) "Stock corporation" means stock insurance corporation.
639 (c) "Mutual" or "mutual corporation" means a mutual insurance corporation.
640 [(21)] (25) "Credit [disability] accident and health insurance" means insurance on a debtor
641 to provide indemnity for payments coming due on a specific loan or other credit transaction while
642 the debtor is disabled.
643 [(22)] (26) "Credit insurance" means surety insurance under which mortgagees and other
644 creditors are indemnified against losses caused by the default of debtors.
645 [(23)] (27) "Credit life insurance" means insurance on the life of a debtor in connection

646 with a loan or other credit transaction.

647 [~~(24)~~] (28) "Creditor" means a person, including an insured, having any claim, whether:

648 (a) matured;

649 (b) unmatured;

650 (c) liquidated;

651 (d) unliquidated;

652 (e) secured;

653 (f) unsecured;

654 (g) absolute;

655 (h) fixed; or

656 (i) contingent.

657 [~~(25)~~] (29) (a) "Customer service representative" means a person that provides insurance
658 services and insurance product information:

659 (i) for its agent, broker, or consultant employer; and

660 (ii) to its employer's customer, client, or organization.

661 (b) A customer service representative may only operate within the scope of authority of
662 its agent, broker, or consultant employer.

663 (30) "Deadline" means the final date or time:

664 (a) imposed by:

665 (i) statute;

666 (ii) rule; or

667 (iii) order; and

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

669 [~~(26)~~] (31) "Deemer clause" means a provision under this title under which upon the
670 occurrence of a condition precedent, the commissioner is deemed to have taken a specific action.
671 If the statute so provides, the condition precedent may be the commissioner's failure to take a
672 specific action.

673 [~~(27)~~] (32) "Degree of relationship" means the number of steps between two persons
674 determined by counting the generations separating one person from a common ancestor and then
675 counting the generations to the other person.

676 [~~(28)~~] (33) "Department" means the Insurance Department.

677 [(29)] (34) "Director" means a member of the board of directors of a corporation.
678 [(30) "Disability insurance" means insurance written to:]
679 [(a) indemnify for losses and expenses resulting from accident or sickness;]
680 [(b) provide payments to replace income lost from accident or sickness; and]
681 [(c) pay for services resulting directly from accident or sickness, including medical,
682 surgical, hospital, and other ancillary expenses.]
683 (35) "Disability" means a physiological or psychological condition that partially or totally
684 limits an individual's ability to:
685 (a) perform the duties of:
686 (i) that individual's occupation; or
687 (ii) any occupation for which the individual is reasonably suited by education, training, or
688 experience; or
689 (b) perform two or more of the following basic activities of daily living:
690 (i) eating;
691 (ii) toileting;
692 (iii) transferring;
693 (iv) bathing; or
694 (v) dressing.
695 [(31)] (36) "Domestic insurer" means an insurer organized under the laws of this state.
696 [(32)] (37) "Domiciliary state" means the state in which an insurer:
697 (a) is incorporated;
698 (b) is organized; or
699 (c) in the case of an alien insurer, enters into the United States.
700 [(33)] (38) "Employee benefits" means one or more benefits or services provided
701 employees or their dependents.
702 [(34)] (39) (a) "Employee welfare fund" means a fund:
703 (i) established or maintained, whether directly or through trustees, by:
704 (A) one or more employers;
705 (B) one or more labor organizations; or
706 (C) a combination of employers and labor organizations; and
707 (ii) that provides employee benefits paid or contracted to be paid, other than income from

708 investments of the fund, by or on behalf of an employer doing business in this state or for the
709 benefit of any person employed in this state.
710 (b) "Employee welfare fund" includes a plan funded or subsidized by user fees or tax
711 revenues.
712 (40) "Endorsement" means a written agreement attached to a policy or certificate to modify
713 one or more of the provisions of the policy or certificate.
714 [(35)] (41) "Excludes" is not exhaustive and does not mean that other things are not also
715 excluded. The items listed are representative examples for use in interpretation of this title.
716 (42) "Expense reimbursement insurance" means insurance:
717 (a) written to provide payments for expenses relating to hospital confinements resulting
718 from illness or injury; and
719 (b) written:
720 (i) as a daily limit for a specific number of days in a hospital; and
721 (ii) to have a one or two day waiting period following a hospitalization.
722 [(36)] (43) "Fidelity insurance" means insurance guaranteeing the fidelity of persons
723 holding positions of public or private trust.
724 (44) (a) "Filed" means that a filing is:
725 (i) submitted to the department in accordance with any applicable statute, rule, or filing
726 order;
727 (ii) received by the department within the time period provided in the applicable statute,
728 rule, or filing order; and
729 (iii) accompanied with the applicable one or more filing fees required by:
730 (A) Section 31A-3-103; or
731 (B) rule.
732 (b) "Filed" does not include a filing that is rejected by the department because it is not
733 submitted in accordance with Subsection (44)(a).
734 (45) "Filing," when used as a noun, means an item required to be filed with the department
735 including:
736 (a) a policy;
737 (b) a rate;
738 (c) a form;

739 (d) a document;
740 (e) a plan;
741 (f) a manual;
742 (g) an application;
743 (h) a report;
744 (i) a certificate;
745 (j) an endorsement;
746 (k) an actuarial certification;
747 (l) a licensee annual statement;
748 (m) a licensee renewal application; or
749 (n) an advertisement.
750 [(37)] (46) "First party insurance" means an insurance policy or contract in which the
751 insurer agrees to pay claims submitted to it by the insured for the insured's losses.
752 [(38)] (47) "Foreign insurer" means an insurer domiciled outside of this state, including
753 an alien insurer.
754 [(39)] (48) (a) "Form" means a policy, certificate, or application prepared for general use.
755 (b) "Form" does not include a document specially prepared for use in an individual case.
756 [(40)] (49) "Franchise insurance" means individual insurance policies provided through
757 a mass marketing arrangement involving a defined class of persons related in some way other than
758 through the purchase of insurance.
759 (50) "Health care" means any of the following intended for use in the diagnosis, treatment,
760 mitigation, or prevention of a human ailment or impairment:
761 (a) professional services;
762 (b) personal services;
763 (c) facilities;
764 (d) equipment;
765 (e) devices;
766 (f) supplies; or
767 (g) medicine.
768 [(41)] (51) (a) "Health care insurance" or "health insurance" means [disability] insurance
769 providing [benefits solely of medical, surgical, hospital, or other ancillary services or payment of

770 ~~medical, surgical, hospital, or other ancillary expenses incurred.~~]:
771 (i) health care benefits; or
772 (ii) payment of incurred health care expenses.
773 (b) "Health care insurance" or "health insurance" does not include [~~disability~~] accident and
774 health insurance providing benefits for:
775 (i) replacement of income;
776 (ii) short-term accident;
777 (iii) fixed indemnity;
778 (iv) credit [~~disability~~] accident and health;
779 (v) supplements to liability;
780 (vi) workers' compensation;
781 (vii) automobile medical payment;
782 (viii) no-fault automobile;
783 (ix) equivalent self-insurance; or
784 (x) any type of [~~disability~~] accident and health insurance coverage that is a part of or
785 attached to another type of policy.
786 (52) "Income replacement insurance" or "disability income insurance" means insurance
787 written to provide payments to replace income lost from accident or sickness.
788 [~~(42)~~] (53) "Indemnity" means the payment of an amount to offset all or part of an insured
789 loss.
790 [~~(43)~~] (54) "Independent adjuster" means an insurance adjuster required to be licensed
791 under Section 31A-26-201 who engages in insurance adjusting as a representative of insurers.
792 [~~(44)~~] (55) "Independently procured insurance" means insurance procured under Section
793 31A-15-104.
794 [~~(45)~~] (56) "Individual" means a natural person.
795 [~~(46)~~] (57) "Inland marine insurance" includes insurance covering:
796 (a) property in transit on or over land;
797 (b) property in transit over water by means other than boat or ship;
798 (c) bailee liability;
799 (d) fixed transportation property such as bridges, electric transmission systems, radio and
800 television transmission towers and tunnels; and

801 (e) personal and commercial property floaters.
802 [(47)] (58) "Insolvency" means that:
803 (a) an insurer is unable to pay its debts or meet its obligations as they mature;
804 (b) an insurer's total adjusted capital is less than the insurer's mandatory control level RBC
805 under Subsection 31A-17-601[(7)](8)(c); or
806 (c) an insurer is determined to be hazardous under this title.
807 [(48)] (59) (a) "Insurance" means:
808 (i) an arrangement, contract, or plan for the transfer of a risk or risks from one or more
809 persons to one or more other persons; or
810 (ii) an arrangement, contract, or plan for the distribution of a risk or risks among a group
811 of persons that includes the person seeking to distribute that person's risk.
812 (b) "Insurance" includes:
813 (i) risk distributing arrangements providing for compensation or replacement for damages
814 or loss through the provision of services or benefits in kind;
815 (ii) contracts of guaranty or suretyship entered into by the guarantor or surety as a business
816 and not as merely incidental to a business transaction; and
817 (iii) plans in which the risk does not rest upon the person who makes the arrangements,
818 but with a class of persons who have agreed to share it.
819 [(49)] (60) "Insurance adjuster" means a person who directs the investigation, negotiation,
820 or settlement of a claim under an insurance policy other than life insurance or an annuity, on behalf
821 of an insurer, policyholder, or a claimant under an insurance policy.
822 [(50)] (61) "Interinsurance exchange" is defined in Subsection [(81)] (100).
823 [(51)] (62) Except as provided in Subsection [31A-23-102(2)] 31A-23-201.5(1),
824 "insurance agent" or "agent" means a person who represents insurers in soliciting, negotiating, or
825 placing insurance.
826 [(52)] (63) Except as provided in Subsection [31A-23-102(2)] 31A-23-201.5(1),
827 "insurance broker" or "broker" means a person who:
828 (a) acts in procuring insurance on behalf of an applicant for insurance or an insured; and
829 (b) does not act on behalf of the insurer except by collecting premiums or performing other
830 ministerial acts.
831 [(53)] (64) "Insurance business" or "business of insurance" includes:

832 (a) providing health care insurance, as defined in Subsection [(41)] (51), by organizations
833 that are or should be licensed under this title;
834 (b) providing benefits to employees in the event of contingencies not within the control
835 of the employees, in which the employees are entitled to the benefits as a right, which benefits may
836 be provided either:
837 (i) by single employers or by multiple employer groups; or
838 (ii) through trusts, associations, or other entities;
839 (c) providing annuities, including those issued in return for gifts, except those provided
840 by persons specified in Subsections 31A-22-1305(2) and (3);
841 (d) providing the characteristic services of motor clubs as outlined in Subsection [(65)]
842 (77);
843 (e) providing other persons with insurance as defined in Subsection [(48)] (59);
844 (f) making as insurer, guarantor, or surety, or proposing to make as insurer, guarantor, or
845 surety, any contract or policy of title insurance;
846 (g) transacting or proposing to transact any phase of title insurance, including solicitation,
847 negotiation preliminary to execution, execution of a contract of title insurance, insuring, and
848 transacting matters subsequent to the execution of the contract and arising out of it, including
849 reinsurance; and
850 (h) doing, or proposing to do, any business in substance equivalent to Subsections [(53)]
851 (64)(a) through (g) in a manner designed to evade the provisions of this title.
852 [(54)] (65) Except as provided in Subsection [31A-23-102(2)] 31A-23-201.5(1),
853 "insurance consultant" or "consultant" means a person who:
854 (a) advises other persons about insurance needs and coverages;
855 (b) is compensated by the person advised on a basis not directly related to the insurance
856 placed; and
857 (c) is not compensated directly or indirectly by an insurer, agent, or broker for advice
858 given.
859 [(55)] (66) "Insurance holding company system" means a group of two or more affiliated
860 persons, at least one of whom is an insurer.
861 [(56)] (67) (a) "Insured" means a person to whom or for whose benefit an insurer makes
862 a promise in an insurance policy and includes:

863 (i) policyholders;
864 (ii) subscribers;
865 (iii) members; and
866 (iv) beneficiaries.
867 (b) The definition in Subsection [~~(56)~~] (67)(a) applies only to this title and does not define
868 the meaning of this word as used in insurance policies or certificates.
869 [~~(57)~~] (68) (a) (i) "Insurer" means any person doing an insurance business as a principal
870 including:
871 (A) fraternal benefit societies;
872 (B) issuers of gift annuities other than those specified in Subsections 31A-22-1305(2) and
873 (3);
874 (C) motor clubs;
875 (D) employee welfare plans; and
876 (E) any person purporting or intending to do an insurance business as a principal on that
877 person's own account.
878 (ii) "Insurer" does not include a governmental entity, as defined in Section 63-30-2, to the
879 extent it is engaged in the activities described in Section 31A-12-107.
880 (b) "Admitted insurer" is defined in Subsection [~~(94)~~] (115)(b).
881 (c) "Alien insurer" is defined in Subsection [~~(4)~~] (5).
882 (d) "Authorized insurer" is defined in Subsection [~~(94)~~] (115)(b).
883 (e) "Domestic insurer" is defined in Subsection [~~(31)~~] (36).
884 (f) "Foreign insurer" is defined in Subsection [~~(38)~~] (47).
885 (g) "Nonadmitted insurer" is defined in Subsection [~~(94)~~] (115)(a).
886 (h) "Unauthorized insurer" is defined in Subsection [~~(94)~~] (115)(a).
887 [~~(58)~~] (69) (a) Except as provided in Section 31A-1-103, "legal expense insurance" means
888 insurance written to indemnify or pay for specified legal expenses.
889 (b) "Legal expense insurance" includes arrangements that create reasonable expectations
890 of enforceable rights, but it does not include the provision of, or reimbursement for, legal services
891 incidental to other insurance coverages.
892 [~~(59)~~] (70) (a) "Liability insurance" means insurance against liability:
893 (i) for death, injury, or disability of any human being, or for damage to property, exclusive

894 of the coverages under:
895 (A) Subsection [~~(62)~~] (74) for medical malpractice insurance;
896 (B) Subsection [~~(77)~~] (92) for professional liability insurance; and
897 (C) Subsection [~~(97)~~] (119) for workers' compensation insurance;
898 (ii) for medical, hospital, surgical, and funeral benefits to persons other than the insured
899 who are injured, irrespective of legal liability of the insured, when issued with or supplemental to
900 insurance against legal liability for the death, injury, or disability of human beings, exclusive of
901 the coverages under:
902 (A) Subsection [~~(62)~~] (74) for medical malpractice insurance;
903 (B) Subsection [~~(77)~~] (92) for professional liability insurance; and
904 (C) Subsection [~~(97)~~] (118) for workers' compensation insurance;
905 (iii) for loss or damage to property resulting from accidents to or explosions of boilers,
906 pipes, pressure containers, machinery, or apparatus;
907 (iv) for loss or damage to any property caused by the breakage or leakage of sprinklers,
908 water pipes and containers, or by water entering through leaks or openings in buildings; or
909 (v) for other loss or damage properly the subject of insurance not within any other kind
910 or kinds of insurance as defined in this chapter, if such insurance is not contrary to law or public
911 policy.
912 (b) "Liability insurance" includes:
913 (i) vehicle liability insurance as defined in Subsection [~~(95)~~] (116);
914 (ii) residential dwelling liability insurance as defined in Subsection [~~(83)~~] (102); and
915 (iii) making inspection of, and issuing certificates of inspection upon, elevators, boilers,
916 machinery, and apparatus of any kind when done in connection with insurance on them.
917 [~~(60)~~] (71) "License" means the authorization issued by the insurance commissioner under
918 this title to engage in some activity that is part of or related to the insurance business. It includes
919 certificates of authority issued to insurers.
920 [~~(61)~~] (72) (a) "Life insurance" means insurance on human lives and insurances pertaining
921 to or connected with human life.
922 (b) The business of life insurance includes:
923 (i) granting death benefits;
924 [~~(i)~~] (ii) granting annuity benefits;

925 [(ii)] (iii) granting endowment benefits;
926 [(iii)] (iv) granting additional benefits in the event of death by accident [or accidental
927 means];
928 [(iv)] (v) granting additional benefits to safeguard the policy against lapse in the event of
929 [the total and permanent] disability [of the insured]; and
930 [(v)] (vi) providing optional methods of settlement of proceeds.
931 (73) (a) "Long-term care insurance" means an insurance policy or rider advertised,
932 marketed, offered, or designated to provide coverage:
933 (i) in a setting other than an acute care unit of a hospital;
934 (ii) for not less than 12 consecutive months for each covered person on the basis of:
935 (A) expenses incurred;
936 (B) indemnity;
937 (C) prepayment; or
938 (D) another method;
939 (iii) for one or more necessary or medically necessary services that are:
940 (A) diagnostic;
941 (B) preventative;
942 (C) therapeutic;
943 (D) rehabilitative;
944 (E) maintenance; or
945 (F) personal care; and
946 (iv) that may be issued by:
947 (A) an insurer;
948 (B) a fraternal benefit society;
949 (C) (I) a nonprofit health hospital; and
950 (II) a medical service corporation;
951 (D) a prepaid health plan;
952 (E) a health maintenance organization; or
953 (F) an entity similar to the entities described in Subsections (73)(a)(iv)(A) through (E) to
954 the extent that the entity is otherwise authorized to issue life or health care insurance.
955 (b) "Long-term care insurance" includes:

956 (i) any of the following that provide directly or supplement long-term care insurance:
957 (A) a group or individual annuity or rider; or
958 (B) a life insurance policy or rider;
959 (ii) a policy or rider that provides for payment of benefits based on:
960 (A) cognitive impairment; or
961 (B) functional capacity; or
962 (iii) a qualified long-term care insurance contract.
963 (c) "Long-term care insurance" does not include:
964 (i) a policy that is offered primarily to provide basic Medicare supplement coverage;
965 (ii) basic hospital expense coverage;
966 (iii) basic medical/surgical expense coverage;
967 (iv) hospital confinement indemnity coverage;
968 (v) major medical expense coverage;
969 (vi) income replacement or related asset-protection coverage;
970 (vii) accident only coverage;
971 (viii) coverage for a specified:
972 (A) disease; or
973 (B) accident;
974 (ix) limited benefit health coverage; or
975 (x) a life insurance policy that accelerates the death benefit to provide the option of a lump
976 sum payment:
977 (A) if neither the benefits nor eligibility is conditioned on the receipt of long-term care;
978 and
979 (B) the coverage is for one or more the following qualifying events:
980 (I) terminal illness;
981 (II) medical conditions requiring extraordinary medical intervention; or
982 (III) permanent institutional confinement.
983 [~~(62)~~] (74) "Medical malpractice insurance" means insurance against legal liability
984 incident to the practice and provision of medical services other than the practice and provision of
985 dental services.
986 [~~(63)~~] (75) "Member" means a person having membership rights in an insurance

987 corporation.

988 [~~(64)~~] (76) "Minimum capital" or "minimum required capital" means the capital that must

989 be constantly maintained by a stock insurance corporation as required by statute.

990 [~~(65)~~] (77) "Motor club" means a person:

991 (a) licensed under:

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

993 (ii) Chapter 11, Motor Clubs; or

994 (iii) Chapter 14, Foreign Insurers; and

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

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

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

998 (iii) trip reimbursement, towing services, emergency road services, stolen automobile

999 services, a combination of these services, or any other services given in Subsections

1000 31A-11-102(1)(b) through (f).

1001 [~~(66)~~] (78) "Mutual" means mutual insurance corporation.

1002 [~~(67)~~] (79) "Nonparticipating" means a plan of insurance under which the insured is not

1003 entitled to receive dividends representing shares of the surplus of the insurer.

1004 [~~(68)~~] (80) "Ocean marine insurance" means insurance against loss of or damage to:

1005 (a) ships or hulls of ships;

1006 (b) goods, freight, cargoes, merchandise, effects, disbursements, profits, moneys,

1007 securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia interests,

1008 or other cargoes in or awaiting transit over the oceans or inland waterways;

1009 (c) earnings such as freight, passage money, commissions, or profits derived from

1010 transporting goods or people upon or across the oceans or inland waterways; or

1011 (d) a vessel owner or operator as a result of liability to employees, passengers, bailors,

1012 owners of other vessels, owners of fixed objects, customs or other authorities, or other persons in

1013 connection with maritime activity.

1014 [~~(69)~~] (81) "Order" means an order of the commissioner.

1015 (82) "Outline of coverage" means a summary that explains an accident and health

1016 insurance policy.

1017 [~~(70)~~] (83) "Participating" means a plan of insurance under which the insured is entitled

1018 to receive dividends representing shares of the surplus of the insurer.

1019 [(71)] (84) "Person" includes an individual, partnership, corporation, incorporated or
1020 unincorporated association, joint stock company, trust, reciprocal, syndicate, or any similar entity
1021 or combination of entities acting in concert.

1022 [(72)] (85) (a) (i) "Policy" means any document, including attached endorsements and
1023 riders, purporting to be an enforceable contract, which memorializes in writing some or all of the
1024 terms of an insurance contract.

1025 (ii) "Policy" includes a service contract issued by:

1026 (A) a motor club under Chapter 11, Motor Clubs; [and]

1027 (B) a service contract provided under Chapter 6a, Service Contracts; and

1028 [(B)] (C) a corporation licensed under:

1029 (I) Chapter 7, Nonprofit Health Service Insurance Corporations; or

1030 (II) Chapter 8, Health Maintenance Organizations and Limited Health Plans.

1031 (iii) "Policy" does not include:

1032 (A) a certificate under a group insurance contract; or

1033 (B) a document that does not purport to have legal effect.

1034 (b) "Group insurance policy" means a policy covering a group of persons that is issued to
1035 a policyholder on behalf of the group, for the benefit of group members who are selected under
1036 procedures defined in the policy or in agreements which are collateral to the policy. This type of
1037 policy may include members of the policyholder's family or dependents.

1038 (c) "Blanket insurance policy" means a group policy covering classes of persons without
1039 individual underwriting, where the persons insured are determined by definition of the class with
1040 or without designating the persons covered.

1041 [(73)] (86) "Policyholder" means the person who controls a policy, binder, or oral contract
1042 by ownership, premium payment, or otherwise.

1043 (87) "Policy illustration" means a presentation or depiction that includes nonguaranteed
1044 elements of a policy of life insurance over a period of years.

1045 (88) "Policy summary" means a synopsis describing the elements of a life insurance policy.

1046 [(74)] (89) (a) "Premium" means the monetary consideration for an insurance policy, and
1047 includes assessments, membership fees, required contributions, or monetary consideration,
1048 however designated.

1049 (b) Consideration paid to third party administrators for their services is not "premium,"
1050 though amounts paid by third party administrators to insurers for insurance on the risks
1051 administered by the third party administrators are "premium."
1052 [~~(75)~~] (90) "Principal officers" of a corporation means the officers designated under
1053 Subsection 31A-5-203(3).
1054 [~~(76)~~] (91) "Proceedings" includes actions and special statutory proceedings.
1055 [~~(77)~~] (92) "Professional liability insurance" means insurance against legal liability
1056 incident to the practice of a profession and provision of any professional services.
1057 [~~(78)~~] (93) "Property insurance" means insurance against loss or damage to real or personal
1058 property of every kind and any interest in that property, from all hazards or causes, and against loss
1059 consequential upon the loss or damage including vehicle comprehensive and vehicle physical
1060 damage coverages, but excluding inland marine insurance and ocean marine insurance as defined
1061 under Subsections [~~(46)~~] (57) and [~~(68)~~] (80).
1062 [~~(79)~~] (94) (a) "Public agency insurance mutual" means any entity formed by joint venture
1063 or interlocal cooperation agreement by two or more political subdivisions or public agencies of the
1064 state for the purpose of providing insurance coverage for the political subdivisions or public
1065 agencies.
1066 (b) Any public agency insurance mutual created under this title and Title 11, Chapter 13,
1067 Interlocal Cooperation Act, is considered to be a governmental entity and political subdivision of
1068 the state with all of the rights, privileges, and immunities of a governmental entity or political
1069 subdivision of the state.
1070 (95) "Qualified long-term care insurance contract" or "federally tax qualified long-term
1071 care insurance contract" means:
1072 (a) an individual or group insurance contract that meets the requirements of Section
1073 7702B(b), Internal Revenue Code; or
1074 (b) the portion of a life insurance contract that provides long-term care insurance:
1075 (i) (A) by rider; or
1076 (B) as a part of the contract; and
1077 (ii) that satisfies the requirements of Section 7702B(b) and (e), Internal Revenue Code.
1078 (96) (a) "Rate" means:
1079 (i) the cost of a given unit of insurance; or

1080 (ii) for property-casualty insurance, that cost of insurance per exposure unit either
1081 expressed as:
1082 (A) a single number; or
1083 (B) a pure premium rate, adjusted before any application of individual risk variations based
1084 on loss or expense considerations to account for the treatment of:
1085 (I) expenses;
1086 (II) profit; and
1087 (III) individual insurer variation in loss experience.
1088 (b) "Rate" does not include a minimum premium.
1089 [~~(80)~~] (97) (a) Except as provided in Subsection [~~(80)~~] (97)(b), "rate service organization"
1090 means any person who assists insurers in rate making or filing by:
1091 (i) collecting, compiling, and furnishing loss or expense statistics;
1092 (ii) recommending, making, or filing rates or supplementary rate information; or
1093 (iii) advising about rate questions, except as an attorney giving legal advice.
1094 (b) "Rate service organization" does not mean:
1095 (i) an employee of an insurer;
1096 (ii) a single insurer or group of insurers under common control;
1097 (iii) a joint underwriting group; or
1098 (iv) a natural person serving as an actuarial or legal consultant.
1099 (98) "Rating manual" means any of the following used to determine initial and renewal
1100 policy premiums:
1101 (a) a manual of rates;
1102 (b) classifications;
1103 (c) rate-related underwriting rules; and
1104 (d) rating formulas that describe steps, policies, and procedures for determining initial and
1105 renewal policy premiums.
1106 (99) "Received by the department" means:
1107 (a) except as provided in Subsection (99)(b), the date delivered to and stamped received
1108 by the department, whether delivered:
1109 (i) in person;
1110 (ii) by a delivery service; or

1111 (iii) electronically; and
1112 (b) if an item with a department imposed deadline is delivered to the department by a
1113 delivery service, the delivery service's postmark date or pick-up date unless otherwise stated in:
1114 (i) statute;
1115 (ii) rule; or
1116 (iii) a specific filing order.
1117 [(81)] (100) "Reciprocal" or "interinsurance exchange" means any unincorporated
1118 association of persons:
1119 (a) operating through an attorney-in-fact common to all of them; and
1120 (b) exchanging insurance contracts with one another that provide insurance coverage on
1121 each other.
1122 [(82)] (101) "Reinsurance" means an insurance transaction where an insurer, for
1123 consideration, transfers any portion of the risk it has assumed to another insurer. In referring to
1124 reinsurance transactions, this title sometimes refers to:
1125 (a) the insurer transferring the risk as the "ceding insurer"; and
1126 (b) the insurer assuming the risk as the:
1127 (i) "assuming insurer"; or
1128 (ii) "assuming reinsurer."
1129 [(83)] (102) "Residential dwelling liability insurance" means insurance against liability
1130 resulting from or incident to the ownership, maintenance, or use of a residential dwelling that is
1131 a detached single family residence or multifamily residence up to four units.
1132 [(84)] (103) "Retrocession" means reinsurance with another insurer of a liability assumed
1133 under a reinsurance contract. A reinsurer "retrocedes" when it reinsures with another insurer part
1134 of a liability assumed under a reinsurance contract.
1135 (104) "Rider" means an endorsement to:
1136 (a) an insurance policy; or
1137 (b) an insurance certificate.
1138 [(85)] (105) (a) "Security" means any:
1139 (i) note;
1140 (ii) stock;
1141 (iii) bond;

1142 (iv) debenture;
1143 (v) evidence of indebtedness;
1144 (vi) certificate of interest or participation in any profit-sharing agreement;
1145 (vii) collateral-trust certificate;
1146 (viii) preorganization certificate or subscription;
1147 (ix) transferable share;
1148 (x) investment contract;
1149 (xi) voting trust certificate;
1150 (xii) certificate of deposit for a security;
1151 (xiii) certificate of interest of participation in an oil, gas, or mining title or lease or in
1152 payments out of production under such a title or lease;
1153 (xiv) commodity contract or commodity option;
1154 (xv) any certificate of interest or participation in, temporary or interim certificate for,
1155 receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed in
1156 Subsections [~~(85)~~] (105)(a)(i) through (xiv); or
1157 (xvi) any other interest or instrument commonly known as a security.
1158 (b) "Security" does not include:
1159 (i) any insurance or endowment policy or annuity contract under which an insurance
1160 company promises to pay money in a specific lump sum or periodically for life or some other
1161 specified period; or
1162 (ii) a burial certificate or burial contract.
1163 [~~(86)~~] (106) "Self-insurance" means any arrangement under which a person provides for
1164 spreading its own risks by a systematic plan.
1165 (a) Except as provided in this Subsection [~~(86)~~] (106), self-insurance does not include an
1166 arrangement under which a number of persons spread their risks among themselves.
1167 (b) Self-insurance does include an arrangement by which a governmental entity, as defined
1168 in Section 63-30-2, undertakes to indemnify its employees for liability arising out of the
1169 employees' employment.
1170 (c) Self-insurance does include an arrangement by which a person with a managed
1171 program of self-insurance and risk management undertakes to indemnify its affiliates, subsidiaries,
1172 directors, officers, or employees for liability or risk which is related to the relationship or

1173 employment.

1174 (d) Self-insurance does not include any arrangement with independent contractors.

1175 (107) "Short-term care insurance" means any insurance policy or rider advertised,

1176 marketed, offered, or designed to provide coverage that is similar to long-term care insurance but

1177 that provides coverage for less than 12 consecutive months for each covered person.

1178 [(87)] (108) (a) "Subsidiary" of a person means an affiliate controlled by that person either

1179 directly or indirectly through one or more affiliates or intermediaries.

1180 (b) "Wholly owned subsidiary" of a person is a subsidiary of which all of the voting shares

1181 are owned by that person either alone or with its affiliates, except for the minimum number of

1182 shares the law of the subsidiary's domicile requires to be owned by directors or others.

1183 [(88)] (109) Subject to Subsection [(48)] (59)(b), "surety insurance" includes:

1184 (a) a guarantee against loss or damage resulting from failure of principals to pay or

1185 perform their obligations to a creditor or other obligee;

1186 (b) bail bond insurance; and

1187 (c) fidelity insurance.

1188 [(89)] (110) (a) "Surplus" means the excess of assets over the sum of paid-in capital and

1189 liabilities.

1190 (b) (i) "Permanent surplus" means the surplus of a mutual insurer that has been designated

1191 by the insurer as permanent.

1192 (ii) Sections 31A-5-211, 31A-7-201, 31A-8-209, 31A-9-209, and 31A-14-209 require that

1193 mutuals doing business in this state maintain specified minimum levels of permanent surplus.

1194 (iii) Except for assessable mutuals, the minimum permanent surplus requirement is

1195 essentially the same as the minimum required capital requirement that applies to stock insurers.

1196 (c) "Excess surplus" means:

1197 (i) for life or [disability insurers, as defined in Subsection 31A-17-601(3),] accident and

1198 health insurers, health organizations, and property and casualty insurers[;] as defined in

1199 [Subsection] Section 31A-17-601[(4)], the lesser of:

1200 (A) that amount of an insurer's or health organization's total adjusted capital, as defined

1201 in Subsection [(92)] (113), that exceeds the product of:

1202 (I) 2.5; and

1203 (II) the sum of the insurer's or health organization's minimum capital or permanent surplus

1204 required under Section 31A-5-211, 31A-9-209, or 31A-14-205; or
1205 (B) that amount of an insurer's or health organization's total adjusted capital, as defined
1206 in Subsection [(92)] 113, that exceeds the product of:
1207 (I) 3.0; and
1208 (II) the authorized control level RBC as defined in Subsection 31A-17-601[(7)](8)(a); and
1209 (ii) for monoline mortgage guaranty insurers, financial guaranty insurers, and title insurers,
1210 that amount of an insurer's paid-in-capital and surplus that exceeds the product of:
1211 (A) 1.5; and
1212 (B) the insurer's total adjusted capital required by Subsection 31A-17-609(1).
1213 [(90)] (111) "Third party administrator" or "administrator" means any person who collects
1214 charges or premiums from, or who, for consideration, adjusts or settles claims of residents of the
1215 state in connection with insurance coverage, annuities, or service insurance coverage, except:
1216 (a) a union on behalf of its members;
1217 (b) a person [exempt as a trust under Section 514 of] administering any:
1218 (i) pension plan subject to the federal Employee Retirement Income Security Act of 1974;
1219 (ii) governmental plan as defined in Section 414(d), Internal Revenue Code; or
1220 (iii) nonelecting church plan as described in Section 410(d), Internal Revenue Code;
1221 (c) an employer on behalf of the employer's employees or the employees of one or more
1222 of the subsidiary or affiliated corporations of the employer;
1223 (d) an insurer licensed under Chapter 5, 7, 8, 9, or 14, but only [with respect to insurance
1224 issued by the insurer] for a line of insurance for which the insurer holds a license in this state; or
1225 (e) a person licensed or exempt from licensing under Chapter 23 or 26 whose activities are
1226 limited to those authorized under the license the person holds or for which the person is exempt.
1227 [(91)] (112) "Title insurance" means the insuring, guaranteeing, or indemnifying of owners
1228 of real or personal property or the holders of liens or encumbrances on that property, or others
1229 interested in the property against loss or damage suffered by reason of liens or encumbrances upon,
1230 defects in, or the unmarketability of the title to the property, or invalidity or unenforceability of any
1231 liens or encumbrances on the property.
1232 [(92)] (113) "Total adjusted capital" means the sum of an insurer's or health organization's
1233 statutory capital and surplus as determined in accordance with:
1234 (a) the statutory accounting applicable to the annual financial statements required to be

1235 filed under Section 31A-4-113; and

1236 (b) any other items provided by the RBC instructions, as RBC instructions is defined in

1237 [~~Subsection~~] Section 31A-17-601[~~(6)~~].

1238 [~~(93)~~] (114) (a) "Trustee" means "director" when referring to the board of directors of a

1239 corporation.

1240 (b) "Trustee," when used in reference to an employee welfare fund, means an individual,

1241 firm, association, organization, joint stock company, or corporation, whether acting individually

1242 or jointly and whether designated by that name or any other, that is charged with or has the overall

1243 management of an employee welfare fund.

1244 [~~(94)~~] (115) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted insurer"

1245 means an insurer:

1246 (i) not holding a valid certificate of authority to do an insurance business in this state; or

1247 (ii) transacting business not authorized by a valid certificate.

1248 (b) "Admitted insurer" or "authorized insurer" means an insurer:

1249 (i) holding a valid certificate of authority to do an insurance business in this state; and

1250 (ii) transacting business as authorized by a valid certificate.

1251 [~~(95)~~] (116) "Vehicle liability insurance" means insurance against liability resulting from

1252 or incident to ownership, maintenance, or use of any land vehicle or aircraft, exclusive of vehicle

1253 comprehensive and vehicle physical damage coverages under Subsection [~~(78)~~] (93).

1254 [~~(96)~~] (117) "Voting security" means a security with voting rights, and includes any

1255 security convertible into a security with a voting right associated with it.

1256 [~~(97)~~] (118) "Workers' compensation insurance" means:

1257 (a) insurance for indemnification of employers against liability for compensation based

1258 on:

1259 (i) compensable accidental injuries; and

1260 (ii) occupational disease disability;

1261 (b) employer's liability insurance incidental to workers compensation insurance and written

1262 in connection with it; and

1263 (c) insurance assuring to the persons entitled to workers compensation benefits the

1264 compensation provided by law.

1265 Section 6. Section **31A-2-214** is amended to read:

1266 **31A-2-214. Market assistance programs -- Joint underwriting associations.**
1267 (1) (a) If the commissioner finds that in any part of this state a line of insurance is not
1268 generally available in the marketplace or that it is priced in such a manner as to severely limit its
1269 availability, and that the public interest requires it, [he] the commissioner may by rule implement
1270 a market assistance program whereby all licensed insurers and agents may pool their information
1271 as to the available markets.
1272 (b) Insurers doing business in this state may, at their own instance or at the request of the
1273 commissioner, prepare and submit to the commissioner, for [his] the commissioner's approval and
1274 adoption, voluntary plans providing any line of insurance coverage for all or any part of this state
1275 in which this insurance is not generally available in the voluntary market or is priced in such a
1276 manner as to severely limit its availability and in which the public interest requires the availability
1277 of this coverage.
1278 (2) (a) If the commissioner finds after notice and hearing that a market assistance program
1279 formed under Subsection (1)(a) or (b) has not met the needs it was intended to address, [he] the
1280 commissioner may by rule form a joint underwriting association to make available the insurance
1281 to applicants who are in good faith entitled to but unable to procure this insurance through ordinary
1282 methods.
1283 (b) The commissioner shall allow any market assistance program formed under Subsection
1284 (1)(a) or (b) a minimum of 30 days operation before [he] the commissioner forms a joint
1285 underwriting association. The commissioner may not adopt a rule forming a joint underwriting
1286 association unless [he] the commissioner finds as a result of the hearing that:
1287 (i) a certain coverage is not available or that the price for that coverage is no longer
1288 commensurate with the risk in this state; and
1289 (ii) the coverage is:
1290 (A) vital to the economic health of this state[, is];
1291 (B) vital to the quality of life in this state[, is];
1292 (C) vital in maintaining competition in insurance in this state[,]; or
1293 (D) the number of people affected is significant enough to justify its creation.
1294 [(b)] (c) The commissioner may not adopt a rule forming a joint underwriting association
1295 under Subsection (2)(a) on the basis that applicants for particular lines of insurance are unable to
1296 pay a premium that is commensurate with the risk involved or that the number of applicants or

1297 people affected is too small to justify its creation.
1298 [~~(c)~~] (d) Each joint underwriting association formed under Subsection (2)(a) shall require
1299 participation by all insurers licensed and engaged in writing that line of insurance or any
1300 component of that line of insurance within this state.
1301 [~~(d)~~] (e) Each association formed under Subsection (2)(a) shall:
1302 (i) give consideration to:
1303 (A) the need for adequate and readily accessible coverage;
1304 (B) alternative methods of improving the market affected;
1305 (C) the preference of the insurers and agents;
1306 (D) the inherent limitations of the insurance mechanism;
1307 (E) the need for reasonable underwriting standards; and
1308 (F) the requirement of reasonable loss prevention measures;
1309 (ii) establish procedures that will create minimum interference with the voluntary market;
1310 (iii) allocate the burden imposed by the association equitably and efficiently among the
1311 insurers doing business in this state;
1312 (iv) establish procedures for applicants and participants to have grievances reviewed by
1313 an impartial body;
1314 (v) provide for the method of classifying risks and making and filing applicable rates; and
1315 (vi) specify:
1316 (A) the basis of participation of insurers and agents in the association;
1317 (B) the conditions under which risks must be accepted; and
1318 (C) the commission rates to be paid for insurance business placed with the association.
1319 [~~(e)~~] (f) Any deficit in an association in any year shall be recouped by rate increases for
1320 the association, applicable prospectively. Any surplus in excess of the loss reserves of the
1321 association in any year shall be distributed either by rate decreases or by distribution to the
1322 members of the association on a pro-rata basis.
1323 (3) Notwithstanding [~~the provisions of~~] Subsection (2), the commissioner may not create
1324 a joint underwriting association under [~~that subsection~~] Subsection (2) for:
1325 (a) life insurance[~~,~~];
1326 (b) annuities[~~, disability~~];
1327 (c) accident and health insurance[~~,~~];

1328 (d) ocean marine insurance[,];
1329 (e) medical malpractice insurance[,];
1330 (f) earthquake insurance[,];
1331 (g) workers' compensation insurance[,];
1332 (h) public agency insurance mutuals[,]; or
1333 (i) private passenger automobile liability insurance.
1334 (4) Every insurer and agent participating in a joint underwriting association adopted by the
1335 commissioner under Subsection (2) shall provide the services prescribed by the association to any
1336 person seeking coverage of the kind available in the plan, including full information about the
1337 requirements and procedures for obtaining coverage with the association.
1338 (5) If the commissioner finds that the lack of cooperating insurers or agents in an area
1339 makes the functioning of the association difficult, [he] the commissioner may order the association
1340 to:
1341 (a) establish branch service offices[,];
1342 (b) make special contracts for provision of the service[,]; or
1343 (c) take other appropriate steps to ensure that service is available.
1344 (6) The association may issue policies for a period of one year. If, at the end of any one
1345 year period, the commissioner determines that the market conditions justify the continued
1346 existence of the association, [he] the commissioner may reauthorize its existence. In reauthorizing
1347 the association, the commissioner shall follow the procedure set forth in Subsection (2).
1348 Section 7. Section **31A-2-217** is enacted to read:
1349 **31A-2-217. Coordination with other states.**
1350 (1) (a) Subject to Subsection (1)(b), the commissioner, by rule, may adopt one or more
1351 agreements with another governmental regulatory agency, within and outside of this state, or with
1352 the National Association of Insurance Commissioners to address:
1353 (i) licensing of insurance companies;
1354 (ii) licensing of agents;
1355 (iii) regulation of premium rates and policy forms; and
1356 (iv) regulation of insurer insolvency and insurance receiverships.
1357 (b) An agreement described in Subsection (1)(a), may authorize the commissioner to
1358 modify a requirement of this title if the commissioner determines that the requirements under the

1359 agreement provide protections similar to or greater than the requirements under this title.
1360 (2) (a) The commissioner may negotiate an interstate compact that addresses issuing
1361 certificates of authority, if the commissioner determines that:
1362 (i) each state participating in the compact has requirements for issuing certificates of
1363 authority that provide protections similar to or greater than the requirements of this title; or
1364 (ii) the interstate compact contains requirements for issuing certificates of authority that
1365 provide protections similar to or greater than the requirements of this title.
1366 (b) If an interstate compact described in Subsection (2)(a) is adopted by the Legislature,
1367 the commissioner may issue certificates of authority to insurers in accordance with the terms of
1368 the interstate compact.
1369 (3) If any provision of this title conflicts with a provision of the annual statement
1370 instructions or the National Association of Insurance Commissioners Accounting Practices and
1371 Procedures Manual, the commissioner may, by rule, resolve the conflict in favor of the annual
1372 statement instructions or the National Association of Insurance Commissioners Accounting
1373 Practices and Procedures Manual.
1374 (4) The commissioner may, by rule, accept the information prescribed by the National
1375 Association of Insurance Commissioners instead of the documents required to be filed with an
1376 application for a certificate of authority under:
1377 (a) Section 31A-4-103, 31A-5-204, 31A-8-205, or 31A-14-201; or
1378 (b) rules made by the commissioner.
1379 (5) Before November 30, 2001, the commissioner shall report to the Business, Labor, and
1380 Economic Development Interim Committee regarding the status of:
1381 (a) any agreements entered into under Subsection (1);
1382 (b) any interstate compact entered into under Subsection (2); and
1383 (c) any rule made under Subsections (3) and (4).
1384 (6) This section shall be repealed in accordance with Section 63-55-231.
1385 Section 8. Section **31A-4-103** is amended to read:
1386 **31A-4-103. Certificate of authority.**
1387 (1) Each certificate of authority issued by the commissioner shall specify:
1388 (a) the name of the insurer[,];
1389 (b) the kinds of insurance it is authorized to transact in Utah[,]; and

1390 (c) any other information the commissioner requires.
1391 (2) A certificate of authority issued under this chapter remains in force until, under
1392 Subsection (3), the certificate of authority is:
1393 (a) revoked;
1394 (b) suspended; or
1395 (c) limited.
1396 (3) (a) After an adjudicative proceeding under Title 63, Chapter 46b, Administrative
1397 Procedures Act, the commissioner may revoke, suspend, or limit in whole or in part the certificate
1398 of authority of any insurer if:
1399 (i) the insurer is found to have:
1400 (A) failed to pay when due any fee due under Section 31A-3-103;
1401 (B) violated or failed to comply with:
1402 (I) this title;
1403 (II) a rule made under Subsection 31A-2-201(3); or
1404 (III) an order issued under Subsection 31A-2-201(4); or
1405 (ii) the insurer's methods and practices in the conduct of business endanger the legitimate
1406 interests of customers and the public.
1407 (b) An order suspending or limiting a certificate of authority issued under this chapter shall
1408 specify:
1409 (i) the period of the suspension or limitation, which in no event may be in excess of 12
1410 months;
1411 (ii) the conditions and limitations imposed on the insurer during the suspension or
1412 limitation; and
1413 (iii) the conditions and procedures for reinstatement from suspension or limitation.
1414 (4) Subject to the requirements of this section and in accordance with Title 63, Chapter
1415 46a, Utah Administrative Rulemaking Act, the commissioner shall by rule prescribe procedures
1416 to renew or reinstate a certificate of authority.
1417 (5) An insurer under this chapter whose certificate of authority is suspended or revoked,
1418 but that continues to act as an authorized insurer, is subject to the penalties for acting as an insurer
1419 without a certificate of authority.
1420 (6) Any insurer holding a certificate of authority in this state shall immediately report to

1421 the commissioner a suspension or revocation of that insurer's certificate of authority in any:
1422 (a) state;
1423 (b) the District of Columbia; or
1424 (c) a territory of the United States.
1425 (7) (a) An order revoking a certificate of authority under Subsection (3) may specify a time
1426 within which the former authorized insurer may not apply for a new certificate of authority, except
1427 that the time may not exceed five years from the date the certificate of authority is revoked.
1428 (b) If no time is specified in an order revoking a certificate of authority under Subsection
1429 (3), the former authorized insurer may not apply for a new certificate of authority for five years
1430 from the date the certificate of authority is revoked without express approval by the commissioner.
1431 (8) (a) Subject to Subsection (8)(b), the insurer shall pay all fees under Section 31A-3-103
1432 that would have been payable if the certificate of authority had not been suspended or revoked,
1433 unless the commissioner, in accordance with rule, waives the payment of the fees by no later than
1434 the day of:
1435 (i) a suspension under Subsection (3) of an insurer's certificate of authority ends; or
1436 (ii) a new certificate of authority is issued to an insurer whose certificate of authority is
1437 revoked under Subsection (3).
1438 (b) If a new certificate of authority is issued more than three years after the revocation of
1439 a similar certificate of authority, this Subsection (8) applies only to the fees that would have
1440 accrued during the three years immediately following the revocation.
1441 Section 9. Section **31A-4-113** is amended to read:
1442 **31A-4-113. Annual statements.**
1443 (1) (a) Each authorized insurer shall annually, on or before March 1, file with the
1444 commissioner a true statement of its financial condition, transactions, and affairs as of December
1445 31 of the preceding year. [~~This~~]
1446 (b) The statement required by Subsection (1)(a) shall be:
1447 (i) verified by the oaths of at least two of the insurer's principal officers[~~.~~]; and
1448 (ii) in the general form and provide the information as prescribed by the commissioner by
1449 rule.
1450 (c) The commissioner may, for good cause shown, extend the date for filing the statement[~~.~~
1451 ~~The~~] required by Subsection (1)(a), except that the deadline for filing fee payment may not be

1452 extended.

1453 [(2) The statement shall be in the general form and provide the information as prescribed

1454 by rule of the commissioner. In the absence of a statute providing otherwise, the statement shall

1455 be prepared in accordance with the annual statement instructions and the Accounting Practices and

1456 Procedures Manual which is published by the National Association of Insurance Commissioners.]

1457 [(3)] (2) The annual statement of an alien insurer shall:

1458 (a) relate only to its transactions and affairs in the United States unless the commissioner

1459 requires otherwise[. The statement shall]; and

1460 (b) be verified by:

1461 (i) the insurer's United States manager; or [by its]

1462 (ii) the insurer's authorized officers.

1463 Section 10. Section **31A-5-211** is amended to read:

1464 **31A-5-211. Minimum capital or permanent surplus requirements.**

1465 (1) (a) Except as provided in Subsections (4) and (5), insurers being organized or operating

1466 under this chapter shall maintain minimum capital or permanent surplus for a mutual, in amounts

1467 specified in Subsection (2).

1468 (b) The certificate of authority issued under Section 31A-5-212 does not permit an insurer

1469 to transact types of insurance for which the insurer does not have the required minimum capital

1470 or permanent surplus for a mutual, in at least the amounts specified under Subsection (2).

1471 (c) The types of insurance under this section are defined in Section 31A-1-301. Minimum

1472 capital and permanent surplus requirements under this section are based upon all types of insurance

1473 transacted by the insurer in any and all areas which it operates, whether or not only a portion of

1474 those types of insurance is or is to be transacted in this state.

1475 (2) The minimum capital, or permanent surplus for a nonassessable mutual, is as follows

1476 for the indicated types of insurance:

1477 (a) life, annuity, [disability] accident and health, or any combination of these $400,000

1478 (b) subject to an aggregate maximum of $1,000,000 for more than one of the following

1479 types of coverages:

1480 (i) property insurance 200,000

1481 (ii) surety insurance 300,000

1482 (iii) bail bonds insurance only 100,000

1483 (iv) marine and transportation insurance 200,000
1484 (v) vehicle liability insurance, residential dwelling liability insurance,
1485 or both 400,000
1486 (vi) liability insurance 600,000
1487 (vii) workers' compensation insurance 300,000
1488 (c) title insurance 200,000
1489 (d) professional liability insurance, excluding medical malpractice 700,000
1490 (e) professional liability, including medical malpractice 1,000,000
1491 (f) all types of insurance, except life, annuity, or title 2,000,000
1492 (3) Prior to beginning operations, an insurer licensed under this chapter shall have total
1493 adjusted capital in excess of the company action level RBC as defined in Subsection
1494 31A-17-601[~~(7)~~](8)(b).
1495 (4) (a) Subject to Subsections (4)(b) and (4)(c), an insurer holding a valid certificate of
1496 authority to transact insurance in this state prior to July 1, 1986, continues to be authorized to
1497 transact the same kinds of insurance as permitted by that certificate of authority, if the insurer
1498 maintains not less than the amount of minimum capital or permanent surplus required for that
1499 authority under the laws of this state in force immediately prior to July 1, 1986.
1500 (b) If, after July 1, 1986, an insurer ever has minimum capital or permanent surplus that
1501 meets or exceeds the requirements of Subsections (2) and (3), then Subsection (4)(a) is
1502 inapplicable to that insurer and it shall comply with Subsections (2) and (3).
1503 (c) Any insurer satisfying the minimum capital or permanent surplus requirement through
1504 application of Subsection (4)(a) shall comply with Subsections (2) and (3) by July 1, 1990.
1505 (d) Beginning July 1, 1987, former county mutuals shall comply with the capital and
1506 surplus requirements of this section.
1507 (5) (a) An assessable mutual may be organized under this chapter, but it may not issue life
1508 insurance or annuities. An assessable mutual need not have a permanent surplus if the assessment
1509 liability of its policyholders is unlimited and all insurance policies clearly state that. If assessments
1510 are limited to a specified amount or a specified multiple of annual advance premiums, the
1511 minimum permanent surplus is the amount that would be required under Subsections (2) and (3)
1512 if the corporation were not assessable, reduced by an amount that reasonably reflects the value of
1513 the policyholders' assessment liability in satisfying the financial needs of the corporation. The

1514 liability of members in an assessable mutual is joint and several up to the limits provided by the
1515 articles of incorporation or this title.
1516 (b) (i) Except as provided in Subsections (5)(c) and (d), no certificate of authority may be
1517 issued to an assessable mutual until it has at least 400 bona fide applications for insurance from
1518 not less than 400 separate applicants, on separate risks located in this state, in each of the classes
1519 of business upon which assessments may be separately levied. A full year's premium shall be paid
1520 with each application and the aggregate premium is at least $50,000 for each class.
1521 (ii) If at any time while the corporation is an assessable mutual, the business plan is
1522 amended to include an additional class of business on which assessments may be separately levied,
1523 identical requirements of Subsection (5)(b)(i) are applicable to each additional class.
1524 (c) Five or more employers may join in the formation of an assessable mutual to write only
1525 workers' compensation insurance if, instead of the requirements of Subsection (5)(b), policies are
1526 simultaneously put into effect that cover at least 1,500 employees, with no single employer having
1527 more than 1/5 of the employees insured by the assessable mutual. A full year's premium shall be
1528 paid by each employer, aggregating at least $200,000.
1529 (d) The number and amount of required initial applications and premium payments may
1530 be reduced by substituting surplus for the applications or premium payments. The commissioner
1531 shall determine the reduction in required initial applications and premium payments that is
1532 appropriate for a given amount of surplus. The insurer shall continue to be assessable until
1533 conversion under Subsection 31A-5-508(1) to a nonassessable mutual.
1534 (6) The capital or permanent surplus requirements of Subsection (2) apply to persons
1535 seeking certificates of authority under this chapter to write reinsurance. This subsection may not
1536 be construed as requiring reinsurers to obtain a certificate of authority. However, Section
1537 31A-17-404 imposes alternate safety prerequisites to reserve credit being granted for reinsurance
1538 ceded to a reinsurer without a certificate of authority.
1539 Section 11. Section **31A-5-418** is amended to read:
1540 **31A-5-418. Dividends and other distributions.**
1541 (1) Subject to the requirements of Section 16-10a-842 and Subsection 31A-16-106(2), a
1542 stock corporation may make distributions under Section 16-10a-640 if all the following conditions
1543 are satisfied:
1544 (a) A dividend may not be paid that would reduce the insurer's total adjusted capital below

1545 the insurer's company action level RBC as defined in Subsection 31A-17-601[~~(7)~~](8)(b).
1546 (b) Except as to excess surplus, or unless the commissioner issues an order allowing
1547 otherwise, a dividend may not be paid that exceeds the insurer's net gain from operations or net
1548 income for the period ending December 31 of the preceding year.
1549 (2) Title 67, Chapter 4a, Unclaimed Property Act, applies to unclaimed dividends and
1550 distributions in insurance corporations.
1551 Section 12. Section **31A-5-703** is amended to read:
1552 **31A-5-703. Nonrenewals, cancellations, or revisions of ceded reinsurance**
1553 **agreements.**
1554 (1) (a) A nonrenewal, cancellation, or revision of ceded reinsurance agreements is not
1555 subject to the reporting requirements of Section 31A-5-701 if:
1556 (i) the nonrenewal, cancellation, or revision is not material; or
1557 (ii) with respect to a property and casualty business, the insurer's total ceded written
1558 premium [~~represents~~], on an annualized basis, is less than 10% of its total written premium for
1559 direct and assumed business; or
1560 (iii) with respect to a life, annuity, and [~~disability~~] accident and health business, the total
1561 reserve credit taken for business ceded [~~represents~~], on an annualized basis, is less than 10% of the
1562 statutory reserve requirement prior to a cession.
1563 (b) For purposes of this part, a material nonrenewal, cancellation, or revision is one that
1564 affects:
1565 (i) with respect to a property and casualty business:
1566 (A) more than 50% of the insurer's total ceded written premium; or
1567 (B) more than 50% of the insurer's total ceded indemnity and loss adjustment reserves;
1568 (ii) with respect to a life, annuity, and [~~disability~~] accident and health business, more than
1569 50% of the total reserve credit taken for business ceded, on an annualized basis, as indicated in the
1570 insurer's most recent annual statement; or
1571 (iii) with respect to either property and casualty or life, annuity, or [~~disability~~] accident and
1572 health business[~~, is either of the following events~~]:
1573 (A) an authorized reinsurer representing more than 10% of a total cession is replaced by
1574 one or more unauthorized reinsurers; or
1575 (B) previously established collateral requirements have been reduced or waived as respects

1576 one or more unauthorized reinsurers representing collectively more than 10% of a total cession.
1577 (2) (a) The following information is required to be disclosed in any report filed pursuant
1578 to Section 31A-5-701 of a material nonrenewal, cancellation, or revision of a ceded reinsurance
1579 agreement:
1580 (i) the effective date of the nonrenewal, cancellation, or revision;
1581 (ii) the description of the transaction with an identification of the initiator of the
1582 transaction;
1583 (iii) the purpose of, or reason for the transaction; and
1584 (iv) if applicable, the identity of the replacement reinsurers.
1585 (b) (i) Insurers are required to report all material nonrenewals, cancellations, or revisions
1586 of ceded reinsurance agreements on a nonconsolidated basis unless the insurer:
1587 (A) is part of a consolidated group of insurers that uses a pooling arrangement or 100%
1588 reinsurance agreement that affects the solvency and integrity of the insurer's reserves; and
1589 (B) ceded substantially all of its direct and assumed business to the pool.
1590 (ii) An insurer is considered to have ceded substantially all of its direct and assumed
1591 business to a pool if:
1592 (A) the insurer has less than $1,000,000 total direct plus assumed written premiums during
1593 a calendar year that are not subject to a pooling arrangement; and
1594 (B) the net income of the business not subject to the pooling arrangement represents less
1595 than 5% of the insurer's capital and surplus.
1596 Section 13. Section **31A-6a-102** is amended to read:
1597 **31A-6a-102. Scope and purposes.**
1598 (1) The purposes of this chapter are to:
1599 (a) create a legal framework within which service contracts may be sold in this state;
1600 (b) encourage innovation in the marketing and development of more economical and
1601 effective ways of providing services under service contracts, while placing the risk of innovation
1602 on the service contract providers rather than on consumers; and
1603 (c) permit and encourage fair and effective competition among different systems of
1604 providing and paying for these services.
1605 (2) Service contracts may not be issued, sold, or offered for sale in this state unless the
1606 provider has complied with this chapter. [~~Subsections 31A-1-103(3)(i), (j), and (k) limit the~~

1607 application of this chapter to certain persons engaged in a limited manner in providing extended
1608 warranties or service contracts.]
1609 (3) This chapter applies only to a service contract not otherwise exempted from this title
1610 by Section 31A-1-103.
1611 Section 14. Section **31A-6a-110** is amended to read:
1612 **31A-6a-110. Rulemaking.**
1613 (1) Pursuant to Title 63, Chapter 46a, Utah Administrative Rulemaking Act, the
1614 commissioner may make rules necessary to assist in the enforcement of this chapter.
1615 (2) The commissioner may by rule or order, after a hearing, exempt certain service contract
1616 providers or service contract providers for a specific class of service contracts that are not
1617 otherwise exempt under [Subsections] Subsection 31A-1-103(3)[(i), (j), or (k),] from any provision
1618 of this title. The commissioner may order substitute requirements on a finding that a particular
1619 provision of this title is not necessary for the protection of the public or that the substitute
1620 requirement is reasonably certain to provide equivalent protection to the public.
1621 Section 15. Section **31A-8-101** is amended to read:
1622 **31A-8-101. Definitions.**
1623 For purposes of this chapter:
1624 (1) "Basic health care services" means:
1625 (a) emergency care[,];
1626 (b) inpatient hospital and physician care[,];
1627 (c) outpatient medical services[,]; and
1628 (d) out-of-area coverage.
1629 (2) "Director of health" means the executive director of the Department of Health or his
1630 authorized representative.
1631 (3) "Enrollee" means [any] an individual:
1632 (a) who has entered into a contract with [a health maintenance] an organization for health
1633 care; or
1634 (b) in whose behalf [such] an arrangement for health care has been made.
1635 (4) "Health care" [means professional or personal services, facilities, equipment, devices,
1636 supplies, or medicine, intended for use in the diagnosis, treatment, mitigation, or prevention of any
1637 human ailment or impairment] is as defined in Section 31A-1-301.

1638 (5) "Health maintenance organization" means any person[,]:
1639 (a) other than:
1640 (i) an insurer licensed under Chapter 7; or
1641 (ii) an individual who contracts to render professional or personal services that [he] the
1642 individual directly performs [himself, which:]; and
1643 (b) that:
1644 [(a)] (i) furnishes at a minimum, either directly or through arrangements with others, basic
1645 health care services to an enrollee in return for prepaid periodic payments agreed to in amount
1646 prior to the time during which the health care may be furnished; and
1647 [(b)] (ii) is obligated to the enrollee to arrange for or to directly provide available and
1648 accessible health care.
1649 (6) (a) "Limited health plan" means, except as limited under Subsection (6)(b), any person
1650 who furnishes, either directly or through arrangements with others, [the] services:
1651 (i) of:
1652 (A) dentists[,];
1653 (B) optometrists[,];
1654 (C) physical therapists[,];
1655 (D) podiatrists[,];
1656 (E) psychologists[,];
1657 (F) physicians[,];
1658 (G) chiropractic physicians[,];
1659 (H) naturopathic physicians[,];
1660 (I) osteopathic physicians[,];
1661 (J) social workers[,];
1662 (K) family counselors[,];
1663 (L) other health care providers[,]; or
1664 (M) reasonable combinations of [these,] the services described in this Subsection (1)(a)(i);
1665 (ii) to an enrollee;
1666 (iii) in return for prepaid periodic payments agreed to in amount prior to the time during
1667 which the services may be furnished[,]; and [who is]
1668 (iv) for which the person is obligated to the enrollee to arrange for or directly provide

1669 available and accessible the services described in this Subsection (6)(a).
1670 (b) "Limited health plan" does not include:
1671 (i) a health maintenance organization;
1672 (ii) an insurer licensed under Chapter 7; or
1673 (iii) an individual who contracts to render professional or personal services that he
1674 performs himself.
1675 (7) (a) "Nonprofit organization" or "nonprofit corporation" means an organization no part
1676 of the income of which is distributable to its members, trustees, or officers, or a nonprofit
1677 cooperative association, except in a manner allowed under Section 31A-8-406.
1678 (b) "Nonprofit health maintenance organization" and "nonprofit limited health plan" are
1679 used when referring specifically to one of the types of organizations with "nonprofit" status.
1680 (8) "Organization" means health maintenance organization and limited health plan, unless
1681 used in the context of:
1682 (a) "organization permit," in which case see Sections 31A-8-204 and 31A-8-206[,]; or
1683 [~~unless used in the context of~~]
1684 (b) "organization expenses," in which case see Section 31A-8-208.
1685 (9) "Participating provider" means a provider as defined in Subsection (10) who, under [~~an~~
1686 ~~express or implied~~] a contract with the health maintenance organization, has agreed to provide
1687 health care services to enrollees with an expectation of receiving payment, directly or indirectly,
1688 from the health maintenance organization, other than copayment.
1689 (10) "Provider" means any person who furnishes health care directly to the enrollee and
1690 who is licensed or otherwise authorized to furnish this care in this state.
1691 (11) "Uncovered expenditures" means the costs of health care services that are covered by
1692 an organization for which an enrollee is liable in the event of the organization's insolvency.
1693 (12) "Unusual or infrequently used health services" means those health services which are
1694 projected to involve fewer than 10% of the organization's enrollees' encounters with providers,
1695 measured on an annual basis over the organization's entire enrollment.
1696 Section 16. Section **31A-8-103 (Effective 04/30/01)** is amended to read:
1697 **31A-8-103 (Effective 04/30/01). Applicability to other provisions of law.**
1698 (1) (a) Except for exemptions specifically granted under this title, [~~organizations are~~] an
1699 organization is subject to regulation under all of the provisions of this title.

1700 (b) Notwithstanding any provision of this title, [organizations] an organization licensed
1701 under this chapter [are] is:
1702 (i) wholly exempt from [the provisions of] Chapters 7, 9, 10, 11, 12, 13, 19, and 28[. In
1703 addition, organizations are] and not subject to:
1704 [(a)] (A) Chapter 3, except for Part I;
1705 [(b)] (B) Section 31A-4-107;
1706 [(c)] (C) Chapter 5, except for provisions specifically made applicable by this chapter;
1707 [(d)] (D) Chapter 14, except for provisions specifically made applicable by this chapter;
1708 [(e) Chapters] (E) Chapter 17 [and 18], except:
1709 (I) Part VI; or
1710 (II) as made applicable by the commissioner by rule consistent with this chapter; [and]
1711 (F) Chapter 18, except as made applicable by the commissioner by rule consistent with this
1712 chapter; and
1713 [(f)] (G) Chapter 22, except for Parts VI, VII, and XII.
1714 (2) The commissioner may by rule waive other specific provisions of this title that [he] the
1715 commissioner considers inapplicable to health maintenance organizations or limited health plans,
1716 upon a finding that [such a] the waiver will not endanger the interests of:
1717 (a) enrollees[,];
1718 (b) investors[,]; or
1719 (c) the public.
1720 (3) Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, and Title 16, Chapter
1721 10a, Utah Revised Business Corporation Act, do not apply to [organizations] an organization
1722 except as specifically made applicable by:
1723 (a) this chapter;
1724 (b) a provision referenced under this chapter; or
1725 (c) a rule adopted by the commissioner to deal with corporate law issues of health
1726 maintenance organizations that are not settled under this chapter.
1727 (4) (a) Whenever in this chapter [a section, subsection, or paragraph of], Chapter 5, or
1728 Chapter 14 is made applicable to [organizations] an organization, the application is:
1729 (i) of those provisions that apply to a mutual [corporations] corporation if the organization
1730 is nonprofit; and

1731 (ii) of those that apply to a stock [corporations] corporation if the organization is for profit.
1732 [Whenever a provision under]
1733 (b) When Chapter 5 or 14 is made applicable to [organizations] an organization under this
1734 chapter, "mutual" means nonprofit organization.
1735 (5) Solicitation of enrollees by an organization is not a violation of any provision of law
1736 relating to solicitation or advertising by health professionals if that solicitation is made in
1737 accordance with [the provisions of]:
1738 (a) this chapter; and
1739 (b) Chapter 23.
1740 (6) Nothing in this title prohibits any health maintenance organization from meeting the
1741 requirements of any federal law that enables the health maintenance organization to:
1742 (a) receive federal funds; or [to]
1743 (b) obtain or maintain federal qualification status.
1744 (7) Except as provided in Section 31A-8-501, [organizations are] an organization is exempt
1745 from statutes in this title or department rules that restrict or limit [their] its freedom of choice in
1746 contracting with or selecting health care providers, including Section 31A-22-618.
1747 (8) [Organizations are exempt from] the assessment or payment of premium taxes imposed
1748 by Sections 59-9-101 through 59-9-104.
1749 Section 17. Section **31A-8-205** is amended to read:
1750 **31A-8-205. Organization permit and certificate of incorporation.**
1751 (1) Section 31A-5-204 applies to the formation of organizations, except that "Section
1752 31A-5-211" in Subsection 31A-5-204 (5) shall be read "Section 31A-8-209."
1753 (2) In addition to the requirements of Section 31A-5-204, the application for a permit shall
1754 include a description of the initial locations of facilities where health care will be available to
1755 enrollees, the hours during which various services will be provided, the types of health care
1756 personnel to be used at each location and the approximate number of each personnel type to be
1757 available at each location, the methods to be used to monitor the quality of health care furnished,
1758 the method of resolving grievances initiated by enrollees or providers, the method used to give
1759 enrollees an opportunity to participate in matters of policy, the medical records system, and the
1760 method for documentation of utilization of health care by persons insured.
1761 Section 18. Section **31A-8-209** is amended to read:

1762 **31A-8-209. Minimum capital or minimum permanent surplus.**

1763 (1) [~~Health~~] A health maintenance [~~organizations~~] organization being organized or
1764 operating under this chapter shall have and maintain a minimum capital or minimum permanent
1765 surplus of $100,000.

1766 [~~(2) Limited health plans being organized or operating under this chapter shall have and~~
1767 ~~maintain a minimum capital or permanent surplus in an amount determined under Subsection~~
1768 ~~31A-8-210 (9).~~]

1769 [~~(3) For purposes of measuring compliance with Section 31A-8-210, to the extent an~~
1770 ~~organization has capital or permanent surplus in excess of its required minimum capital, or in~~
1771 ~~excess of its required minimum permanent surplus, the excess shall be counted as surplus.~~]

1772 (2) (a) The minimum required capital or minimum permanent surplus for a limited health
1773 plan:

1774 (i) is at least $10,000; and

1775 (ii) may not exceed $100,000.

1776 (b) The initial minimum required capital or minimum permanent surplus for a limited
1777 health plan required by Subsection (2)(a) shall be set by the commissioner, after:

1778 (i) a hearing; and

1779 (ii) consideration of:

1780 (A) the services to be provided by the limited health plan;

1781 (B) the size and geographical distribution of the population the limited health plan
1782 anticipates serving;

1783 (C) the nature of the limited health plan's arrangements with providers; and

1784 (D) the arrangements, agreements, and relationships in place or reasonably anticipated with
1785 respect to:

1786 (I) insolvency insurance;

1787 (II) reinsurance;

1788 (III) lenders subordinating to the interests of enrollees and trade creditors;

1789 (IV) personal and corporate financial guarantees;

1790 (V) provider withholds and assessments;

1791 (VI) surety bonds;

1792 (VII) hold harmless agreements in provider contracts; and

1793 (VIII) other arrangements, agreements, and relationships impacting the security of
1794 enrollees.
1795 (c) Upon a material change in the scope or nature of a limited health plan's operations, the
1796 commissioner may, after a hearing, alter the limited health plan's minimum required capital or
1797 minimum permanent surplus.
1798 (3) Before beginning operations, a health maintenance organization licensed under this
1799 chapter shall have total adjusted capital in excess of the company action level RBC as defined in
1800 Subsection 31A-17-601(8)(b).
1801 (4) Each health maintenance organization authorized to do business in this state shall
1802 maintain assets in an amount equal to the total of the health maintenance organization's:
1803 (a) liabilities;
1804 (b) minimum capital or minimum permanent surplus required by Subsection (1) or (2); and
1805 (c) the company action level RBC as defined in Subsection 31A-17-601(8)(b).
1806 (5) As a prerequisite to receiving an original certificate of authority to do business in this
1807 state, a health maintenance organization shall have initial surplus at least $400,000 in excess of
1808 the capital and surplus required by Subsection (4).
1809 [(4)] (6) The commissioner may allow the minimum capital or permanent surplus account
1810 of an organization to be designated by some other name.
1811 (7) A pattern of persistent deviation from the accounting and investment standards under
1812 this section may be grounds for the commissioner to find that the one or more persons with
1813 authority to make the organization's accounting or investment decisions are incompetent for
1814 purposes of Subsection 31A-5-410(3).
1815 Section 19. Section **31A-8-211** is amended to read:
1816 **31A-8-211. Deposit.**
1817 (1) Except as provided in Subsection (2), each organization authorized in this state shall
1818 maintain a deposit with the commissioner under Section 31A-2-206 in an amount equal to the sum
1819 of:
1820 (a) the organization's minimum capital or minimum permanent surplus [plus] requirement
1821 of Subsection 31A-8-209(1) or (2); and
1822 (b) 50% of [compulsory surplus] the company action level RBC as defined in Subsection
1823 31A-17-601(8)(b).

1824 (2) [A] (a) After a hearing the commissioner may exempt a health maintenance
1825 organization from the deposit requirement of Subsection (1) if:
1826 (i) the commissioner determines that the enrollees' interests are adequately protected;
1827 (ii) the health maintenance organization [which] has been continuously authorized to do
1828 business in this state for at least five years[,]; and [which]
1829 (iii) the health maintenance organization has $5,000,000 surplus [over and above] in
1830 excess of its [compulsory surplus in an amount specified in Subsection (3), may, after a hearing,
1831 be exempted from the deposit requirement of Subsection (1) if the commissioner determines that
1832 the enrollees' interests are adequately protected] company action level RBC as defined in
1833 Subsection 31A-17-601(8)(b).
1834 (b) The commissioner may rescind [such] an exemption given under Subsection (2)(a).
1835 [(3) No health maintenance organization may be exempted under Subsection (2) from the
1836 deposit requirement unless:]
1837 [(a) disregarding assets described in Subsection 31A-8-210 (8)(a), the health maintenance
1838 organization has $1,000,000 of surplus in excess of the amount required to satisfy its compulsory
1839 surplus requirement; or]
1840 [(b) the health maintenance organization has $5,000,000 surplus in excess of the amount
1841 required to satisfy its compulsory surplus requirement.]
1842 Section 20. Section **31A-8-213** is amended to read:
1843 **31A-8-213. Certificate of authority.**
1844 (1) [The] An organization may apply for a certificate of authority at any time prior to the
1845 expiration of its organization permit. The application shall include:
1846 (a) a detailed statement by a principal officer about any material changes that have taken
1847 place or are likely to take place in the facts on which the issuance of the organization permit was
1848 based[,]; and
1849 (b) if any material changes are proposed in the business plan, the information about the
1850 changes that would be required if an organization permit were then being applied for.
1851 (2) The commissioner shall issue a certificate of authority, if [he] the commissioner finds
1852 that:
1853 (a) the [organization satisfies] organization's capital and surplus complies with the
1854 requirements of [Sections] Section 31A-8-209 [and 31A-8-210] as to the operations proposed

1855 under the new certificate of authority;
1856 (b) there is no basis for revoking the organization permit under Section 31A-8-207;
1857 (c) the deposit required by Section 31A-8-211 has been made;
1858 (d) the organization satisfies the requirements of Section 31A-8-104; and
1859 [~~(e) the organization satisfies the surplus requirement of Subsection 31A-8-210 (4) or (5),~~
1860 ~~whichever applies; and~~]
1861 [~~(f)~~] (e) all other applicable requirements of the law have been met.
1862 (3) The certificate of authority shall specify any limits imposed by the commissioner upon
1863 the organization's business or methods of operation, including the general types of health care
1864 services the organization is authorized to provide.
1865 (4) Upon the issuance of the certificate of authority:
1866 (a) the board shall authorize and direct the issuance of certificates for shares, bonds, or
1867 notes subscribed to under the organization permit, and of insurance policies upon qualifying
1868 applications obtained under the organization permit; and
1869 (b) the commissioner shall authorize the release to the organization of all funds held in
1870 escrow under Section 31A-5-208, as adopted by Section 31A-8-206.
1871 (5) (a) An organization may at any time apply to the commissioner for a new or amended
1872 certificate of authority altering the limits on its business or methods of operation. The application
1873 shall contain or be accompanied by that information reasonably required by the commissioner
1874 under Subsections 31A-5-204(2) and 31A-8-205(2). The commissioner shall issue the new
1875 certificate as requested if [~~he~~] the commissioner finds that the organization continues to satisfy the
1876 requirements specified under Subsection (2).
1877 (b) If the commissioner issues a summary order under Section 31A-27-201 against an
1878 organization, [~~he~~] the commissioner may also revoke the organization's certificate and issue a new
1879 one with any limitation he considers necessary.
1880 Section 21. Section **31A-8-402** is amended to read:
1881 **31A-8-402. Contract cancellation or nonrenewal.**
1882 (1) An enrollee may not be cancelled or nonrenewed except for:
1883 [~~(a) failure to pay the charge for the enrollment or coverage;~~]
1884 [~~(b) violation of reasonable, published policies of the organization;~~]
1885 [~~(c) unreasonable refusal to comply with care or treatment prescribed by the health care~~

1886 personnel of the organization; or]
1887 [(d) such other reasons as the commissioner may specify by rule.]
1888 (a) nonpayment of a premium or contribution;
1889 (b) a fraudulent act committed by the plan sponsor;
1890 (c) a violation of participation or contribution rules;
1891 (d) termination of the plan where the issuer is ceasing to offer coverage in the market
1892 according to:
1893 (i) regulations required under the Health Insurance Portability and Accountability Act of
1894 1996 42 U.S.C. 1301, et seq.; and
1895 (ii) Subsections 31A-2-201(3), 31A-4-115(8), and 31A-30-106(1)(k); or
1896 (e) the enrollee moving to outside of the service area.
1897 (2) Every organization authorized under this chapter shall provide its enrollees an
1898 opportunity, at least once each year, to:
1899 (a) enroll again with the organization; or
1900 (b) choose another source through which they may secure health care services or benefits.
1901 (3) This section does not prohibit reasonable underwriting classifications for the purpose
1902 of establishing rates nor does it prohibit experience rating.
1903 (4) (a) The requirement in [Part VII of] Chapter 22, Part VII, Group Accident and Health
1904 Insurance, that a conversion policy be available for certain persons who are no longer entitled to
1905 group coverage does not require an organization to provide a conversion policy to a person
1906 residing outside of the organization's service area.
1907 (b) The commissioner may, by rule or order, define the scope of an organization's service
1908 area.
1909 Section 22. Section **31A-8-407** is amended to read:
1910 **31A-8-407. Written contracts -- Limited liability of enrollee.**
1911 (1) (a) Every contract between [a health maintenance] an organization and a participating
1912 provider of health care services shall be in writing and shall set forth that [in the event the health
1913 maintenance] if the organization:
1914 (i) fails to pay for health care services as set forth in the contract, the enrollee [shall] may
1915 not be liable to the provider for any sums owed by the [health maintenance] organization[.]; and
1916 (ii) the organization becomes insolvent, the rehabilitator or liquidator may require the

1917 participating provider of health care services to:
1918 (A) continue to provide health care services under the contract between the participating
1919 provider and the organization until the later of:
1920 (I) 90 days from the date of the filing of a petition for rehabilitation or the petition for
1921 liquidation; or
1922 (II) the date the term of the contract ends; and
1923 (B) subject to Subsection (1)(c), reduce the fees the participating provider is otherwise
1924 entitled to receive from the organization under the contract between the participating provider and
1925 the organization during the time period described in Subsection (1)(b)(i).
1926 (b) If the conditions of Subsection (1)(a)(ii)(b) are met, the participating provider shall:
1927 (i) accept the reduced payment as payment in full; and
1928 (ii) relinquish the right to collect additional amounts from the insolvent organization's
1929 enrollee.
1930 (c) Notwithstanding Subsection (1)(a)(ii)(b):
1931 (i) the rehabilitator or liquidator may not reduce a fee to less than 75% of the regular fee
1932 set forth in the participating provider contract; and
1933 (ii) the enrollee shall continue to pay the same copayments, deductibles, and other
1934 payments for services received from the participating provider that the enrollee was required to pay
1935 before the filing of:
1936 (A) the petition for reorganization; or
1937 (B) the petition for liquidation.
1938 (2) [In the event that the participating provider contract has not been reduced to writing
1939 as required by Subsection (1) or that the contract fails to contain the required prohibition, the] A
1940 participating provider [shall] may not collect or attempt to collect from the enrollee sums owed
1941 by the [health maintenance] organization or the amount of the regular fee reduction authorized
1942 under Subsection (1)(a)(ii) if the participating provider contract:
1943 (a) is not in writing as required in Subsection (1); or
1944 (b) fails to contain the language required by Subsection (1).
1945 (3) (a) [No participating provider, or agent, trustee, or assignee thereof] A person listed
1946 in Subsection (3)(b) may not bill or maintain any action at law against an enrollee to collect:
1947 (i) sums owed by the [health maintenance] organization[.]; or

1948 (ii) the amount of the regular fee reduction authorized under Subsection (1)(a)(ii).
1949 (b) Subsection (3)(a) applies to:
1950 (i) a participating provider;
1951 (ii) an agent;
1952 (iii) a trustee; or
1953 (iv) an assignee of a person described in Subsections (3)(b)(i) through (iii).
1954 Section 23. Section **31A-8-408** is amended to read:
1955 **31A-8-408. Organizations offering point of service products.**
1956 Effective July 1, 1991, a health maintenance [~~organizations~~] organization offering products
1957 that permit members the option of obtaining covered services from a noncontracted provider,
1958 which is a point of service or [~~POS~~] point of sale product, shall comply with the [~~following~~]
1959 requirements[~~:~~] of Subsections (1) through (7).
1960 (1) The cost of an encounter with a noncontracted provider is considered an uncovered
1961 expenditure as defined in Section 31A-8-101 [~~for purposes of Section 31A-8-210~~].
1962 (2) Any organization offering to sell point of service products shall report the number of
1963 encounters with contracted and noncontracted providers to the commissioner on a monthly basis.
1964 The commissioner shall define the form, content, and due date of the report and shall require
1965 audited reports of the information on a yearly basis.
1966 (3) An organization may not offer point of service products unless it has secured contracts
1967 with participating providers located within the organization's service area for each covered service
1968 other than those unusual or infrequently used health services that are not available from the
1969 organization's health care providers.
1970 (4) An organization may not enroll members who do not work or reside in the service area
1971 as defined by rule, except this Subsection (4) does not apply to dependents of enrollees.
1972 (5) Any organization [~~which~~] that exceeds the 10% limit of unusual or infrequently used
1973 health services as defined in Section 31A-8-101 is subject to a forfeiture of up to $50 per
1974 encounter.
1975 (6) [~~Organizations~~] An organization shall disclose to employees and members the
1976 existence of the 10% limit at or prior to enrollment.
1977 (7) The commissioner shall hold hearings and adopt rules providing any additional
1978 limitations or requirements necessary to secure the public interest in conformity with this section.

1979 Section 24. Section **31A-9-212 (Effective 04/30/01)** is amended to read:

1980 **31A-9-212 (Effective 04/30/01). Separate accounts and subsidiaries.**

1981 (1) Except as provided in Subsections (2) and (3), Sections 31A-5-217 and 31A-5-218
1982 apply to separate accounts and subsidiaries of fraternals. If a fraternal issues contracts on a variable
1983 basis, Subsections 31A-22-902(2) and (6) and 31A-9-209(2) do not apply, except that Subsection
1984 31A-9-209(2) applies to any benefits contained in the variable contracts which are fixed or
1985 guaranteed dollar amounts.

1986 (2) If a fraternal engages in any insurance business other than life, [~~disability~~] accident
1987 and health, annuities, property, or liability insurance, it shall do so through a subsidiary under
1988 Section 31A-5-218.

1989 (3) (a) A local lodge may incorporate under Title 16, Chapter 6a, Utah Revised Nonprofit
1990 Corporation Act, or the corresponding law of the state where it is located, to carry out the
1991 noninsurance activities of the local lodge.

1992 (b) Corporations may be formed under Title 16, Chapter 6a, Utah Revised Nonprofit
1993 Corporation Act, to implement Subsection 31A-9-602(2).

1994 Section 25. Section **31A-11-102** is amended to read:

1995 **31A-11-102. Activities of motor clubs.**

1996 (1) Motor clubs authorized under this chapter may provide or arrange for the following
1997 services:

1998 (a) service as agent or broker in obtaining insurance coverage from authorized insurers,
1999 subject to Chapter 23;

2000 (b) provision of, or payment for, legal services and costs in the defense of traffic offenses
2001 or other legal problems connected with the ownership or use of a motor vehicle, provided the
2002 maximum amount payable for any one incident is not more than 100 times the [~~the~~] annual charge
2003 for the motor club contract;

2004 (c) guaranteed arrest bond certificates and cash bond guarantees as specified under Section
2005 31A-11-112;

2006 (d) payment of specified expenses resulting from an automobile accident, other than
2007 expenses for personal injury or for damage to an automobile, provided the maximum amount
2008 payable for any one accident is not more than 100 times the annual charge for the motor club
2009 contract;

2010 (e) towing and emergency road services and theft services; and
2011 (f) any services relating to travel not involving the transfer and distribution of risk.
2012 (2) Unless they are also insurers under Chapter 5 or 14, motor clubs may not provide any
2013 liability or physical damage insurance or insurance of life or [disability] accident and health,
2014 whether or not related to motor vehicles.
2015 (3) If a motor club is a separate division of a corporation, the activities of the other
2016 divisions of the corporation are not limited by this section, if the motor club division complies with
2017 Subsection 31A-11-106(3).
2018 Section 26. Section **31A-14-201** is amended to read:
2019 **31A-14-201. Application.**
2020 [Any] (1) (a) An incorporated person, other than a foreign health maintenance
2021 organization[, including the United States branch of an alien insurer], authorized as an insurer in
2022 another jurisdiction in the United States may apply under this section for a certificate of authority
2023 as an insurer in this state. [This insurer]
2024 (b) An alien insurer that is incorporated may apply under this section for a certificate of
2025 authority as an insurer in this state.
2026 (2) An applicant for a certificate of authority under this section shall:
2027 (a) use the forms prescribed by the commissioner[. The applicant shall]; and
2028 (b) provide the information and documents the commissioner requests, including the
2029 following[, unless the commissioner excludes any of them because they will not be helpful in
2030 making the decision of whether to issue a certificate of authority]:
2031 [(1)] (i) a copy of the applicant's articles and bylaws;
2032 [(2)] (ii) financial statements for the most recent complete fiscal year, with an explanation
2033 of the bases of all valuations and computations, in the detail reasonably required by the
2034 commissioner;
2035 [(3)] (iii) a summary, as detailed as the commissioner reasonably requires, of the
2036 applicant's financial history for:
2037 (A) the preceding ten years[,]; or [for]
2038 (B) the entire period of the applicant's existence if less than ten years;
2039 [(4)] (iv) [the names of the] for each of the applicant's current or proposed directors and
2040 principal officers [and their addresses and occupations]:

2041 (A) the name of the director or principal officer;
2042 (B) the address of the director or principal officer; and
2043 (C) the occupation for the preceding ten years of the director or principal officer;
2044 [~~(5)~~] (v) for an alien insurer[~~,~~]:
2045 (A) the name of its United States manager, the manager's addresses and occupations for
2046 the preceding ten years; and
2047 (B) if the manager is a corporation, the names, addresses, and occupations of its directors
2048 and principal officers, and its most recent detailed financial statements;
2049 [~~(6)~~] (vi) a schedule listing:
2050 [~~(a)~~] (A) all jurisdictions in which applicant has done or has been authorized to conduct
2051 an insurance business during the preceding ten years;
2052 [~~(b)~~] (B) all jurisdictions in which the applicant has applied for authorization to conduct
2053 an insurance business during the preceding ten years, and the dates and results of those
2054 applications;
2055 [~~(c)~~] (C) all jurisdictions from which the applicant has withdrawn from conducting an
2056 insurance business during the preceding ten years, and the reasons for its withdrawals; and
2057 [~~(d)~~] (D) the name of and the circumstances surrounding any officer, director, or
2058 controlling shareholder of the corporation ever being subject to a:
2059 [~~(i)~~] (I) felony indictment or conviction; or
2060 [~~(ii)~~] (II) civil, criminal, or administrative action alleging fraud;
2061 [~~(7)~~] (vii) a summary description of the applicant's present business operations, including
2062 the coverages written and the states and countries in which it does business;
2063 [~~(8)~~] (viii) a list of any statements, reports, or other documents that have, within the last
2064 five years, been generally transmitted or distributed to or among the insurer's creditors,
2065 shareholders, members, subscribers, or policyholders;
2066 [~~(9)~~] (ix) if the applicant has been in the insurance business for less than ten years, a
2067 summary of the past and a projection of the anticipated operating results at the end of each year
2068 of the first ten years of operation, based, where known, on actual data and otherwise on reasonable
2069 assumptions of loss experience, premium and other income, operating expenses, and acquisition
2070 costs;
2071 [~~(10)~~] (x) a statement that organizational and promotional expenses have been paid, and

2072 that organizational procedures required by the insurer's domiciliary authority are complete;
2073 [(11)] (xi) a statement from the domiciliary regulatory authority and the state of entry into
2074 the United States, if any, that so far as known, the applicant is sound and there are no legitimate
2075 objections to its proposed operations in this state;
2076 [(12)] (xii) the plan for conducting an insurance business in this state, including:
2077 [(a)] (A) the geographical area where business is to be conducted;
2078 [(b)] (B) the types of insurance to be written;
2079 [(c)] (C) the proposed general marketing methods;
2080 [(d)] (D) the proposed method for establishing premium rates; and
2081 [(e)] (E) copies of the policy and application forms to be used in this state;
2082 [(13)] (xiii) any other information the commissioner reasonably requires;
2083 [(14)] (xiv) authorization to the commissioner to make inquiry of any person about the
2084 applicant, its manager under a management contract, its attorney in fact, its general agents, and any
2085 of the officers, directors, or shareholders of any of them designated by the commissioner; and
2086 [(15)] (xv) written agreement by the applicant and any other designated persons that in the
2087 absence of actual malice, no communication made in response to any inquiry under Subsection
2088 [(14)] (2)(xiv) will subject the person making it to an action for damages for defamation brought
2089 by the applicant, the designated person, or a legal representative of either.
2090 (3) No action for damages for defamation lies even in the absence of this agreement.
2091 (4) Notwithstanding Subsection (2), the commissioner may exempt an applicant for a
2092 certificate of authority from providing the information described in Subsection (2) if the
2093 commissioner finds that the information will not be helpful in making the decision of whether to
2094 issue a certificate of authority.
2095 Section 27. Section **31A-14-212** is amended to read:
2096 **31A-14-212. Changes in business plan.**
2097 (1) Within two years after the initial issuance of a certificate of authority to a foreign
2098 insurer by its domiciliary jurisdiction, the insurer may not substantially deviate from its business
2099 plan under Subsection 31A-14-201 [(12)] (2)(xii) unless notice of the proposed action is filed with
2100 the commissioner 30 days in advance of the proposed effective date.
2101 (2) If the commissioner believes that the change proposed under Subsection (1) would be
2102 contrary to Utah law or to the interests of insureds, creditors, or the public, he may prohibit the

2103 application of the change to Utah. In his prohibitory order he shall explain why he has prohibited
2104 the change.
2105 (3) If the commissioner finds after a hearing that the application of the proposed change
2106 outside Utah would endanger the interests of insureds, creditors, or the public in Utah, the
2107 commissioner may revoke the insurer's certificate of authority unless the insurer agrees not to make
2108 the change.
2109 Section 28. Section **31A-15-103** is amended to read:
2110 **31A-15-103. Surplus lines insurance -- Unauthorized insurers.**
2111 (1) Notwithstanding Section 31A-15-102, a foreign insurer that has not obtained a
2112 certificate of authority to do business in this state under Section 31A-14-202 may negotiate for and
2113 make insurance contracts with persons in this state and on risks located in this state, subject to the
2114 limitations and requirements of this section.
2115 (2) For contracts made under this section, the insurer may, in this state, inspect the risks
2116 to be insured, collect premiums and adjust losses, and do all other acts reasonably incidental to the
2117 contract, through employees or through independent contractors.
2118 (3) (a) Subsections (1) and (2) do not permit any person to solicit business in this state on
2119 behalf of an insurer that has no certificate of authority.
2120 (b) Any insurance placed with a nonadmitted insurer shall be placed with a surplus lines
2121 broker licensed under Chapter 23.
2122 (c) The commissioner may by rule prescribe how a surplus lines broker may:
2123 (i) pay or permit the payment, commission, or other remuneration on insurance placed by
2124 the surplus lines broker under authority of the surplus lines broker's license to one holding a license
2125 to act as an insurance agent; and
2126 (ii) advertise the availability of the surplus lines broker's services in procuring, on behalf
2127 of persons seeking insurance, contracts with nonadmitted insurers.
2128 (4) For contracts made under this section, nonadmitted insurers are subject to Sections
2129 31A-23-302 and 31A-26-303 and the rules adopted under those sections.
2130 (5) A nonadmitted insurer may not issue workers' compensation insurance coverage to
2131 employers located in this state, except for stop loss coverages issued to employers securing
2132 workers' compensation under Subsection 34A-2-201(3).
2133 (6) (a) The commissioner may by rule prohibit making contracts under Subsection (1) for

2134 a specified class of insurance if authorized insurers provide an established market for the class in
2135 this state that is adequate and reasonably competitive.
2136 (b) The commissioner may by rule place restrictions and limitations on and create special
2137 procedures for making contracts under Subsection (1) for a specified class of insurance if there
2138 have been abuses of placements in the class or if the policyholders in the class, because of limited
2139 financial resources, business experience, or knowledge, cannot protect their own interests
2140 adequately.
2141 (c) The commissioner may prohibit an individual insurer from making any contract under
2142 Subsection (1) and all insurance agents and brokers from dealing with the insurer if:
2143 (i) the insurer has willfully violated this section, Section 31A-4-102, 31A-23-302, or
2144 31A-26-303, or any rule adopted under any of these sections;
2145 (ii) the insurer has failed to pay the fees and taxes specified under Section 31A-3-301; or
2146 (iii) the commissioner has reason to believe that the insurer is in an unsound condition or
2147 is operated in a fraudulent, dishonest, or incompetent manner or in violation of the law of its
2148 domicile.
2149 (d) (i) The commissioner may issue lists of unauthorized foreign insurers whose solidity
2150 the commissioner doubts, or whose practices the commissioner considers objectionable.
2151 (ii) The commissioner shall issue lists of unauthorized foreign insurers the commissioner
2152 considers to be reliable and solid. [~~The~~]
2153 (iii) In addition to the lists described in Subsections (7)(d)(i) and (ii), the commissioner
2154 may [~~also~~] issue other relevant evaluations of unauthorized insurers. [~~No~~]
2155 (iv) An action [~~lies~~] may not lie against the commissioner or any employee of the
2156 department for any written or oral communication made in, or in connection with the issuance of,
2157 [~~these~~] the lists or evaluations described in this Subsection (6)(d).
2158 (e) A foreign unauthorized insurer shall be listed on the commissioner's "reliable" list only
2159 if the unauthorized insurer:
2160 (i) has delivered a request to the commissioner to be on the list;
2161 (ii) has established satisfactory evidence of good reputation and financial integrity;
2162 (iii) has delivered to the commissioner a copy of its current annual statement certified by
2163 the insurer and continues each subsequent year to file its annual statements with the commissioner
2164 within 60 days of its filing with the insurance regulatory authority where it is domiciled; [~~and~~]

2165 (iv) (A) is in substantial compliance with the solvency standards in Chapter 17, Part VI,
2166 Risk-Based Capital, or maintains capital and surplus of at least [~~$5,000,000~~] $15,000,000,
2167 whichever is greater, and maintains in the United States an irrevocable trust fund in either a
2168 national bank or a member of the Federal Reserve System, or maintains a deposit meeting the
2169 statutory deposit requirements for insurers in the state where it is made, which trust fund or
2170 deposit:
2171 (I) shall be in an amount not less than [~~$1,500,000~~] $2,500,000 for the protection of all of
2172 the insurer's policyholders in the United States;
2173 (II) may consist of cash, securities, or investments of substantially the same character and
2174 quality as those which are "qualified assets" under Section 31A-17-201; and
2175 (III) may include as part of the trust arrangement a letter of credit that qualifies as
2176 acceptable security under Subsection 31A-17-404(3)(c)(iii); or
2177 (B) in the case of any "Lloyd's" or other similar incorporated or unincorporated group of
2178 alien individual insurers, maintains a trust fund that:
2179 (I) shall be in an amount not less than $50,000,000 as security to its full amount for all
2180 policyholders and creditors in the United States of each member of the group;
2181 (II) may consist of cash, securities, or investments of substantially the same character and
2182 quality as those which are "qualified assets" under Section 31A-17-201; and
2183 (III) may include as part of this trust arrangement a letter of credit that qualifies as
2184 acceptable security under Subsection 31A-17-404(3)(c)(iii)[~~.~~]; and
2185 (v) for an alien insurer not domiciled in the United States or a territory of the United
2186 States, is listed on the Quarterly Listing of Alien Insurers maintained by the National Association
2187 of Insurance Commissions International Insurers Department.
2188 (7) A surplus lines broker may not, either knowingly or without reasonable investigation
2189 of the financial condition and general reputation of the insurer, place insurance under this section
2190 with financially unsound insurers or with insurers engaging in unfair practices, or with otherwise
2191 substandard insurers, unless the broker gives the applicant notice in writing of the known
2192 deficiencies of the insurer or the limitations on his investigation, and explains the need to place
2193 the business with that insurer. A copy of this notice shall be kept in the office of the broker for at
2194 least five years. To be financially sound, an insurer shall satisfy standards that are comparable to
2195 those applied under the laws of this state to authorized insurers. Insurers on the "doubtful or

2196 objectionable" list under Subsection (6)(d) and insurers not on the commissioner's "reliable" list
2197 under Subsection (6)[(d)](e) are presumed substandard.
2198 (8) A policy issued under this section shall include a description of the subject of the
2199 insurance and indicate the coverage, conditions, and term of the insurance, the premium charged
2200 and premium taxes to be collected from the policyholder, and the name and address of the
2201 policyholder and insurer. If the direct risk is assumed by more than one insurer, the policy shall
2202 state the names and addresses of all insurers and the portion of the entire direct risk each has
2203 assumed. All policies issued under the authority of this section shall have attached or affixed to
2204 the policy the following statement: "The insurer issuing this policy does not hold a certificate of
2205 authority to do business in this state and thus is not fully subject to regulation by the Utah
2206 insurance commissioner. This policy receives no protection from any of the guaranty associations
2207 created under Title 31A, Chapter 28."
2208 (9) Upon placing a new or renewal coverage under this section, the broker shall promptly
2209 deliver to the policyholder or his agent evidence of the insurance consisting either of the policy as
2210 issued by the insurer or, if the policy is not then available, a certificate, cover note, or other
2211 confirmation of insurance complying with Subsection (8).
2212 (10) If the commissioner finds it necessary to protect the interests of insureds and the
2213 public in this state, the commissioner may by rule subject policies issued under this section to as
2214 much of the regulation provided by this title as is required for comparable policies written by
2215 authorized foreign insurers.
2216 (11) (a) Each surplus lines transaction in this state shall be examined to determine whether
2217 it complies with:
2218 (i) the surplus lines tax levied under Chapter 3;
2219 (ii) the solicitation limitations of Subsection (3);
2220 (iii) the requirement of Subsection (3) that placement be through a surplus lines broker;
2221 (iv) placement limitations imposed under Subsections (6)(a), (b), and (c); and
2222 (v) the policy form requirements of Subsections (8) and (10).
2223 (b) The examination described in Subsection (11)(a) shall take place as soon as practicable
2224 after the transaction. The surplus lines broker shall submit to the examiner information necessary
2225 to conduct the examination within a period specified by rule.
2226 (c) The examination described in Subsection (11)(a) may be conducted by the

2227 commissioner or by an advisory organization created under Section 31A-15-111 and authorized
2228 by the commissioner to conduct these examinations. The commissioner is not required to
2229 authorize any additional advisory organizations to conduct examinations under this Subsection
2230 (11)(c). The commissioner's authorization of one or more advisory organizations to act as
2231 examiners under this subsection shall be by rule. In addition, the authorization shall be evidenced
2232 by a contract, on a form provided by the commissioner, between the authorized advisory
2233 organization and the department.

2234 (d) The person conducting the examination described in Subsection (11)(a) shall collect
2235 a stamping fee of an amount not to exceed 1% of the policy premium payable in connection with
2236 the transaction. Stamping fees collected by the commissioner shall be deposited in the General
2237 Fund. The commissioner shall establish this fee by rule. Stamping fees collected by an advisory
2238 organization are the property of the advisory organization to be used in paying the expenses of the
2239 advisory organization. Liability for paying the stamping fee is as required under Subsection
2240 31A-3-303(1) for taxes imposed under Section 31A-3-301. The commissioner shall adopt a rule
2241 dealing with the payment of stamping fees. If stamping fees are not paid when due, the
2242 commissioner or advisory organization may impose a penalty of 25% of the fee due, plus 1-1/2%
2243 per month from the time of default until full payment of the fee. Fees relative to policies covering
2244 risks located partially in this state shall be allocated in the same manner as under Subsection
2245 31A-3-303(4).

2246 (e) The commissioner, representatives of the department, advisory organizations,
2247 representatives and members of advisory organizations, authorized insurers, and surplus lines
2248 insurers are not liable for damages on account of statements, comments, or recommendations made
2249 in good faith in connection with their duties under this Subsection (11)(e) or under Section
2250 31A-15-111.

2251 (f) Examinations conducted under this Subsection (11) and the documents and materials
2252 related to the examinations are confidential.

2253 Section 29. Section **31A-15-106** is amended to read:

2254 **31A-15-106. Servicing of contracts made out of state.**

2255 (1) A foreign insurer that does not have a certificate of authority to do business in this state
2256 under Section 31A-14-202 may, in this state, collect premiums and adjust losses and do all other
2257 acts reasonably incidental to contracts made outside this state without violating this chapter. Any

2258 premiums collected under this section are subject to Section 31A-3-301.

2259 (2) Subsection (1) does not permit a renewal, extension, increase, or other substantial
2260 change in the terms of any contract under Subsection (1) unless:

2261 (a) it is permitted under Section 31A-15-103;

2262 (b) the contract is for life or [~~disability~~] accident and health insurance or annuities; or

2263 (c) a rule adopted by the commissioner permits this action when the interests of the
2264 policyholder and the public appear to be sufficiently protected.

2265 Section 30. Section **31A-17-201** is amended to read:

2266 **31A-17-201. Qualified assets.**

2267 (1) Except as provided under Subsections (3) and (4), only the qualified assets listed in
2268 Subsection (2) may be used in determining the financial condition of an insurer, except to the
2269 extent an insurer has shown to the commissioner that the insurer has excess surplus, as defined in
2270 Section 31A-1-301.

2271 (2) For purposes of Subsection (1), "qualified assets" means:

2272 [~~(a) investments, securities, properties, and loans acquired or held in accordance with~~
2273 ~~Sections 31A-18-105 and 31A-18-106, and the income due and accrued on these;~~]

2274 [~~(b) the net amount of uncollected and deferred premiums for a life insurer that carries the~~
2275 ~~full annual mean tabular reserve liability;~~]

2276 [~~(c) premiums in the course of collection, other than for life insurance, not more than 90~~
2277 ~~days past due, less commissions payable on the premiums, with the 90-day limitation being~~
2278 ~~inapplicable to premiums payable directly or indirectly by the United States government or any of~~
2279 ~~its instrumentalities;~~]

2280 [~~(d) installment premiums, other than life insurance premiums, in accordance with:~~]

2281 [~~(i) the rules adopted by the commissioner; or~~]

2282 [~~(ii) in the absence of rules adopted by the commissioner, practices formulated or adopted~~
2283 ~~by the National Association of Insurance Commissioners;~~]

2284 [~~(e) notes and similar written obligations that are:~~]

2285 [~~(i) not past due;~~]

2286 [~~(ii) taken for premiums other than life insurance premiums;~~]

2287 [~~(iii) on policies permitted to be issued on that basis; and~~]

2288 [~~(iv) to the extent of the unearned premium reserves carried on the policies;~~]

2289 [(f) amounts recoverable or receivable from reinsurers under a reinsurance contract that
2290 qualifies for reserve credit under Section 31A-17-404;]
2291 [(g) electronic and mechanical machines constituting a data processing and accounting
2292 system, the cost of which is depreciated in full over a period of five years or less;]
2293 [(h) tangible components of the health care delivery systems of insurers licensed under
2294 Chapter 7, with the cost of these assets having a finite useful life being depreciated in full over
2295 periods provided by rule;]
2296 [(i) cash or currency; and]
2297 (a) assets as determined to be admitted in the Accounting Practices and Procedures
2298 Manual, published by the National Association of Insurance Commissioners; and
2299 [(j)] (b) other assets authorized by rule.
2300 (3) (a) Subject to Subsection (5) and even if they could not otherwise be counted under this
2301 chapter, assets acquired in the bona fide enforcement of creditors' rights may be counted for the
2302 purposes of Subsection (1) and Sections 31A-18-105 and 31A-18-106:
2303 (i) for five years after their acquisition if they are real property; and
2304 (ii) for one year if they are not real property.
2305 (b) (i) The commissioner may allow reasonable extensions of the periods described in
2306 Subsection (3)(a), if disposal of the assets within the periods given is not possible without
2307 substantial loss.
2308 (ii) Extensions under Subsection (3)(b)(i) may not, as to any particular asset, exceed a total
2309 of five years.
2310 (4) Subject to Subsection (5), and even though under this chapter the assets could not
2311 otherwise be counted, assets acquired in connection with mergers, consolidations, or bulk
2312 reinsurance, or as a dividend or distribution of assets, may be counted for the same purposes, in
2313 the same manner, and for the same periods as assets acquired under Subsection (3).
2314 (5) Assets described under Subsection (3) or (4) may not be counted for the purposes of
2315 Subsection (1), except to the extent they are counted as assets in determining insurer solvency
2316 under the laws of the state of domicile of the creditor or acquired insurer.
2317 Section 31. Section **31A-17-401** is amended to read:
2318 **31A-17-401. Valuation of assets.**
2319 (1) The commissioner shall value the assets of insurers in accordance with then current

2320 insurance business practices, but not in a manner inconsistent with the provisions of this title. In
2321 valuing assets, the commissioner shall consider any method then current, formulated, or approved
2322 by the National Association of Insurance Commissioners.
2323 (2) Assets that are not qualified assets under Subsection 31A-17-201(2) are considered to
2324 have no value in evaluating an insurer's compliance with Chapter 17, Part 6, Risk-Based Capital.
2325 Those assets may be used in evaluating the insurer's financial condition only to the extent the
2326 insurer has excess surplus.
2327 (3) (a) Insurance subsidiaries are valued on the books of a parent insurer as follows:
2328 (i) Except as provided under Subsections (3)(a)(iii) [~~through (vi)~~] and (iv), common stock
2329 of the subsidiary is valued on the basis of the parent insurer's percentage of ownership of the
2330 common stock multiplied by the total of the subsidiary's capital and surplus, less amounts needed
2331 to liquidate all claims to the capital and surplus which are senior to common stock. Subsection
2332 31A-18-106(1)(k) provides applicable limitations on investments in subsidiaries.
2333 (ii) The value of securities other than common stock issued by a subsidiary is the lesser
2334 of the present value of the future income to be derived under the securities or the amount the parent
2335 insurer would receive as a result of the securities if the subsidiary were liquidated and all creditors
2336 of the subsidiary and holders of the subsidiary's securities with senior priority were paid in full.
2337 The present value of future income derived from securities is determined by rule adopted by the
2338 commissioner. A parent insurer may attribute value to a security of its subsidiary only if the parent
2339 insurer is being paid dividends or interest on the security, and only if the parent insurer can
2340 reasonably anticipate that dividends or interest will continue to be paid on the security.
2341 (iii) Except as provided under [~~Subsections (3)(a)(iv) through (vi)~~] Subsection (3)(iv), any
2342 portion of the subsidiary's value permitted under Subsection (3)(a) that is represented by assets
2343 other than assets listed under Section 31A-17-201, may only be classified as excess surplus of the
2344 parent insurer, and then only to the extent the parent insurer has established that it has excess
2345 surplus under Section 31A-17-202.
2346 (iv) For the purposes of Subsection (3)(a)(iii), assets of a newly acquired subsidiary that
2347 are the equivalent of qualified assets in the subsidiary's domiciliary state, are, for the first five years
2348 after the subsidiary's acquisition, considered to be qualified assets under Section 31A-17-201. This
2349 assumption stands even if the assets are not otherwise qualified assets under Section 31A-17-201.
2350 [~~(v) Under a plan of merger approved by the commissioner, a newly-acquired insurance~~

2351 ~~subsidiary may be valued initially at its cost to the parent insurer, or a greater or lesser value~~
2352 ~~established by the commissioner. The amount in excess of the parent insurer's proportionate share~~
2353 ~~of the subsidiary's capital and surplus shall be written off for regulatory purposes over a period~~
2354 ~~specified by the commissioner in the commissioner's order approving the plan of merger. This~~
2355 ~~period may not exceed five years. Once they are established by the commissioner, any amounts~~
2356 ~~not yet written off may be counted as assets for the purposes specified under Chapter 17, Part 6,~~
2357 ~~Risk-Based Capital.~~]

2358 [~~(vi) Subject to Subsection 31A-18-106(1)(k), an insurance subsidiary that is acquired by~~
2359 ~~another insurer, but not under an approved plan of merger, may be valued initially at the lesser of~~
2360 ~~its cost to the parent insurer, or the parent insurer's proportionate share of the subsidiary's capital~~
2361 ~~and surplus plus 10% of the parent insurer's capital and surplus. The amount in excess of the~~
2362 ~~parent insurer's proportionate share of the subsidiary's capital and surplus shall be written off for~~
2363 ~~regulatory purposes over a period specified by the commissioner in an order approving the~~
2364 ~~acquisition. This period may not exceed ten years.~~]

2365 [~~(vii) For subsidiaries valued under Subsection (3)(a)(v) or (3)(a)(vi), until the excess of~~
2366 ~~the subsidiary's cost over the parent insurer's proportionate share of the subsidiary's capital and~~
2367 ~~surplus is completely amortized, the commissioner shall semiannually review the actual~~
2368 ~~performance of the subsidiary to determine whether the amortization schedule provided by the~~
2369 ~~commissioner's order is reasonable, based on the subsidiary's actual performance. The~~
2370 ~~commissioner may adjust the amortization schedule based on the findings of this semiannual~~
2371 ~~review.~~]

2372 (b) A subsidiary formed or acquired to hold or manage investments that the parent
2373 insurance company might hold or manage directly, shall be valued as if the assets of the subsidiary
2374 were owned directly by the insurer in a percentage equal to the insurer's percentage of ownership
2375 of the subsidiary. The subsidiary investment limitation of Subsection 31A-18-106(1)(k) does not
2376 apply to these subsidiaries.

2377 (c) Subsidiaries other than those described in Subsections (3)(a) and (b) shall be valued
2378 in accordance with Subsection (1). The subsidiary investment limitation under Subsection
2379 31A-18-106(1)(k) applies to these subsidiaries in the same manner as to subsidiaries described in
2380 Subsection (3)(a).

2381 (d) In determining an insurer's financial condition, no value is given to:

2382 (i) any interest held by the insurer in its own stock, including debts due the insurer that are
2383 secured by the insurer's own stock; or
2384 (ii) any proportionate interest in the insurer's own stock, including debts that are secured
2385 by the insurer's own stock, which is held by any corporation, partnership, business unit, firm, or
2386 person owned in whole or in part by the insurer.
2387 (4) The commissioner shall adopt rules to implement the provisions of this section.
2388 Section 32. Section **31A-17-402** is amended to read:
2389 **31A-17-402. Valuation of liabilities.**
2390 The commissioner shall adopt rules specifying the liabilities required to be reported by
2391 insurers in financial statements submitted under Section 31A-2-202 and the methods of valuing
2392 them. For life insurance, those methods shall be consistent with Part 5 of this chapter, Standard
2393 Valuation Law. Title insurance reserves are provided for under Section 31A-17-408. In
2394 determining the financial condition of an insurer, liabilities include:
2395 (l) the estimated amount necessary to pay all its unpaid losses and claims incurred on or
2396 prior to the date of statement, whether reported or unreported, together with the expense of
2397 adjustment or settlement of the loss or claim;
2398 (2) for life, [~~disability~~] accident and health insurance, and annuity contracts:
2399 (a) the reserves on life insurance policies and annuity contracts in force, valued according
2400 to appropriate tables of mortality and the applicable rates of interest;
2401 (b) the reserves for [~~disability~~] accident and health benefits, for both active and disabled
2402 lives;
2403 (c) the reserves for accidental death benefits; and
2404 (d) any additional reserves which may be required by the commissioner by rule, or if no
2405 rule is applicable, then in a manner consistent with the practice formulated or approved by the
2406 National Association of Insurance Commissioners with respect to those types of insurance;
2407 (3) for insurance other than life, [~~disability~~] accident and health, and title insurance, the
2408 amount of reserves equal to the unearned portions of the gross premiums charged on policies in
2409 force, computed on a daily or monthly pro rata basis or other basis approved by the commissioner;
2410 provided that after adopting any one of the methods for computing those reserves, an insurer may
2411 not change methods without the commissioner's written consent;
2412 (4) for ocean marine and other transportation insurance, reserves equal to 50% of the

2413 amount of premiums upon risks covering not more than one trip or passage not terminated, and
2414 computed upon a pro rata basis or, with the commissioner's consent, in accordance with methods
2415 provided under Subsection (3); and
2416 (5) its other liabilities, including taxes, expenses, and other obligations due or accrued at
2417 the date of statement.
2418 Section 33. Section **31A-17-408** is amended to read:
2419 **31A-17-408. Title insurance reserves.**
2420 (1) In addition to an adequate reserve for outstanding losses, a title insurance company
2421 shall either:
2422 (a) maintain and segregate an unearned premium reserve fund of not less than 10 cents for
2423 each $1,000 face amount of retained liability under each title insurance contract or policy on a
2424 single insurance risk issued[~~, except that during each of the 20 years following the year in which~~
2425 ~~the title insurance policy or contract was issued, the reserve applicable to the contract may be~~
2426 ~~reduced by 5% of the original amount of the reserve~~]; or
2427 (b) have the commissioner review and approve a contract of reinsurance applicable to the
2428 title insurance company's policies, which contract adequately covers the exposure or risk which
2429 the unearned premium reserve would serve.
2430 (2) The fund shall be maintained for the protection of policyholders and is not subject to
2431 the claims of stockholders or creditors other than policyholders.
2432 Section 34. Section **31A-17-504** is amended to read:
2433 **31A-17-504. Computation of minimum standard.**
2434 Except as otherwise provided in Sections 31A-17-505, 31A-17-506, and 31A-17-513, the
2435 minimum standard for the valuation of all life insurance policies and annuity and pure endowment
2436 contracts issued prior to January 1, 1994, shall be that provided by the laws in effect immediately
2437 prior to that date. Except as otherwise provided in Sections 31A-17-505, 31A-17-506, and
2438 31A-17-513, the minimum standard for the valuation of all such policies and contracts issued on
2439 or after January 1, 1994, shall be the commissioner's reserve valuation methods defined in Sections
2440 31A-17-507, 31A-17-508, 31A-17-511, and 31A-17-513, 3.5% interest, or in the case of life
2441 insurance policies and contracts, other than annuity and pure endowment contracts, issued on or
2442 after June 1, 1973, 4% interest for such policies issued prior to April 2, 1980, 5.5% interest for
2443 single premium life insurance policies, and 4.5% interest for all other such policies issued on and

2444 after April 2, 1980, and the following tables:
2445 (1) For all ordinary policies of life insurance issued on the standard basis, excluding any
2446 [~~disability~~] accident and health and accidental death benefits in such policies: the National
2447 Association of Insurance Commissioners 1941 Standard Ordinary Mortality Table for such policies
2448 issued prior to the operative date of Subsection 31A-22-408(6)(a) (that is, the Standard
2449 Nonforfeiture Law for Life Insurance), the National Association of Insurance Commissioners 1958
2450 Standard Ordinary Mortality Table for such policies issued on or after the operative date of
2451 Subsection 31A-22-408(6)(a) and prior to the operative date of Subsection 31A-22-408(6)(d),
2452 provided that for any category of such policies issued on female risks, all modified net premiums
2453 and present values referred to in this section may be calculated according to an age not more than
2454 six years younger than the actual age of the insured; and for such policies issued on or after the
2455 operative date of Subsection 31A-22-408(6)(d):
2456 (a) the National Association of Insurance Commissioners 1980 Standard Ordinary
2457 Mortality Table;
2458 (b) at the election of the company for any one or more specified plans of life insurance,
2459 the National Association of Insurance Commissioners 1980 Standard Ordinary Mortality Table
2460 with Ten-Year Select Mortality Factors; or
2461 (c) any ordinary mortality table, adopted after 1980 by the National Association of
2462 Insurance Commissioners, that is approved by rule promulgated by the commissioner for use in
2463 determining the minimum standard of valuation for such policies.
2464 (2) For all industrial life insurance policies issued on the standard basis, excluding any
2465 [~~disability~~] accident and health and accidental death benefits in such policies: the 1941 Standard
2466 Industrial Mortality Table for such policies issued prior to the operative date of Subsection
2467 31A-22-408(6)(c), and for such policies issued on or after such operative date, the National
2468 Association of Insurance Commissioners 1961 Standard Industrial Mortality Table or any
2469 industrial mortality table, adopted after 1980 by the National Association of Insurance
2470 Commissioners, that is approved by rule promulgated by the commissioner for use in determining
2471 the minimum standard of valuation for such policies.
2472 (3) For individual annuity and pure endowment contracts, excluding any disability and
2473 accidental death benefits in such policies:
2474 (a) the 1937 Standard Annuity Mortality Table[~~, or~~];

2475 (b) at the option of the company, the Annuity Mortality Table for 1949, Ultimate[,]; or
2476 (c) any modification of either of these tables approved by the commissioner.
2477 (4) For group annuity and pure endowment contracts, excluding any [~~disability~~] accident
2478 and health and accidental death benefits in such policies:
2479 (a) the Group Annuity Mortality Table for 1951, any modification of such table approved
2480 by the commissioner[,]; or
2481 (b) at the option of the company, any of the tables or modifications of tables specified for
2482 individual annuity and pure endowment contracts.
2483 (5) For total and permanent disability benefits in or supplementary to ordinary policies or
2484 contracts: for policies or contracts issued on or after January 1, 1966, the tables of Period 2
2485 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the
2486 Society of Actuaries, with due regard to the type of benefit or any tables of disablement rates and
2487 termination rates adopted after 1980 by the National Association of Insurance Commissioners, that
2488 are approved by rule promulgated by the commissioner for use in determining the minimum
2489 standard of valuation for such policies; for policies or contracts issued on or after January 1, 1961,
2490 and prior to January 1, 1966, either such tables or, at the option of the company, the Class (3)
2491 Disability Table (1926); and for policies issued prior to January 1, 1961, the Class (3) Disability
2492 Table (1926). Any such table shall, for active lives, be combined with a mortality table permitted
2493 for calculating the reserves for life insurance policies.
2494 (6) For accidental death benefits in or supplementary to policies issued on or after January
2495 1, 1966, the 1959 Accidental Death Benefits Table or any accidental death benefits table adopted
2496 after 1980 by the National Association of Insurance Commissioners, that is approved by rule
2497 promulgated by the commissioner for use in determining the minimum standard of valuation for
2498 such policies, for policies issued on or after January 1, 1961, and prior to January 1, 1966, either
2499 such table or, at the option of the company, the Inter-Company Double Indemnity Mortality Table;
2500 and for policies issued prior to January 1, 1961, the Inter-Company Double Indemnity Mortality
2501 Table. Either table shall be combined with a mortality table for calculating the reserves for life
2502 insurance policies.
2503 (7) For group life insurance, life insurance issued on the substandard basis and other
2504 special benefits: such tables as may be approved by the commissioner.
2505 Section 35. Section **31A-17-505** is amended to read:

2506 **31A-17-505. Computation of minimum standard for annuities.**

2507 (1) Except as provided in Section 31A-17-506, the minimum standard for the valuation
2508 of all individual annuity and pure endowment contracts issued on or after the operative date of this
2509 section, as defined in Subsection (2), and for all annuities and pure endowments purchased on or
2510 after such operative date under group annuity and pure endowment contracts, shall be the
2511 commissioner's reserve valuation methods defined in Sections 31A-17-507 and 31A-17-508 and
2512 the following tables and interest rates:

2513 (a) For individual annuity and pure endowment contracts issued prior to April 2, 1980,
2514 excluding any [~~disability~~] accident and health and accidental death benefits in such contracts: the
2515 1971 Individual Annuity Mortality Table, or any modification of this table approved by the
2516 commissioner, and 6% interest for single premium immediate annuity contracts, and 4% interest
2517 for all other individual annuity and pure endowment contracts.

2518 (b) For individual single premium immediate annuity contracts issued on or after April 2,
2519 1980, excluding any [~~disability~~] accident and health and accidental death benefits in such
2520 contracts: the 1971 Individual Annuity Mortality Table or any individual annuity mortality table,
2521 adopted after 1980 by the National Association of Insurance Commissioners that is approved by
2522 rule promulgated by the commissioner for use in determining the minimum standard of valuation
2523 for such contracts, or any modification of these tables approved by the commissioner, and 7.5%
2524 interest.

2525 (c) For individual annuity and pure endowment contracts issued on or after April 2, 1980,
2526 other than single premium immediate annuity contracts, excluding any [~~disability~~] accident and
2527 health and accidental death benefits in such contracts: the 1971 Individual Annuity Mortality Table
2528 or any individual annuity mortality table adopted after 1980 by the National Association of
2529 Insurance Commissioners, that is approved by rule promulgated by the commissioner for use in
2530 determining the minimum standard of valuation for such contracts, or any modification of these
2531 tables approved by the commissioner, and 5.5% interest for single premium deferred annuity and
2532 pure endowment contracts and 4.5% interest for all other such individual annuity and pure
2533 endowment contracts.

2534 (d) For all annuities and pure endowments purchased prior to April 2, 1980, under group
2535 annuity and pure endowment contracts, excluding any [~~disability~~] accident and health and
2536 accidental death benefits purchased under such contracts: the 1971 Group Annuity Mortality Table

2537 or any modification of this table approved by the commissioner, and 6.5% interest.
2538 (e) For all annuities and pure endowments purchased on or after April 2, 1980, under
2539 group annuity and pure endowment contracts, excluding any [~~disability~~] accident and health and
2540 accidental death benefits purchased under such contracts: the 1971 Group Annuity Mortality Table,
2541 or any group annuity mortality table adopted after 1980 by the National Association of Insurance
2542 Commissioners, that is approved by rule and promulgated by the commissioner for use in
2543 determining the minimum standard of valuation for such annuities and pure endowments, or any
2544 modification of these tables approved by the commissioner, and 7.5% interest.
2545 (2) After June 1, 1973, any company may file with the commissioner a written notice of
2546 its election to comply with the provisions of this section after a specified date before January 1,
2547 1979, which shall be the operative date of this section for such company, provided, if a company
2548 makes no such election, the operative date of this section for such company shall be January 1,
2549 1979.
2550 Section 36. Section **31A-17-507** is amended to read:
2551 **31A-17-507. Reserve valuation method -- Life insurance and endowment benefits.**
2552 (1) Except as otherwise provided in Sections 31A-17-508, 31A-17-511, and 31A-17-513,
2553 reserves according to the commissioner's reserve valuation method, for the life insurance and
2554 endowment benefits of policies providing for a uniform amount of insurance and requiring the
2555 payment of uniform premiums shall be the excess, if any, of the present value, at the date of
2556 valuation, of such future guaranteed benefits provided for by such policies, over the then present
2557 value of any future modified net premiums therefor. The modified net premiums for any such
2558 policy shall be such uniform percentage of the respective contract premiums for such benefits that
2559 the present value, at the date of issue of the policy, of all such modified net premiums shall be
2560 equal to the sum of the then present value of such benefits provided for by the policy and the
2561 excess of Subsection (1)(a) over Subsection (1)(b), as follows:
2562 (a) A net level annual premium equal to the present value, at the date of issue, of such
2563 benefits provided for after the first policy year, divided by the present value, at the date of issue,
2564 of an annuity of one per annum payable on the first and each subsequent anniversary of such policy
2565 on which a premium falls due; provided, however, that such net level annual premium shall not
2566 exceed the net level annual premium on the 19 year premium whole life plan for insurance of the
2567 same amount at an age one year higher than the age at issue of such policy.

2568 (b) A net one year term premium for such benefits provided for in the first policy year.
2569 (2) Provided that for any life insurance policy issued on or after January 1, 1997, for which
2570 the contract premium in the first policy year exceeds that of the second year and for which no
2571 comparable additional benefit is provided in the first year for such excess and which provides an
2572 endowment benefit or a cash surrender value or a combination thereof in an amount greater than
2573 such excess premium, the reserve according to the commissioner's reserve valuation method as of
2574 any policy anniversary occurring on or before the assumed ending date defined herein as the first
2575 policy anniversary on which the sum of any endowment benefit and any cash surrender value then
2576 available is greater than such excess premium shall, except as otherwise provided in Section
2577 31A-17-511, be the greater of the reserve as of such policy anniversary calculated as described in
2578 Subsection (1) and the reserve as of such policy anniversary calculated as described in that
2579 subsection, but with:
2580 (a) the value defined in Subsection (1)(a) being reduced by 15% of the amount of such
2581 excess first year premium[,];
2582 (b) all present values of benefits and premiums being determined without reference to
2583 premiums or benefits provided for by the policy after the assumed ending date[,];
2584 (c) the policy being assumed to mature on such date as an endowment[,]; and
2585 (d) the cash surrender value provided on such date being considered as an endowment
2586 benefit. In making the above comparison the mortality and interest bases stated in Sections
2587 31A-17-504 and 31A-17-506 shall be used.
2588 (3) Reserves according to the commissioner's reserve valuation method for:
2589 (a) life insurance policies providing for a varying amount of insurance or requiring the
2590 payment of varying premiums;
2591 (b) group annuity and pure endowment contracts purchased under a retirement plan or plan
2592 of deferred compensation, established or maintained by an employer, including a partnership or
2593 sole proprietorship, or by an employee organization, or by both, other than a plan providing
2594 individual retirement accounts or individual retirement annuities under [~~26 U.S.C. Sec. 408, as~~
2595 ~~amended~~] Section 408, Internal Revenue Code;
2596 (c) [~~disability~~] accident and health and accidental death benefits in all policies and
2597 contracts; and
2598 (d) all other benefits, except life insurance and endowment benefits in life insurance

2599 policies and benefits provided by all other annuity and pure endowment contracts, shall be
2600 calculated by a method consistent with the principles of Subsections (1) and (2).
2601 Section 37. Section **31A-17-508** is amended to read:
2602 **31A-17-508. Reserve valuation method -- Annuity and pure endowment benefits.**
2603 (1) This section shall apply to all annuity and pure endowment contracts other than group
2604 annuity and pure endowment contracts purchased under a retirement plan or plan of deferred
2605 compensation, established or maintained by an employer, including a partnership or sole
2606 proprietorship, or by an employee organization, or by both, other than a plan providing individual
2607 retirement accounts or individual retirement annuities under [~~26 U.S.C. Sec. 408, as amended~~]
2608 Section 408, Internal Revenue Code.
2609 (2) Reserves according to the commissioner's annuity reserve method for benefits under
2610 annuity or pure endowment contracts, excluding any [~~disability~~] accident and health and accidental
2611 death benefits in such contracts, shall be the greatest of the respective excesses of the present
2612 values, at the date of valuation, of the future guaranteed benefits, including guaranteed
2613 nonforfeiture benefits, provided for by such contracts at the end of each respective contract year,
2614 over the present value, at the date of valuation, of any future valuation considerations derived from
2615 future gross considerations, required by the terms of such contract, that become payable prior to
2616 the end of such respective contract year. The future guaranteed benefits shall be determined by
2617 using the mortality table, if any, and the interest rate, or rates, specified in such contracts for
2618 determining guaranteed benefits. The valuation considerations are the portions of the respective
2619 gross considerations applied under the terms of such contracts to determine nonforfeiture values.
2620 Section 38. Section **31A-17-509** is amended to read:
2621 **31A-17-509. Minimum reserves.**
2622 (1) In no event shall a company's aggregate reserves for all life insurance policies,
2623 excluding [~~disability~~] accident and health and accidental death benefits, issued on or after January
2624 1, 1994, be less than the aggregate reserves calculated in accordance with the methods set forth in
2625 Sections 31A-17-507, 31A-17-508, 31A-17-511, and 31A-17-512 and the mortality table or tables
2626 and rate or rates of interest used in calculating nonforfeiture benefits for such policies.
2627 (2) In no event shall the aggregate reserves for all policies, contracts, and benefits be less
2628 than the aggregate reserves determined by the qualified actuary to be necessary to render the
2629 opinion required by Section 31A-17-503.

2630 Section 39. Section **31A-17-513** is amended to read:

2631 **31A-17-513. Minimum standards for accident and health plans.**

2632 The commissioner shall promulgate a rule containing the minimum standards applicable
2633 to the valuation of [~~disability~~] accident and health plans.

2634 Section 40. Section **31A-17-601** is amended to read:

2635 **31A-17-601. Definitions.**

2636 As used in this part:

2637 (1) "Adjusted RBC report" means an RBC report that has been adjusted by the
2638 commissioner in accordance with Subsection 31A-17-602[~~(4)~~] (5).

2639 (2) "Corrective order" means an order issued by the commissioner specifying corrective
2640 action that the commissioner determines is required.

2641 (3) "Health organization" means:

2642 (a) an entity that is authorized under Chapter 7 or 8; and

2643 (b) that is:

2644 (i) a health maintenance organization;

2645 (ii) a limited health service organization;

2646 (iii) a dental or vision plan;

2647 (iv) a hospital, medical, and dental indemnity or service corporation; or

2648 (v) other managed care organization.

2649 [~~(3)~~] (4) "Life or [~~disability~~] accident and health insurer" means:

2650 (a) an insurance company licensed to write life insurance, disability insurance, or both; or

2651 (b) a licensed property casualty insurer writing only disability insurance.

2652 [~~(4)~~] (5) "Property and casualty insurer" means any insurance company licensed to write
2653 lines of insurance other than life but does not include a monoline mortgage guaranty insurer,
2654 financial guaranty insurer, or title insurer.

2655 [~~(5)~~] (6) "RBC" means risk-based capital.

2656 [~~(6)~~] (7) "RBC instructions" means the RBC report including risk-based capital
2657 instructions adopted by the department by rule.

2658 [~~(7)~~] (8) "RBC level" means an insurer's or health organization's authorized control level
2659 RBC, company action level RBC, mandatory control level RBC, or regulatory action level RBC.

2660 (a) "Authorized control level RBC" means the number determined under the risk-based

2661 capital formula in accordance with the RBC instructions;
2662 (b) "Company action level RBC" means the product of 2.0 and its authorized control level
2663 RBC;
2664 (c) "Mandatory control level RBC" means the product of .70 and the authorized control
2665 level RBC; and
2666 (d) "Regulatory action level RBC" means the product of 1.5 and its authorized control
2667 level RBC.
2668 [(8)] (9) (a) "RBC plan" means a comprehensive financial plan containing the elements
2669 specified in Subsection 31A-17-603(2). [If]
2670 (b) Notwithstanding Subsection (9)(a), the plan is a "revised RBC plan" if:
2671 (i) the commissioner rejects the RBC plan[,]; and [it]
2672 (ii) the plan is revised by the insurer or health organization, with or without the
2673 commissioner's recommendation[, the plan shall be called the "Revised RBC Plan."].
2674 [(9)] (10) "RBC report" means the report required in Section 31A-17-602.
2675 Section 41. Section **31A-17-602** is amended to read:
2676 **31A-17-602. RBC reports -- RBC of life and accident and health insurers -- RBC of**
2677 **property and casualty insurers.**
2678 (1) Every domestic life or [disability] accident and health insurer [and], every domestic
2679 property and casualty insurer, and every domestic health organization shall:
2680 (a) on or before March 1, prepare and submit to the commissioner a report of its RBC
2681 levels as of the end of the calendar year just ended, in a form and containing the information as is
2682 required by the RBC instructions; [and]
2683 (b) file its RBC report with the insurance commissioner in any state in which the insurer
2684 or health organization is authorized to do business, if the insurance commissioner of that state
2685 notifies the insurer or health organization of its request in writing, in which case the insurer or
2686 health organization may file its RBC report not later than the later of:
2687 (i) 15 days from the receipt of notice to file its RBC report with that state; or
2688 (ii) March 1[.]; and
2689 (c) file the documents described in Subsections (1)(a) and (b) with the National
2690 Association of Insurance Commissioners in accordance with RBC instructions.
2691 (2) A life and [disability] accident and health insurer's RBC shall be determined in

2692 accordance with the formula set forth in the RBC instructions. The formula shall take into account
2693 and may adjust for the covariance between:
2694 (a) the risk with respect to the insurer's assets;
2695 (b) the risk of adverse insurance experience with respect to the insurer's liabilities and
2696 obligations;
2697 (c) the interest rate risk with respect to the insurer's business; and
2698 (d) all other business risks and other relevant risks as set forth in the RBC instructions.
2699 (3) A property and casualty insurer's RBC shall be determined in accordance with the
2700 formula set forth in the RBC instructions. The formula shall take the following into account and
2701 may adjust for the covariance between:
2702 (a) asset risk;
2703 (b) credit risk;
2704 (c) underwriting risk; and
2705 (d) all other business risks and the other relevant risks as set forth in the RBC instructions.
2706 (4) A health organization's RBC shall be determined in accordance with the formula set
2707 forth in the RBC instructions. The formula shall take the following into account and may adjust
2708 for the covariance between:
2709 (a) asset risk;
2710 (b) credit risk;
2711 (c) underwriting risk; and
2712 (d) all other business risks and such other relevant risks as are set forth in the RBC
2713 instructions.
2714 [~~(4)~~] (5) (a) If a domestic insurer files an RBC report that the commissioner determines
2715 is inaccurate, the commissioner shall adjust the RBC report to correct the inaccuracy and shall
2716 notify the insurer of the adjustment.
2717 (b) The notice under Subsection [~~(4)~~] (5)(a) shall contain a statement of the reason for the
2718 adjustment.
2719 (6) The commissioner may make rules to assist in applying the provisions of this part to
2720 health organizations.
2721 Section 42. Section **31A-17-603** is amended to read:
2722 **31A-17-603. Company action level event.**

2723 (1) "Company action level event" means any of the following events:
2724 (a) the filing of an RBC report by an insurer or health organization that indicates that:
2725 (i) the insurer's or health organization's total adjusted capital is greater than or equal to its
2726 regulatory action level RBC but less than its company action level RBC; or
2727 (ii) if a life or [disability] accident and health insurer, the insurer has:
2728 (A) total adjusted capital that is greater than or equal to its company action level RBC but
2729 less than the product of its authorized control level RBC and 2.5; and
2730 (B) a negative trend, determined in accordance with the "trend test calculation" included
2731 in the RBC instructions;
2732 (b) the notification by the commissioner to the insurer or health organization of an adjusted
2733 RBC report that indicates an event in Subsection (1)(a), provided the insurer or health organization
2734 does not challenge the adjusted RBC report under Section 31A-17-607; or
2735 (c) if, pursuant to Section 31A-17-607, an insurer or health organization challenges an
2736 adjusted RBC report that indicates the event in Subsection (1)(a), the notification by the
2737 commissioner to the insurer or health organization that after a hearing the commissioner rejects
2738 the insurer's or health organization's challenge.
2739 (2) (a) In the event of a company action level event, the insurer or health organization shall
2740 prepare and submit to the commissioner an RBC plan that shall:
2741 (i) identify the conditions that contribute to the company action level event;
2742 (ii) contain proposals of corrective actions that the insurer or health organization intends
2743 to take and that are expected to result in the elimination of the company action level event;
2744 (iii) provide projections of the insurer's or health organization's financial results in the
2745 current year and at least the four succeeding years, both in the absence of proposed corrective
2746 actions and giving effect to the proposed corrective actions, including projections of:
2747 (A) statutory operating income[,];
2748 (B) net income[,];
2749 (C) capital[, and];
2750 (D) surplus; and
2751 (E) RBC levels;
2752 (iv) identify the key assumptions impacting the insurer's or health organization's
2753 projections and the sensitivity of the projections to the assumptions; and

2754 (v) identify the quality of, and problems associated with, the insurer's or health
2755 organization's business, including its assets, anticipated business growth and associated surplus
2756 strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.
2757 (b) For purposes of Subsection (2)(a)(iii), the projections for both new and renewal
2758 business may include separate projections for each major line of business and separately identify
2759 each significant income, expense, and benefit component.
2760 (3) The RBC plan shall be submitted:
2761 (a) within 45 days of the company action level event; or
2762 (b) if the insurer or health organization challenges an adjusted RBC report pursuant to
2763 Section 31A-17-607, within 45 days after notification to the insurer or health organization that
2764 after a hearing the commissioner rejects the insurer's or health organization's challenge.
2765 (4) (a) Within 60 days after the submission by an insurer or health organization of an RBC
2766 plan to the commissioner, the commissioner shall notify the insurer or health organization whether
2767 the RBC plan:
2768 (i) shall be implemented; or
2769 (ii) is unsatisfactory.
2770 (b) If the commissioner determines the RBC plan is unsatisfactory, the notification to the
2771 insurer or health organization shall set forth the reasons for the determination, and may propose
2772 revisions that will render the RBC plan satisfactory. Upon notification from the commissioner,
2773 the insurer or health organization shall:
2774 (i) prepare a revised RBC plan that incorporates any revision proposed by the
2775 commissioner; and
2776 (ii) submit the revised RBC plan to the commissioner:
2777 (A) within 45 days after the notification from the commissioner; or
2778 (B) if the insurer challenges the notification from the commissioner under Section
2779 31A-17-607, within 45 days after a notification to the insurer or health organization that after a
2780 hearing the commissioner rejects the insurer's or health organization's challenge.
2781 (5) In the event of a notification by the commissioner to an insurer or health organization
2782 that the insurer's or health organization's RBC plan or revised RBC plan is unsatisfactory, the
2783 commissioner may specify in the notification that the notification constitutes a regulatory action
2784 level event subject to the insurer's or health organization's right to a hearing under Section

2785 31A-17-607.

2786 (6) Every domestic insurer or health organization that files an RBC plan or revised RBC
2787 plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the
2788 insurance commissioner in any state in which the insurer or health organization is authorized to
2789 do business if:

2790 (a) the state has an RBC provision substantially similar to Subsection 31A-17-608(1); and

2791 (b) the insurance commissioner of that state notifies the insurer or health organization of
2792 its request for the filing in writing, in which case the insurer or health organization shall file a copy
2793 of the RBC plan or revised RBC plan in that state no later than the later of:

2794 (i) 15 days after the receipt of notice to file a copy of its RBC plan or revised RBC plan
2795 with that state; or

2796 (ii) the date on which the RBC plan or revised RBC plan is filed under Subsections (3) and
2797 (4).

2798 Section 43. Section **31A-17-604** is amended to read:

2799 **31A-17-604. Regulatory action level event.**

2800 (1) "Regulatory action level event" means with respect to any insurer or health
2801 organization, any of the following events:

2802 (a) the filing of an RBC report by the insurer or health organization that indicates that the
2803 insurer's or health organization's total adjusted capital is greater than or equal to its authorized
2804 control level RBC but less than its regulatory action level RBC;

2805 (b) the notification by the commissioner to an insurer or health organization of an adjusted
2806 RBC report that indicates the event in Subsection (1)(a), provided the insurer or health
2807 organization does not challenge the adjusted RBC report under Section 31A-17-607;

2808 (c) if, pursuant to Section 31A-17-607, the insurer or health organization challenges an
2809 adjusted RBC report that indicates the event in Subsection (1)(a), the notification by the
2810 commissioner to the insurer or health organization that after a hearing the commissioner rejects
2811 the insurer's or health organization's challenge;

2812 (d) the failure of the insurer or health organization to file an RBC report by March 1,
2813 unless the insurer or health organization has:

2814 (i) provided an explanation for the failure that is satisfactory to the commissioner; and

2815 (ii) cured the failure within ten days after March 1;

2816 (e) the failure of the insurer or health organization to submit an RBC plan to the
2817 commissioner within the time period set forth in Subsection 31A-17-603(3);
2818 (f) notification by the commissioner to the insurer or health organization that:
2819 (i) the RBC plan or revised RBC plan submitted by the insurer or health organization is
2820 unsatisfactory; and
2821 (ii) the notification constitutes a regulatory action level event with respect to the insurer
2822 or health organization, provided the insurer has not challenged the determination under Section
2823 31A-17-607;
2824 (g) if, pursuant to Section 31A-17-607, the insurer or health organization challenges a
2825 determination by the commissioner under Subsection (1)(f), the notification by the commissioner
2826 to the insurer or health organization that after a hearing the commissioner rejects the challenge;
2827 or
2828 (h) notification by the commissioner to the insurer or health organization that the insurer
2829 or health organization has failed to adhere to its RBC plan or revised RBC plan, but only if:
2830 (i) the failure has a substantial adverse effect on the ability of the insurer or health
2831 organization to eliminate the company action level event in accordance with its RBC plan or
2832 revised RBC plan; and
2833 (ii) the commissioner has so stated in the notification, provided the insurer or health
2834 organization has not challenged the determination under Section 31A-17-607; or
2835 (iii) if, pursuant to Section 31A-17-607, the insurer or health organization challenges a
2836 determination by the commissioner under Subsection (1)(h), the notification by the commissioner
2837 to the insurer or health organization that after a hearing the commissioner rejects the challenge.
2838 (2) In the event of a regulatory action level event the commissioner shall:
2839 (a) require the insurer or health organization to prepare and submit an RBC plan or, if
2840 applicable, a revised RBC plan;
2841 (b) perform any examination or analysis the commissioner considers necessary of the
2842 assets, liabilities, and operations of the insurer or health organization, including a review of its
2843 RBC plan or revised RBC plan; and
2844 (c) subsequent to the examination or analysis, issue a corrective order specifying the
2845 corrective action the commissioner determines is required.
2846 (3) In determining a corrective action, the commissioner may take into account such

2847 factors the commissioner considers relevant with respect to the insurer or health organization based
2848 upon the commissioner's examination or analysis of the assets, liabilities, and operations of the
2849 insurer or health organization, including the results of any sensitivity tests undertaken pursuant to
2850 the RBC instructions. The RBC plan or revised RBC plan shall be submitted:
2851 (a) within 45 days after the occurrence of the regulatory action level event;
2852 (b) if the insurer or health organization challenges an adjusted RBC report pursuant to
2853 Section 31A-17-607 and the commissioner determines the challenge is not frivolous, within 45
2854 days after the notification to the insurer or health organization that after a hearing the
2855 commissioner rejects the insurer's or health organization's challenge; or
2856 (c) if the insurer or health organization challenges a revised RBC plan pursuant to Section
2857 31A-17-607 and the commissioner determines the challenge is not frivolous, within 45 days after
2858 the notification to the insurer or health organization that after a hearing the commissioner rejects
2859 the insurer's or health organization's challenge.
2860 Section 44. Section **31A-17-605** is amended to read:
2861 **31A-17-605. Authorized control level event.**
2862 (1) "Authorized control level event" means any of the following events:
2863 (a) the filing of an RBC report by the insurer or health organization that indicates that the
2864 insurer's or health organization's total adjusted capital is greater than or equal to its mandatory
2865 control level RBC but less than its authorized control level RBC;
2866 (b) the notification by the commissioner to the insurer or health organization of an adjusted
2867 RBC report that indicates the event in Subsection (1)(a), provided the insurer or health
2868 organization does not challenge the adjusted RBC report under Section 31A-17-607;
2869 (c) if, pursuant to Section 31A-17-607, the insurer or health organization challenges an
2870 adjusted RBC report that indicates the event in Subsection (1)(a), notification by the commissioner
2871 to the insurer or health organization that after a hearing the commissioner rejects the insurer's or
2872 health organization's challenge;
2873 (d) the failure of the insurer or health organization to respond, in a manner satisfactory to
2874 the commissioner, to a corrective order, provided the insurer or health organization has not
2875 challenged the corrective order under Section 31A-17-607; or
2876 (e) if the insurer or health organization has challenged a corrective order under Section
2877 31A-17-607 and the commissioner after a hearing rejects the challenge or modifies the corrective

2878 order, the failure of the insurer or health organization to respond, in a manner satisfactory to the
2879 commissioner, to the corrective order subsequent to rejection or modification by the commissioner.
2880 (2) (a) In the event of an authorized control level event with respect to an insurer or health
2881 organization, the commissioner shall:
2882 (i) take any action required under Section 31A-17-604 regarding an insurer or health
2883 organization with respect to which a regulatory action level event has occurred; or
2884 (ii) take any action as is necessary to cause the insurer or health organization to be placed
2885 under regulatory control under Section 31A-27-201 if the commissioner considers it to be in the
2886 best interests of:
2887 (A) the policyholders [~~and~~] or members;
2888 (B) creditors of the insurer or health organization; and
2889 (C) the public.
2890 (b) In the event the commissioner takes an action described in Subsection (2)(a), the
2891 authorized control level event is sufficient grounds for the commissioner to take action under
2892 Section 31A-27-201, and the commissioner shall have the rights, powers, and duties with respect
2893 to the insurer or health organization set forth in Section 31A-27-201.
2894 (c) If the commissioner takes an action under Subsection (2)(a) pursuant to an adjusted
2895 RBC report, the insurer or health organization is entitled to the protections afforded to [~~insurers~~]
2896 an insurer or health organization under Section 31A-27-203 pertaining to summary proceedings.
2897 Section 45. Section **31A-17-606** is amended to read:
2898 **31A-17-606. Mandatory control level event.**
2899 (1) "Mandatory control level event" means any of the following events:
2900 (a) the filing of an RBC report that indicates that the insurer's or health organization's total
2901 adjusted capital is less than its mandatory control level RBC;
2902 (b) notification by the commissioner to the insurer or health organization of an adjusted
2903 RBC report that indicates the event in Subsection (1)(a), provided the insurer or health
2904 organization does not challenge the adjusted RBC report under Section 31A-17-607; or
2905 (c) if, pursuant to Section 31A-17-607, the insurer or health organization challenges an
2906 adjusted RBC report that indicates the event in Subsection (1)(a), notification by the commissioner
2907 to the insurer or health organization that after a hearing the commissioner rejects the insurer's or
2908 health organization's challenge.

2909 (2) (a) [~~(i)~~] In the event of a mandatory control level event with respect to [~~a life~~] an
2910 insurer or health organization, the commissioner shall take any actions necessary to place the
2911 insurer under regulatory control under Section 31A-27-201.
2912 [~~(ii)~~] (b) The mandatory control level event is sufficient grounds for the commissioner to
2913 take action under Section 31A-27-201, and the commissioner shall have the rights, powers, and
2914 duties with respect to the insurer or health organization as are set forth in Section 31A-27-201.
2915 [~~(iii)~~] (c) If the commissioner takes an action pursuant to an adjusted RBC report, the
2916 insurer or health organization is entitled to the protections of Section 31A-27-203 pertaining to
2917 summary proceedings.
2918 [~~(iv)~~] (d) Notwithstanding the other provisions of Subsection (2), the commissioner may
2919 forego action for up to 90 days after the mandatory control level event if the commissioner finds
2920 there is a reasonable expectation that the mandatory control level event may be eliminated within
2921 the 90-day period.
2922 [~~(b) (i) In the event of a mandatory control level with respect to a property and casualty~~
2923 ~~insurer, the commissioner shall take any action necessary to place the insurer under regulatory~~
2924 ~~control under Section 31A-27-201.~~]
2925 [~~(ii) The mandatory control level event is sufficient grounds for the commissioner to take~~
2926 ~~action under Section 31A-27-201 and the commissioner shall have the rights, powers, and duties~~
2927 ~~with respect to the insurer set forth in Section 31A-27-201.~~]
2928 [~~(iii) If the commissioner takes actions pursuant to an adjusted RBC report, the insurer~~
2929 ~~shall be entitled to the protections of Section 31A-27-203 pertaining to summary proceedings.~~]
2930 [~~(iv) Notwithstanding any other provision of this section, the commissioner may forego~~
2931 ~~action for up to 90 days after the mandatory control level event if the commissioner finds there is~~
2932 ~~a reasonable expectation that the mandatory control level event may be eliminated within the~~
2933 ~~90-day period.~~]
2934 Section 46. Section **31A-17-607** is amended to read:
2935 **31A-17-607. Hearings.**
2936 (1) (a) Following receipt of a notice described in Subsection (2), the insurer or health
2937 organization shall have the right to a confidential departmental hearing at which the insurer or
2938 health organization may challenge any determination or action by the commissioner.
2939 (b) The insurer or health organization shall notify the commissioner of its request for a

2940 hearing within five days after the notification by the commissioner under Subsections
2941 31A-17-604(1), (2), and (3).
2942 (c) Upon receipt of the insurer's or health organization's request for a hearing, the
2943 commissioner shall set a date for the hearing, which date shall be no less than ten nor more than
2944 30 days after the date of the insurer's or health organization's request.
2945 (2) An insurer or health organization has the right to a hearing under Subsection (1) after:
2946 (a) notification to an insurer or health organization by the commissioner of an adjusted
2947 RBC report;
2948 (b) notification to an insurer or health organization by the commissioner that:
2949 (i) the insurer's or health organization's RBC plan or revised RBC plan is unsatisfactory;
2950 and
2951 (ii) the notification constitutes a regulatory action level event with respect to the insurer
2952 or health organization;
2953 (c) notification to any insurer or health organization by the commissioner that the insurer
2954 or health organization has failed to adhere to its RBC plan or revised RBC plan and that the failure
2955 has substantial adverse effect on the ability of the insurer or health organization to eliminate the
2956 company action level event with respect to the insurer or health organization in accordance with
2957 its RBC plan or revised RBC plan; or
2958 (d) notification to an insurer or health organization by the commissioner of a corrective
2959 order with respect to the insurer or health organization.
2960 Section 47. Section **31A-17-608** is amended to read:
2961 **31A-17-608. Confidentiality -- Prohibition on announcements -- Prohibition on use**
2962 **in ratemaking.**
2963 (1) (a) The commissioner shall keep confidential to the extent that information in a report
2964 or plan is not required to be included in a publicly available annual statement schedule, any detail
2965 in an RBC report or RBC plan including the results or report of any examination or analysis of an
2966 insurer or health organization performed pursuant to this part, that is filed by a domestic or foreign
2967 insurer or health organization with the commissioner or any corrective order issued by the
2968 commissioner pursuant to examination or analysis.
2969 (b) Information kept confidential under Subsection (1)(a) may not be made public or be
2970 subject to subpoena, other than by the commissioner and then only for the purpose of enforcement

2971 actions taken by the commissioner pursuant to this part or any other provision of the insurance
2972 laws of this state.
2973 (2) (a) Except as otherwise required under this part, any insurer or health organization,
2974 agent, broker, or other person engaged in any manner in the insurance business may not publish,
2975 disseminate, circulate or place before the public, or cause, directly or indirectly, the publishing,
2976 disseminating, circulating or placing before the public including, in a newspaper, magazine, other
2977 publication, a notice, circular, pamphlet, letter, or poster, or over any radio or television station,
2978 an advertisement, announcement, or statement containing an assertion, representation, or statement
2979 with regard to the RBC levels of any insurer or health organization, or of any component derived
2980 in the calculation.
2981 (b) If any materially false statement with respect to the comparison regarding an insurer's
2982 or health organization's total adjusted capital to its RBC levels, or an inappropriate comparison of
2983 any other amount to the insurer's or health organization's RBC levels is published in any written
2984 publication and the insurer or health organization is able to demonstrate to the commissioner with
2985 substantial proof the falsity of the statement or the inappropriateness, the insurer or health
2986 organization may publish an announcement in a written publication if the sole purpose of the
2987 announcement is to rebut the materially false statement or inappropriate comparison.
2988 (3) The commissioner may not use an RBC instruction, report, plan, or revised plan:
2989 (a) for ratemaking;
2990 (b) as evidence in any rate proceeding; or
2991 (c) to calculate or derive any element of an appropriate premium level or rate of return for
2992 any line of insurance or coverage that an insurer or health organization or any affiliate is authorized
2993 to write or cover.
2994 Section 48. Section **31A-17-609** is amended to read:
2995 **31A-17-609. Alternate adjusted capital.**
2996 (1) Except as provided in Section 31A-17-602, [~~insurers~~] an insurer or health organization
2997 licensed under Chapters 5, 7, 8, 9, and 14 shall maintain total adjusted capital as defined in Section
2998 31A-1-301 in an amount equal to the greater of:
2999 (a) 175% of the minimum required capital, or of the minimum permanent surplus in the
3000 case of nonassessable mutuals, required by Section 31A-5-211, 31A-7-201, 31A-8-209,
3001 31A-9-209, or 31A-14-205; or

3002 (b) the net total of:
3003 (i) 10% of net insurance premiums earned during the year; plus
3004 (ii) 5% of the admitted value of common stocks and real estate; plus
3005 (iii) 2% of the admitted value of all other invested assets, exclusive of cash deposits,
3006 short-term investments, policy loans, and premium notes; less
3007 (iv) the amount of any asset valuation reserve being maintained by the insurer or health
3008 organization, but not to exceed the sum of Subsections (1)(b)(ii) and (iii).
3009 (2) As used in Subsection (1)(b), "premiums earned" means premiums and other
3010 consideration earned for insurance in the 12-month period ending on the date the calculation is
3011 made.
3012 (3) The commissioner may consider an insurer or health organization to be financially
3013 hazardous under Subsection 31A-27-307(3), if the insurer or health organization does not have
3014 qualified assets in an aggregate value exceeding the sum of the insurer's or health organization's
3015 liabilities and the total adjusted capital required by Subsection (1).
3016 (4) The commissioner shall consider an insurer or health organization to be financially
3017 hazardous under Subsection 31A-27-307(3) if the insurer or health organization does not have
3018 qualified assets in an aggregate value exceeding the sum of the insurer's or health organization's
3019 liabilities and 70% of the total adjusted capital required by Subsection (1).
3020 Section 49. Section **31A-17-610** is amended to read:
3021 **31A-17-610. Foreign insurers.**
3022 (1) (a) Any foreign insurer or health organization shall, upon the written request of the
3023 commissioner, submit to the commissioner an RBC report as of the end of the most recent calendar
3024 year by the later of:
3025 (i) the date an RBC report would be required to be filed by a domestic insurer or health
3026 organization under this part; or
3027 (ii) 15 days after the request is received by the foreign insurer or health organization.
3028 (b) Any foreign insurer or health organization shall, at the written request of the
3029 commissioner, promptly submit to the commissioner a copy of any RBC plan that is filed with the
3030 insurance commissioner of any other state.
3031 (2) (a) The commissioner may require a foreign insurer or health organization to file an
3032 RBC plan with the commissioner if:

3033 (i) there is a company action level event, regulatory action level event, or authorized
3034 control level event with respect to the foreign insurer or health organization as determined under:
3035 (A) the RBC statute applicable in the state of domicile of the insurer or health
3036 organization; or[,]
3037 (B) if no RBC statute is in force in that state, under [the provisions of] this part; and
3038 (ii) the insurance commissioner of the state of domicile of the foreign insurer or health
3039 organization fails to require the foreign insurer or health organization to file an RBC plan in the
3040 manner specified under:
3041 (A) that state's RBC statute; or[,]
3042 (B) if no RBC statute is in force in that state, under Section 31A-17-603.
3043 (b) If the commissioner requires a foreign insurer or health organization to file an RBC
3044 plan, the failure of the foreign insurer or health organization to file the RBC plan with the
3045 commissioner is grounds to order the insurer or health organization to cease and desist from
3046 writing new insurance business in this state.
3047 (3) The commissioner may make application to the Third District Court for Salt Lake
3048 County permitted under Section 31A-27-401 with respect to the liquidation of property of a foreign
3049 [insurers] insurer or health organization found in this state if:
3050 (a) a mandatory control level event occurs with respect to any foreign insurer or health
3051 organization; and
3052 (b) no domiciliary receiver has been appointed with respect to the foreign insurer or health
3053 organization under the rehabilitation and liquidation statute applicable in the state of domicile of
3054 the foreign insurer or health organization.
3055 Section 50. Section **31A-17-613** is amended to read:
3056 **31A-17-613. Effective date of notice.**
3057 A notice by the commissioner to an insurer or health organization that may result in
3058 regulatory action under this chapter is effective the sooner of:
3059 (1) the date the insurer or health organization receives the notice; or
3060 (2) three days after mailing the notice.
3061 Section 51. Section **31A-18-105** is amended to read:
3062 **31A-18-105. Permitted classes of investments.**
3063 The following classes of investment may be counted for the purposes specified under

3064 Chapter 17, Part 6, Risk-Based Capital:
3065 (1) bonds or other evidences of indebtedness of:
3066 (a) (i) governmental units in the United States or Canada[~~, or~~];
3067 (ii) instrumentalities of [~~those~~] the governmental units[~~,~~] described in Subsection (1)(a)(i);
3068 or [~~of~~]
3069 (iii) private corporations domiciled in the United States[~~,~~]; and
3070 (b) including demand deposits and certificates of deposits in solvent banks and savings and
3071 loan institutions;
3072 (2) equipment trust obligations or certificates [~~which~~] that are adequately secured
3073 instruments evidencing an interest in transportation equipment [~~which~~] that is located wholly or
3074 in part within the United States, with a right to receive determined portions of the rental, or to
3075 purchase other fixed obligatory payments for the use or purchase of the transportation equipment;
3076 (3) loans secured by:
3077 (a) mortgages[~~,~~];
3078 (b) trust deeds[~~,~~]; or
3079 (c) other statutorily authorized types of security interests in real estate located in the United
3080 States;
3081 (4) loans secured by pledged securities or evidences of debt eligible for investment under
3082 this section;
3083 (5) preferred stocks of United States corporations;
3084 (6) common stocks of United States corporations;
3085 (7) real estate which is used as the home office or branch office of the insurer;
3086 (8) real estate in the United States which produces substantial income;
3087 (9) loans upon the security of the insurer's own policies in amounts that are adequately
3088 secured by the policies and that do not exceed the surrender value of the policies;
3089 (10) financial futures contracts used for hedging and not for speculation, as approved under
3090 rules adopted by the commissioner;
3091 (11) investments in foreign securities of the classes permitted under this section as required
3092 for compliance with Section 31A-18-103;
3093 (12) investments permitted under Subsection 31A-18-102(2); and
3094 (13) other investments as the commissioner authorizes by rule.

3095 Section 52. Section **31A-19a-101** is amended to read:

3096 **31A-19a-101. Title -- Scope and purposes.**

3097 (1) This chapter is known as the "Utah Rate Regulation Act."

3098 (2) (a) (i) Except as provided in Subsection (2)(a)(ii), this chapter applies to all kinds and

3099 lines of direct insurance written on risks or operations in this state by an insurer authorized to do

3100 business in this state.

3101 (ii) This chapter does not apply to:

3102 (A) life insurance other than credit life insurance;

3103 (B) variable and fixed annuities;

3104 (C) health and [disability] accident and health insurance other than credit [disability]

3105 accident and health insurance; and

3106 (D) reinsurance.

3107 (b) This chapter applies to all insurers authorized to do any line of business, except those

3108 specified in Subsection (2)(a)(ii).

3109 (3) It is the purpose of this chapter to:

3110 (a) protect policyholders and the public against the adverse effects of excessive,

3111 inadequate, or unfairly discriminatory rates;

3112 (b) encourage independent action by and reasonable price competition among insurers so

3113 that rates are responsive to competitive market conditions;

3114 (c) provide formal regulatory controls for use if independent action and price competition

3115 fail;

3116 (d) provide regulatory procedures for the maintenance of appropriate data reporting

3117 systems;

3118 (e) authorize cooperative action among insurers in the rate-making process, and regulate

3119 that cooperation to prevent practices that bring about a monopoly or lessen or destroy competition;

3120 (f) encourage the most efficient and economic marketing practices; and

3121 (g) regulate the business of insurance in a manner that, under the McCarran-Ferguson Act,

3122 15 U.S.C. Secs. 1011 through 1015, will preclude application of federal antitrust laws.

3123 (4) Rate filings made prior to July 1, 1986, under former Title 31, Chapter 18, are

3124 continued. Rate filings made after July 1, 1986, are subject to the requirements of this chapter.

3125 Section 53. Section **31A-21-103** is amended to read:

3126 **31A-21-103. Capacity to contract.**

3127 Any person 16 years of age or older who is otherwise competent to contract under Utah
3128 law, and who is not subject to any legal disability, may contract for insurance. If there is a
3129 conservator appointed under Title 75, the conservator, rather than the person whose property is
3130 subject to the conservatorship, may contract for insurance to protect the property under
3131 conservatorship. In the case of a conservatorship over the person or property of a person under 16
3132 years of age, the conservator may invest funds of the estate in life or [~~disability~~] <u>accident and</u>
3133 <u>health</u> insurance or annuity contracts, but only with the approval of the court having jurisdiction
3134 over the conservatorship.

3135 Section 54. Section **31A-21-104** is amended to read:

3136 **31A-21-104. Insurable interest and consent.**

3137 (1) (a) An insurer may not knowingly provide insurance to a person who does not have or
3138 expect to have an insurable interest in the subject of the insurance.

3139 (b) A person may not knowingly procure, directly, by assignment, or otherwise, an interest
3140 in the proceeds of an insurance policy unless he has or expects to have an insurable interest in the
3141 subject of the insurance.

3142 (c) Except as provided in Subsections (6), (7), and (8), any insurance provided in violation
3143 of this subsection is subject to Subsection (5).

3144 (2) As used in this chapter:

3145 (a) "Insurable interest" in a person means, for persons closely related by blood or by law,
3146 a substantial interest engendered by love and affection, or in the case of other persons, a lawful and
3147 substantial interest in having the life, health, and bodily safety of the person insured continue.
3148 Policyholders in group insurance contracts need no insurable interest if certificate holders or
3149 persons other than group policyholders who are specified by the certificate holders are the
3150 recipients of the proceeds of the policies. Each person has an unlimited insurable interest in his
3151 own life and health. A shareholder or partner has an insurable interest in the life of other
3152 shareholders or partners for purposes of insurance contracts that are an integral part of a legitimate
3153 buy-sell agreement respecting shares or a partnership interest in the business.

3154 (b) "Insurable interest" in property or liability means any lawful and substantial economic
3155 interest in the nonoccurrence of the event insured against.

3156 (c) "Viatical settlement" means a written contract entered into by a person who is the

3157 policyholder of a life insurance policy insuring the life of a terminally ill person, under which the
3158 insured assigns, transfers ownership, irrevocably designates a specific person or otherwise
3159 alienates all control and right in the insurance policy to another person, when the proceeds of the
3160 contract is paid to the policyholder of the insurance policy or the policyholder's designee prior to
3161 the death of the subject.
3162 (3) Except as provided in Subsection (4), an insurer may not knowingly issue an individual
3163 life or [~~disability~~] accident and health insurance policy to a person other than the one whose life
3164 or health is at risk unless that person, who is 18 years of age or older and not under guardianship
3165 under Title 75, Chapter 5, Protection of Persons Under Disability and Their Property, has given
3166 written consent to the issuance of the policy. The person shall express consent either by signing
3167 an application for the insurance with knowledge of the nature of the document, or in any other
3168 reasonable way. Any insurance provided in violation of this subsection is subject to Subsection (5).
3169 (4) (a) A life or [~~disability~~] accident and health insurance policy may be taken out without
3170 consent in the following cases:
3171 (i) A person may obtain insurance on a dependent who does not have legal capacity.
3172 (ii) A creditor may, at the creditor's expense, obtain insurance on the debtor in an amount
3173 reasonably related to the amount of the debt.
3174 (iii) A person may obtain life and [~~disability~~] accident and health insurance on immediate
3175 family members living with or dependent on the person.
3176 (iv) A person may obtain [~~a disability~~] an accident and health insurance policy on others
3177 that would merely indemnify the policyholder against expenses he would be legally or morally
3178 obligated to pay.
3179 (v) The commissioner may adopt rules permitting issuance of insurance for a limited term
3180 on the life or health of a person serving outside the continental United States who is in the public
3181 service of the United States, if the policyholder is related within the second degree by blood or by
3182 marriage to the person whose life or health is insured.
3183 (b) Consent may be given by another in the following cases:
3184 (i) A parent, a person having legal custody of a minor, or a guardian of the person under
3185 Title 75, Chapter 5, Protection of Persons Under Disability and Their Property, may consent to the
3186 issuance of a policy on a dependent child or on a person under guardianship under Title 75,
3187 Chapter 5, Protection of Persons Under Disability and Their Property.

3188 (ii) A grandparent may consent to the issuance of life or [~~disability~~] accident and health
3189 insurance on a grandchild.
3190 (iii) A court of general jurisdiction may give consent to the issuance of a life or [~~disability~~]
3191 accident and health insurance policy on an ex parte application showing facts the court considers
3192 sufficient to justify the issuance of that insurance.
3193 (5) An insurance policy is not invalid because the policyholder lacks insurable interest or
3194 because consent has not been given, but a court with appropriate jurisdiction may order the
3195 proceeds to be paid to some person who is equitably entitled to them, other than the one to whom
3196 the policy is designated to be payable, or it may create a constructive trust in the proceeds or a part
3197 of them on behalf of such a person, subject to all the valid terms and conditions of the policy other
3198 than those relating to insurable interest or consent.
3199 (6) This section does not prevent any organization described under 26 U.S.C. Sec.
3200 501(c)(3), (e), or (f), as amended, and the regulations made under this section, and which is
3201 regulated under Title 13, Chapter 22, Charitable Solicitations Act, from soliciting and procuring,
3202 by assignment or designation as beneficiary, a gift or assignment of an interest in life insurance on
3203 the life of the donor or assignor or from enforcing payment of proceeds from that interest.
3204 (7) This section does not prevent:
3205 (a) any policyholder of life insurance, whether or not the policyholder is also the subject
3206 of the insurance, from entering into a viatical settlement;
3207 (b) any person from soliciting a person to enter into a viatical settlement; or
3208 (c) a person from enforcing payment of proceeds from the interest obtained under a viatical
3209 settlement.
3210 (8) Notwithstanding Subsection (1), an insurer authorized under this title to issue a
3211 workers' compensation policy may issue a workers' compensation policy to a sole proprietorship,
3212 corporation, or partnership that elects not to include any owner, corporate officer, or partner as an
3213 employee under the policy even if at the time the policy is issued the sole proprietorship,
3214 corporation, or partnership has no employees.
3215 Section 55. Section **31A-21-201** is amended to read:
3216 **31A-21-201. Filing and approval of forms.**
3217 (1) (a) A form subject to Subsection 31A-21-101(1), except as exempted under
3218 Subsections 31A-21-101(2) through (6), may not be used, sold, or offered for sale unless it has

3219 been filed with the commissioner.
3220 (b) A form is considered filed with the commissioner when the commissioner receives:
3221 (i) the form;
3222 (ii) the applicable filing fee as prescribed under Section 31A-3-103; and
3223 (iii) the applicable transmittal forms as required by the commissioner.
3224 (2) In filing a form for use in this state the insurer is responsible for assuring that the form
3225 is in compliance with this title and rules adopted by the commissioner.
3226 (3) (a) The commissioner may [~~disapprove~~] prohibit the use of a form at any time upon
3227 a finding that:
3228 (i) it is:
3229 (A) inequitable;
3230 (B) unfairly discriminatory;
3231 (C) misleading;
3232 (D) deceptive;
3233 (E) obscure;
3234 (F) unfair;
3235 (G) encourages misrepresentation; or
3236 (H) not in the public interest;
3237 (ii) it provides benefits or contains other provisions that endanger the solidity of the
3238 insurer;
3239 (iii) in the case of the basic policy and the application for a basic policy, it fails to
3240 conspicuously, as defined by rule, provide:
3241 (A) the exact name of the insurer [~~and~~];
3242 (B) its state of domicile; and
3243 (C) the address of its administrative office.
3244 (iv) it violates a statute or a rule adopted by the commissioner; or
3245 (v) it is otherwise contrary to law.
3246 (b) Subsection (3)(a)(iii) does not apply to riders and endorsements to a basic policy.
3247 (c) (i) Whenever the commissioner [~~disapproves~~] prohibits the use of a form under
3248 Subsection (3)(a), the commissioner may order that, on or before a date not less than 15 days after
3249 the order, the use of the form be discontinued.

3250 (ii) Once a form has been [disapproved] prohibited, it may not be used unless appropriate
3251 changes are filed with and [approved] reviewed by the commissioner.
3252 (iii) Whenever the commissioner [disapproves] prohibits the use a form under Subsection
3253 (3)(a), the commissioner may require the insurer to disclose contract deficiencies to existing
3254 policyholders.
3255 (d) The commissioner's [disapproval] prohibition under this Subsection (3) shall:
3256 (i) be in writing [and constitutes];
3257 (ii) constitute an order[. The order shall]; and
3258 (iii) state the reasons for [disapproval] the prohibition.
3259 (4) (a) If, after a hearing, the commissioner determines that it is in the public interest, the
3260 commissioner may require by rule or order that certain forms be subject to the commissioner's
3261 approval prior to their use.
3262 (b) The rule or order described in Subsection (4)(a) shall prescribe the filing procedures
3263 for the forms if different than stated in this section.
3264 (c) The types of forms that may be addressed under Subsection (4)(a) include:
3265 (i) forms for a particular class of insurance;
3266 (ii) forms for a specific line of insurance;
3267 (iii) a specific type of form; or
3268 (iv) forms for a specific market segment.
3269 Section 56. Section **31A-21-301** is amended to read:
3270 **31A-21-301. Clauses required to be in a prominent position.**
3271 (1) The following portions of insurance policies shall appear conspicuously in the policy:
3272 (a) [the name and state of domicile of the insurer] as required by Subsection 31A-21-201
3273 (3)(a)(iii)[;]:
3274 (i) the exact name of the insurer;
3275 (ii) the state of domicile of the insurer; and
3276 (iii) the address of the administrative office of the insurer;
3277 (b) information that two or more insurers under Subsection (1)(a) undertake only several
3278 liability, as required by Section 31A-21-306;
3279 (c) if a policy is assessable, a statement of that;
3280 (d) a statement that benefits are variable, as required by Subsection 31A-22-411(1);

3281 however, the methods of calculation need not be in a prominent position;
3282 (e) the right to return a life or [~~disability~~] accident and health insurance policy under
3283 Sections 31A-22-423 and 31A-22-606; and
3284 (f) the beginning and ending dates of insurance protection.
3285 (2) Each clause listed in Subsection (1) shall be displayed conspicuously and separately
3286 from any other clause.
3287 Section 57. Section **31A-21-303** is amended to read:
3288 **31A-21-303. Termination of insurance policies by insurers.**
3289 (1) (a) Except as otherwise provided in this section, in other statutes, or by rule under
3290 Subsection (1)(c), this section applies to all policies of insurance other than life and [~~disability~~]
3291 accident and health insurance and annuities, if the policies of insurance are issued on forms that
3292 are subject to filing and approval under Subsection 31A-21-201(1).
3293 (b) A policy may provide terms more favorable to insureds than this section requires.
3294 (c) The commissioner may by rule totally or partially exempt from this section classes of
3295 insurance policies in which the insureds do not need protection against arbitrary or unannounced
3296 termination.
3297 (d) The rights provided by this section are in addition to and do not prejudice any other
3298 rights the insureds may have at common law or under other statutes.
3299 (2) (a) As used in this Subsection (2), "grounds" means:
3300 (i) material misrepresentation;
3301 (ii) substantial change in the risk assumed, unless the insurer should reasonably have
3302 foreseen the change or contemplated the risk when entering into the contract;
3303 (iii) substantial breaches of contractual duties, conditions, or warranties;
3304 (iv) attainment of the age specified as the terminal age for coverage, in which case the
3305 insurer may cancel by notice under Subsection (2)(c), accompanied by a tender of proportional
3306 return of premium; or
3307 (v) in the case of automobile insurance, revocation or suspension of the driver's license of
3308 the named insured or any other person who customarily drives the car.
3309 (b) (i) Except as provided in Subsection (2)(e) or unless the conditions of Subsection
3310 (2)(b)(ii) are met, an insurance policy may not be canceled by the insurer before the earlier of:
3311 (A) the expiration of the agreed term; or

3312 (B) one year from the effective date of the policy or renewal.
3313 (ii) Notwithstanding Subsection (2)(b)(i), an insurance policy may be canceled by the
3314 insurer for:
3315 (A) nonpayment of a premium when due; or
3316 (B) on grounds defined in Subsection (2)(a).
3317 (c) (i) The cancellation provided by Subsection (2)(b), except cancellation for nonpayment
3318 of premium, is effective no sooner than 30 days after the delivery or first-class mailing of a written
3319 notice to the policyholder.
3320 (ii) Cancellation for nonpayment of premium is effective no sooner than ten days after
3321 delivery or first class mailing of a written notice to the policyholder.
3322 (d) (i) Notice of cancellation for nonpayment of premium shall include a statement of the
3323 reason for cancellation.
3324 (ii) Subsection (6) applies to the notice required for grounds of cancellation other than
3325 nonpayment of premium.
3326 (e) (i) Subsections (2)(a) through (d) do not apply to any insurance contract that has not
3327 been previously renewed if the contract has been in effect less than 60 days when the written notice
3328 of cancellation is mailed or delivered.
3329 (ii) A cancellation under this Subsection (2)(e) may not be effective until at least ten days
3330 after the delivery to the insured of a written notice of cancellation.
3331 (iii) If the notice required by this Subsection (2)(e) is sent by first-class mail, postage
3332 prepaid, to the insured at the insured's last-known address, delivery is considered accomplished
3333 after the passing, since the mailing date, of the mailing time specified in the Utah Rules of Civil
3334 Procedure.
3335 (iv) A policy cancellation subject to this Subsection (2)(e) is not subject to the procedures
3336 described in Subsection (6).
3337 (3) A policy may be issued for a term longer than one year or for an indefinite term if the
3338 policy includes a clause providing for cancellation by the insurer by giving notice as provided in
3339 Subsection (4)(b)(i) 30 days prior to any anniversary date.
3340 (4) (a) Subject to Subsections (2), (3), and (4)(b), a policyholder has a right to have the
3341 policy renewed:
3342 (i) on the terms then being applied by the insurer to similar risks; and

3343 (ii) (A) for an additional period of time equivalent to the expiring term if the agreed term
3344 is one year or less; or
3345 (B) for one year if the agreed term is longer than one year.
3346 (b) Except as provided in Subsection (4)(c), the right to renewal under Subsection (4)(a)
3347 is extinguished if:
3348 (i) at least 30 days prior to the policy expiration or anniversary date a notice of intention
3349 not to renew the policy beyond the agreed expiration or anniversary date is delivered or sent by
3350 first-class mail by the insurer to the policyholder at the policyholder's last-known address;
3351 (ii) not more than 45 nor less than 14 days prior to the due date of the renewal premium,
3352 the insurer delivers or sends by first-class mail a notice to the policyholder at the policyholder's
3353 last-known address, clearly stating:
3354 (A) the renewal premium;
3355 (B) how it may be paid; and
3356 (C) that failure to pay the renewal premium by the due date extinguishes the policyholder's
3357 right to renewal;
3358 (iii) the policyholder has:
3359 (A) accepted replacement coverage; or
3360 (B) requested or agreed to nonrenewal; or
3361 (iv) the policy is expressly designated as nonrenewable.
3362 (c) Unless the conditions of Subsection (4)(b)(iii) or (iv) apply, an insurer may not fail to
3363 renew an insurance policy as a result of a telephone call or other inquiry that:
3364 (i) references a policy coverage; and
3365 (ii) does not result in a claim being filed or paid.
3366 (5) (a) (i) Subject to Subsection (5)(b), if the insurer offers or purports to renew the policy,
3367 but on less favorable terms or at higher rates, the new terms or rates take effect on the renewal date
3368 if the insurer delivered or sent by first-class mail to the policyholder notice of the new terms or
3369 rates at least 30 days prior to the expiration date of the prior policy.
3370 (ii) If the insurer did not give the prior notification described in Subsection (5)(a)(i) to the
3371 policyholder the new terms or rates do not take effect until 30 days after the notice is delivered or
3372 sent by first-class mail, in which case the policyholder may elect to cancel the renewal policy at
3373 any time during the 30-day period.

3374 (iii) Return premiums or additional premium charges shall be calculated proportionately
3375 on the basis that the old rates apply.
3376 (b) Subsection (5)(a) does not apply if the only change in terms that is adverse to the
3377 policyholder is:
3378 (i) a rate increase generally applicable to the class of business to which the policy belongs;
3379 (ii) a rate increase resulting from a classification change based on the altered nature or
3380 extent of the risk insured against; or
3381 (iii) a policy form change made to make the form consistent with Utah law.
3382 (6) (a) If a notice of cancellation or nonrenewal under Subsection (2)(c) does not state with
3383 reasonable precision the facts on which the insurer's decision is based, the insurer shall send by
3384 first-class mail or deliver that information within ten working days after receipt of a written request
3385 by the policyholder.
3386 (b) A notice under Subsection (2)(c) is not effective unless it contains information about
3387 the policyholder's right to make the request.
3388 (7) If a risk-sharing plan under Section 31A-2-214 exists for the kind of coverage provided
3389 by the insurance being cancelled or nonrenewed, a notice of cancellation or nonrenewal required
3390 under Subsection (2)(c) or (4)(b)(i) may not be effective unless it contains instructions to the
3391 policyholder for applying for insurance through the available risk-sharing plan.
3392 (8) There is no liability on the part of, and no cause of action against, any insurer, its
3393 authorized representatives, agents, employees, or any other person furnishing to the insurer
3394 information relating to the reasons for cancellation or nonrenewal or for any statement made or
3395 information given by them in complying or enabling the insurer to comply with this section unless
3396 actual malice is proved by clear and convincing evidence.
3397 (9) This section does not alter any common law right of contract rescission for material
3398 misrepresentation.
3399 Section 58. Section **31A-21-307** is amended to read:
3400 **31A-21-307. Other insurance.**
3401 (1) When two or more policies promise to indemnify an insured against the same loss
3402 without intending cumulative coverage, no "other insurance" provisions of the policies may reduce
3403 the aggregate protection of the insured below the lesser of the actual insured loss suffered by the
3404 insured and the maximum indemnification promised by any policy without regard to any "other

3405 insurance" provision.
3406 (2) Subject to Subsection (1), the policies may by their terms define the extent to which
3407 each insurance is primary and each is excess, but if the "other insurance" terms of the policies are
3408 inconsistent, there is joint and several liability to the insured on any coverage which overlaps and
3409 which has inconsistent terms. Subsequent settlement among the insurers does not alter any rights
3410 of the insured. The commissioner may adopt rules consistent with this section concerning "other
3411 insurance."
3412 (3) This section does not apply to [~~disability~~] accident and health insurance policies. Refer
3413 to Section 31A-22-619 for the coordination of [~~disability~~] accident and health benefits.
3414 Section 59. Section **31A-21-401** is amended to read:
3415 **31A-21-401. Scope and construction of part.**
3416 This part applies to all mass marketed life or [~~disability~~] accident and health insurance,
3417 notwithstanding Subsection 31A-1-103(3)[~~(h)~~]. This part may not be construed to limit the
3418 application of other provisions of this title to insurers effecting mass marketed life or [~~disability~~]
3419 accident and health insurance policies on persons in this state.
3420 Section 60. Section **31A-21-402** is amended to read:
3421 **31A-21-402. Definitions.**
3422 As used in this part:
3423 (1) "Direct response solicitation" means any offer by an insurer to persons in this state,
3424 either directly or through a third party, to effect life or [~~disability~~] accident and health insurance
3425 coverage which enables the individual to apply or enroll for the insurance on the basis of the offer.
3426 Direct response solicitation does not include solicitations for insurance through an employee
3427 benefit plan exempt from state regulation under preemptive federal law, nor does it include
3428 solicitations through the individual's creditor with respect to credit life or credit [~~disability~~]
3429 accident and health insurance.
3430 (2) "Mass marketed life or [~~disability~~] accident and health insurance" means the insurance
3431 under any individual, franchise, group, or blanket policy of life or [~~disability~~] accident and health
3432 insurance which is offered by means of direct response solicitation through a sponsoring
3433 organization or through the mails or other mass communications media and under which the
3434 person insured pays all or substantially all of the cost of his insurance.
3435 Section 61. Section **31A-21-403** is amended to read:

3436 **31A-21-403. Orders terminating effectiveness of policies.**
3437 Upon the commissioner's order, no mass marketed life or [~~disability~~] accident and health
3438 insurance issued by an insurer may continue to be effected on persons in this state. The
3439 commissioner may issue an order under this section only if he finds, after a hearing, that the total
3440 charges for the insurance to the persons insured are unreasonable in relation to the benefits
3441 provided. The commissioner's findings under this section must be in writing. Orders under this
3442 section may direct the insurer to cease effecting the insurance until the total charges for the
3443 insurance are found by the commissioner to be reasonable in relation to the benefits provided.
3444 Section 62. Section **31A-21-404** is amended to read:
3445 **31A-21-404. Out-of-state insurers.**
3446 Any insurer extending mass marketed life or [~~disability~~] accident and health insurance
3447 under a group or blanket policy issued outside of this state to residents of this state shall, with
3448 respect to the mass marketed life or [~~disability~~] accident and health insurance policy:
3449 (1) comply with Sections 31A-23-302 and 31A-23-303 and Part III of Chapter 26; and
3450 (2) upon the commissioner's request, deliver to the commissioner a copy of any mass
3451 marketed life or [~~disability~~] accident and health insurance policy, certificates issued under these
3452 policies, and advertising material used in this state in connection with the policy.
3453 Section 63. Section **31A-21-501** is amended to read:
3454 **31A-21-501. Definitions.**
3455 For purposes of this part:
3456 (1) "Applicant" means:
3457 (a) in the case of an individual life or [~~disability~~] accident and health policy, the person
3458 who seeks to contract for insurance benefits; or
3459 (b) in the case of a group life or [~~disability~~] accident and health policy, the proposed
3460 certificate holder.
3461 (2) "Cohabitant" means an emancipated individual pursuant to Section 15-2-1 or an
3462 individual who is 16 years of age or older who:
3463 (a) is or was a spouse of the other party;
3464 (b) is or was living as if a spouse of the other party;
3465 (c) is related by blood or marriage to the other party;
3466 (d) has one or more children in common with the other party; or

3467 (e) resides or has resided in the same residence as the other party.
3468 (3) "Child abuse" means the commission or attempt to commit against a child a criminal
3469 offense described in:
3470 (a) Title 76, Chapter 5, Part 1, Assault and Related Offenses;
3471 (b) Title 76, Chapter 5, Part 4, Sexual Offenses;
3472 (c) Subsections 76-9-702(1) through (4), Lewdness- Sexual battery; or
3473 (d) Section 76-9-702.5, Lewdness Involving a Child.
3474 (4) "Domestic violence" means any criminal offense involving violence or physical harm
3475 or threat of violence or physical harm, or any attempt, conspiracy, or solicitation to commit a
3476 criminal offense involving violence or physical harm, when committed by one cohabitant against
3477 another and includes commission or attempt to commit, any of the following offenses by one
3478 cohabitant against another:
3479 (a) aggravated assault, as described in Section 76-5-103;
3480 (b) assault, as described in Section 76-5-102;
3481 (c) criminal homicide, as described in Section 76-5-201;
3482 (d) harassment, as described in Section 76-5-106;
3483 (e) telephone harassment, as described in Section 76-9-201;
3484 (f) kidnaping, child kidnaping, or aggravated kidnaping, as described in Sections 76-5-301,
3485 76-5-301.1, and 76-5-302;
3486 (g) mayhem, as described in Section 76-5-105;
3487 (h) sexual offenses, as described in Title 76, Chapter 5, Part 4, and Title 76, Chapter 5a;
3488 (i) stalking, as described in Section 76-5-106.5;
3489 (j) unlawful detention, as described in Section 76-5-304;
3490 (k) violation of a protective order or ex parte protective order, as described in Section
3491 76-5-108;
3492 (l) any offense against property described in Title 76, Chapter 6, Part 1, 2, or 3;
3493 (m) possession of a deadly weapon with intent to assault, as described in Section
3494 76-10-507; or
3495 (n) discharge of a firearm from a vehicle, near a highway, or in the direction of any person,
3496 building, or vehicle, as described in Section 76-10-508.
3497 (5) "Subject of domestic abuse" means an individual who is, has been, may currently be,

3498 or may have been subject to domestic violence or child abuse.
3499 Section 64. Section **31A-21-502** is amended to read:
3500 **31A-21-502. Scope of part.**
3501 This part applies to only life and [~~disability~~] accident and health insurance.
3502 Section 65. Section **31A-21-503** is amended to read:
3503 **31A-21-503. Discrimination based on domestic violence or child abuse prohibited.**
3504 (1) Except as provided in Subsection (2), an insurer of life or [~~disability~~] accident and
3505 health insurance may not consider whether an insured or applicant is the subject of domestic abuse
3506 as a factor to:
3507 (a) refuse to insure the applicant;
3508 (b) refuse to continue to insure the insured;
3509 (c) refuse to renew or reissue a policy to insure the insured or applicant;
3510 (d) limit the amount, extent, or kind of coverage available to the insured or applicant;
3511 (e) charge a different rate for coverage to the insured or applicant;
3512 (f) exclude or limit benefits or coverage under an insurance policy or contract for losses
3513 incurred;
3514 (g) deny a claim; or
3515 (h) terminate coverage or fail to provide conversion privileges in violation of Sections
3516 31A-22-612 and 31A-22-710 under a group [~~disability~~] accident and health policy for the insured
3517 because the coverage was issued in the name of the perpetrator of the domestic violence or abuse.
3518 (2) (a) Notwithstanding Subsection (1), an insurer may underwrite based on the physical
3519 or mental condition of an insured or applicant if the underwriting is based on a determination that
3520 there is a correlation between the medical or mental condition and a material increase in insurance
3521 risk.
3522 (b) For purposes of Subsection (2)(a), the fact that an insured or applicant is a subject of
3523 domestic abuse is not a mental or physical condition.
3524 (c) The determination required by Subsection (2)(a) shall be made in conformance with
3525 sound actuarial principles.
3526 (d) Within 30 days after receiving an oral or written request from an insured or applicant,
3527 an insurer shall disclose in writing:
3528 (i) the basis of an action permitted under Subsection (2)(a); and

3529 (ii) if the policy has been issued or modified, the extent the action taken will impact the
3530 amount, extent, or kind of coverage or benefits available to the insured.
3531 Section 66. Section **31A-21-505** is amended to read:
3532 **31A-21-505. Limit on liability.**
3533 An insurer that issues a life or [~~disability~~] accident and health insurance policy to an
3534 individual who is the subject of domestic abuse is not liable civilly or criminally for the death of
3535 or any injuries to the insured as a result of domestic violence or child abuse beyond the obligations
3536 of the insurer under:
3537 (1) the insurance policy; or
3538 (2) this title.
3539 Section 67. Section **31A-22-307** is amended to read:
3540 **31A-22-307. Personal injury protection coverages and benefits.**
3541 (1) Personal injury protection coverages and benefits include:
3542 (a) the reasonable value of all expenses for necessary medical, surgical, X-ray, dental,
3543 rehabilitation, including prosthetic devices, ambulance, hospital, and nursing services, not to
3544 exceed a total of $3,000 per person;
3545 (b) (i) the lesser of $250 per week or 85% of any loss of gross income and loss of earning
3546 capacity per person from inability to work, for a maximum of 52 consecutive weeks after the loss,
3547 except that this benefit need not be paid for the first three days of disability, unless the disability
3548 continues for longer than two consecutive weeks after the date of injury; and
3549 (ii) a special damage allowance not exceeding $20 per day for a maximum of 365 days,
3550 for services actually rendered or expenses reasonably incurred for services that, but for the injury,
3551 the injured person would have performed for his household, except that this benefit need not be
3552 paid for the first three days after the date of injury unless the person's inability to perform these
3553 services continues for more than two consecutive weeks;
3554 (c) funeral, burial, or cremation benefits not to exceed a total of $1,500 per person; and
3555 (d) compensation on account of death of a person, payable to his heirs, in the total of
3556 $3,000.
3557 (2) (a) To determine the reasonable value of the medical expenses provided for in
3558 Subsection (1) and under Subsection 31A-22-309 (1)(e), the commissioner shall conduct a relative
3559 value study of services and accommodations for the diagnosis, care, recovery, or rehabilitation of

3560 an injured person in the most populous county in the state to assign a unit value and determine the
3561 75th percentile charge for each type of service and accommodation. The study shall be updated
3562 every other year. In conducting the study, the department may consult or contract with appropriate
3563 public and private medical and health agencies or other technical experts. The costs and expenses
3564 incurred in conducting, maintaining, and administering the relative value study shall be funded by
3565 the tax created under Section 59-9-105. Upon completion of the study, the department shall
3566 prepare and publish a relative value study which sets forth the unit value and the 75th percentile
3567 charge assigned to each type of service and accommodation.
3568 (b) The reasonable value of any service or accommodation is determined by applying the
3569 unit value and the 75th percentile charge assigned to the service or accommodation under the
3570 relative value study. If a service or accommodation is not assigned a unit value or the 75th
3571 percentile charge under the relative value study, the value of the service or accommodation shall
3572 equal the reasonable cost of the same or similar service or accommodation in the most populous
3573 county of this state.
3574 (c) This subsection does not preclude the department from adopting a schedule already
3575 established or a schedule prepared by persons outside the department, if it meets the requirements
3576 of this subsection.
3577 (d) Every insurer shall report to the Commissioner of Insurance any patterns of
3578 overcharging, excessive treatment, or other improper actions by a health provider within 30 days
3579 after such insurer has knowledge of such pattern.
3580 (e) (i) In disputed cases, a court on its own motion or on the motion of either party may
3581 designate an impartial medical panel of not more than three licensed physicians to examine the
3582 claimant and testify on the issue of the reasonable value of the claimant's medical services or
3583 expenses.
3584 (ii) An impartial medical panel designated under Subsection (2)(e)(i) shall consist of a
3585 majority of health care professionals within the same license classification and specialty as the
3586 provider of the claimant's medical services or expenses.
3587 (3) Medical expenses as provided for in Subsection (1)(a) and in Subsection 31A-22-309
3588 (1)(e) include expenses for any nonmedical remedial care and treatment rendered in accordance
3589 with a recognized religious method of healing.
3590 (4) The insured may waive for the named insured and the named insured's spouse only the

3591 loss of gross income benefits of Subsection (1)(b)(i) if the insured states in writing that:
3592 (a) within 31 days of applying for coverage, neither the insured nor the insured's spouse
3593 received any earned income from regular employment; and
3594 (b) for at least 180 days from the date of the writing and during the period of insurance,
3595 neither the insured nor the insured's spouse will receive earned income from regular employment.
3596 (5) This section does not prohibit the issuance of policies of insurance providing coverages
3597 greater than the minimum coverage required under this chapter nor does it require the segregation
3598 of those minimum coverages from other coverages in the same policy.
3599 (6) Deductibles are not permitted with respect to the insurance coverages required under
3600 this section.
3601 Section 68. Section **31A-22-403** is amended to read:
3602 **31A-22-403. Incontestability.**
3603 (1) This section does not apply to group policies.
3604 (2) Each life insurance policy is, and shall state that, after it has been in force during the
3605 lifetime of the insured for a period of two years from its date of issue, it is incontestable except for
3606 the following:
3607 (a) The policy may be contested for nonpayment of premiums.
3608 (b) The policy may be contested as to:
3609 (i) provisions relating to [~~disability~~] accident and health benefits allowed under Section
3610 31A-22-609[~~,~~]; and [~~as to~~]
3611 (ii) additional benefits in the event of death by accident [~~or accidental means~~].
3612 (c) If the policy allows the insured, after the policy's issuance and for an additional
3613 premium, to obtain a death benefit which is larger than when the policy was originally issued, then
3614 the payment of the additional increment of benefit is contestable until two years after the
3615 incremental increase of benefits, but the only ground of contest that may arise is in connection with
3616 the incremental increase.
3617 (3) A reinstated life insurance policy or annuity contract may be contested for two years
3618 following reinstatement on the same basis as at original issuance, but only as to matters arising in
3619 connection with the reinstatement. Any grounds for contest available at original issuance continue
3620 to be available for contest until the policy has been in force for a total of two years during the
3621 lifetime of the insured.

3622 (4) The limitations on incontestability under this section preclude only a contest of the
3623 validity of the policy, and do not preclude the good faith assertion at any time of defenses based
3624 upon provisions in the policy which exclude or qualify coverage, whether or not those
3625 qualifications or exclusions are specifically excepted in the policy's incontestability clause.
3626 Provisions on which the contestable period would normally run may not be reformulated as
3627 coverage exclusions or restrictions to take advantage of this Subsection (4).
3628 Section 69. Section **31A-22-404** is amended to read:
3629 **31A-22-404. Suicide.**
3630 (1) (a) Suicide is not a defense to a claim under a life insurance policy that has been in
3631 force as to a policyholder or certificate holder for two years from the date [~~the coverage is~~
3632 ~~effective~~] of issuance of the policy, whether:
3633 (i) the suicide was voluntary or involuntary; or
3634 (ii) the insured was sane or insane.
3635 (b) If a suicide occurs within the two-year period described in Subsection (1)(a), the
3636 insurer shall pay to the beneficiary an amount not less than the premium paid for the life insurance
3637 policy.
3638 (2) (a) If after a life insurance policy is in effect the policy allows the insured to obtain a
3639 death benefit that is larger than when the policy was originally effective for an additional premium,
3640 the payment of the additional increment of benefit may be limited in the event of a suicide within
3641 a two-year period beginning on the date the increment increase takes effect.
3642 (b) If a suicide occurs within the two-year period described in Subsection (2)(a), the
3643 insurer shall pay to the beneficiary an amount not less than the additional premium paid for the
3644 additional increment of benefit.
3645 (3) This section does not apply to:
3646 (a) policies insuring against death by accident only; or
3647 (b) the accident or double indemnity provisions of an insurance policy.
3648 Section 70. Section **31A-22-415** is amended to read:
3649 **31A-22-415. Simultaneous death.**
3650 Section 75-2-702 applies to all policies of life and [~~disability~~] accident and health
3651 insurance.
3652 Section 71. Section **31A-22-423** is amended to read:

3653 **31A-22-423. Policy and annuity examination period.**
3654 (1) (a) Except as provided under Subsection (2), all life insurance policies and annuities
3655 shall contain a notice prominently printed on or attached to the cover or front page stating that the
3656 policyholder has the right to return the policy for any reason on or before:
3657 (i) ten days after delivery; or
3658 (ii) in case of a replacement policy, 20 days after the replacement policy is delivered.
3659 (b) For purposes of this section, "return" means a written statement on the policy or an
3660 accompanying writing that the policy is being returned for termination of coverage that is delivered
3661 to or mailed first class to the insurer or its agent.
3662 (c) A policy returned under this section is void from the date of [~~return~~] issuance.
3663 (d) A policyholder returning a policy is entitled to a refund of any premium paid[~~, except~~
3664 ~~that the insurer may retain an amount not exceeding that determined by rule adopted by the~~
3665 ~~commissioner~~].
3666 (2) This section does not apply to:
3667 (a) group policies; and
3668 (b) other classes of life insurance policies that the commissioner specifies by rule after
3669 finding that a right to return those policies would be impracticable or unnecessary to protect the
3670 policyholder's interests.
3671 Section 72. Section **31A-22-424** is enacted to read:
3672 **31A-22-424. Documents constituting entire life insurance policy.**
3673 (1) A life insurance policy shall contain a provision that defines the documents and
3674 agreements that constitute the entire contract between the parties.
3675 (2) Except as permitted by Section 31A-21-106, all documents and agreements defined
3676 under Subsection (1) shall be attached to the policy.
3677 Section 73. Section **31A-22-510** is amended to read:
3678 **31A-22-510. Requirements for group life insurance delivered in another jurisdiction.**
3679 (1) [~~No~~] A Utah resident may not be enrolled in a policy of group life insurance delivered
3680 in another jurisdiction in violation of Subsection (2) or (3), notwithstanding any contrary provision
3681 in Subsection 31A-1-103(3) [~~(h)~~].
3682 (2) Unless specifically authorized by the commissioner under Section 31A-22-509,
3683 coverage under a group life insurance policy delivered in another jurisdiction may not be initially

3684 provided to any person unless the policy conforms substantially to one of the types of groups
3685 specified under Sections 31A-22-502 through 31A-22-508.
3686 (3) [~~No coverage~~] Coverage may not be initially provided to any person in Utah under a
3687 group life policy issued in another jurisdiction by an insurer not authorized to engage in life
3688 insurance business in Utah unless the policyholder conforms substantially to the type of group
3689 specified under Section 31A-22-502, 31A-22-503, or 31A-22-504.
3690 Section 74. Section **31A-22-517** is amended to read:
3691 **31A-22-517. Conversion on termination of eligibility.**
3692 (1) If any portion of the insurance on a person covered under the policy ceases because of
3693 termination of employment or of membership in the classes eligible for coverage, the person is
3694 entitled to be issued by the insurer, without evidence of insurability, an individual policy of life
3695 insurance without [~~disability~~] accident and health or other supplementary benefits, if an application
3696 for the individual policy is made and the first premium paid to the insurer within 31 days after the
3697 termination.
3698 (2) The individual policy shall, at the option of the person entitled, be on any form then
3699 customarily issued by the insurer at the age and for the amount applied for, except that the group
3700 policy may exclude the option to elect term insurance.
3701 (3) The individual policy shall be for an amount not in excess of the life insurance which
3702 ceases because of the termination, less the amount of any life insurance for which the person is
3703 eligible because of the termination and within 30 days after it. Any amount of insurance which
3704 matures on or before the termination, as an endowment payable to the person insured, whether in
3705 one sum, in installments, or in the form of an annuity, is not included in the amount which is
3706 considered to cease because of the termination.
3707 (4) The premium on the individual policy shall be at the insurer's customary rate at the
3708 time of termination, which is applicable to the form and amount of the individual policy, to the
3709 class of risk to which the person belonged when terminated from the group policy, and to the age
3710 attained on the effective date of the individual policy.
3711 (5) Subject to the conditions of this section, the conversion privilege is available:
3712 (a) to a surviving dependent, if any, at the death of the employee or member, with respect
3713 to the survivor's coverage under the group policy which terminates by reason of the death; and
3714 (b) to the dependent of the employee or member upon termination of coverage of the

3715 dependent, while the employee or member remains insured, because the dependent ceases to be
3716 a qualified dependent under the group policy.
3717 Section 75. Section **31A-22-518** is amended to read:
3718 **31A-22-518. Conversion on termination of policy.**
3719 [If] (1) Subject to Subsection (2), if the group policy terminates or is amended to terminate
3720 the insurance of any class of covered persons, every insured person whose insurance terminates,
3721 including the insured dependent of a covered person who has been insured for at least five years
3722 prior to the termination date, is entitled to have the insurer issue to [him] the person an individual
3723 policy of life insurance, subject to the conditions and limitations in Section 31A-22-517[, except
3724 that the].
3725 (2) The group policy [may] described in Subsection (1) shall provide [either] that[: (1)
3726 The] the amount of the individual policy may not [exceed] be less than the smaller of:
3727 (a) the amount of the person's life insurance protection ceasing because of the termination
3728 or amendment of the group policy, less the amount of any life insurance for which [he] the person
3729 is eligible under any group policy issued or reinstated by the same or another insurer within 30
3730 days after the termination[. (2) The amount of the individual policy may not exceed]; or
3731 (b) $10,000.
3732 Section 76. Section **31A-22-520** is amended to read:
3733 **31A-22-520. Continuation of coverage during total disability.**
3734 (1) An insured person in a group life insurance policy may continue coverage during the
3735 total disability of the insured person or dependent by timely payment to the policyholder of that
3736 portion, if any, of the premium that would have been required on behalf of the insured person in
3737 the absence of total disability.
3738 (2) The continuation shall be on a premium paying basis until the earlier of:
3739 (a) six months from the date of total disability;
3740 (b) approval by the insurer of continuation of the coverage under any disability provision
3741 the group insurance policy may contain; or
3742 (c) the discontinuance of the group insurance policy.
3743 (3) If the group policy has a waiting period for [a disability] an accident and health benefit,
3744 the continuation extends to the end of the waiting period, even if the group policy is otherwise
3745 discontinued.

3746 Section 77. Section **31A-22-522** is enacted to read:

3747 **31A-22-522. Required provision for notice of termination.**

3748 (1) A policy for group or blanket life insurance coverage issued or renewed after July 1,
3749 2001, shall include a provision that obligates the policyholder to notify each employee or group
3750 member:

3751 (a) in writing;

3752 (b) 30 days before the date the coverage is terminated; and

3753 (c) (i) that the group or blanket life insurance coverage is being terminated; and

3754 (ii) the rights the employee or group member has to continue coverage upon termination.

3755 (2) For a policy for group or blanket life insurance coverage described in Subsection (1),
3756 an insurer shall:

3757 (a) include a statement of a policyholder's obligations under Subsection (1) in the insurer's
3758 monthly notice to the policyholder of premium payments due; and

3759 (b) provide a sample notice to the policyholder at least once a year.

3760 Section 78. Section **31A-22-600** is amended to read:

3761 **31A-22-600. Scope of Part VI.**

3762 (1) [This] Except where a provision's appreciation is otherwise specifically limited, this
3763 part applies to all [disability]:

3764 (a) accident and health insurance contracts, including credit [disability,] accident and
3765 health;

3766 (b) franchise[, and];

3767 (c) group contracts[, except where a provision's application is otherwise specifically
3768 limited.]; and

3769 (d) a life insurance and annuity policy, but only if:

3770 (i) it includes supplemental benefits and riders including accelerated benefits; and

3771 (ii) receipt of benefits in contingent on morbidity requirements.

3772 (2) Nothing in this part applies to or affects:

3773 (a) workers' compensation insurance;

3774 (b) reinsurance; or

3775 [(c) annuities or life insurance, or their supplemental contracts which contain only those
3776 provisions relating to disability insurance which provide additional benefits in case of

3777 ~~dismemberment or loss of sight by accident, safeguard the contract against lapse, or give a special~~
3778 ~~surrender value or special benefit or an annuity if the insured or annuitant becomes totally and~~
3779 ~~permanently disabled, as defined by the contract or supplemental contract; (d) disability~~]
3780 (c) accident and health insurance when it is part of or supplemental to liability, steam
3781 boiler, elevator, automobile, or other insurance covering loss of or damage to property, provided
3782 the loss, damage, or expense arises out of a hazard directly related to the other insurance.
3783 (3) Except as provided in Subsection (1), this part does not apply to or affect a life
3784 insurance or annuity policy including a life insurance policy:
3785 (a) with a rider or supplemental benefit that accelerates the death benefit contingent upon
3786 a mortality risk specifically for one or more of the qualifying events of:
3787 (i) terminal illness;
3788 (ii) medical conditions requiring extraordinary medical intervention; or
3789 (iii) permanent institutional confinement; and
3790 (b) that provides the option of a lump-sum payment for those benefits.
3791 Section 79. Section **31A-22-601** is amended to read:
3792 **31A-22-601. Applicability of life insurance provisions.**
3793 Sections 31A-22-412 through 31A-22-417 apply to death benefits in [~~disability~~] accident
3794 and health insurance policies.
3795 Section 80. Section **31A-22-602** is amended to read:
3796 **31A-22-602. Premium rates.**
3797 (1) This section does not apply to group [~~disability~~] accident and health insurance.
3798 (2) The benefits in [~~a disability~~] an accident and health insurance policy shall be
3799 reasonable in relation to the premiums charged.
3800 (3) The commissioner shall disapprove [~~a disability~~] an accident and health insurance
3801 policy form if it does not satisfy Subsection (2).
3802 Section 81. Section **31A-22-603** is amended to read:
3803 **31A-22-603. Persons insured under an individual accident and health policy.**
3804 A policy of individual [~~disability~~] accident and health insurance may insure only one
3805 person, except that originally or by subsequent amendment, upon the application of an adult
3806 policyholder, a policy may insure any two or more eligible members of the policyholder's family,
3807 including husband, wife, dependent children, and any other person dependent upon the

3808 policyholder.

3809 Section 82. Section **31A-22-604** is amended to read:

3810 **31A-22-604. Reimbursement by insurers of Medicaid benefits.**

3811 (1) As used in this section, "Medicaid" means the program under Title XIX of the federal
3812 Social Security Act.

3813 (2) Any [~~disability~~] accident and health insurer, including a group [~~disability~~] accident and
3814 health insurance plan, as defined in Section 607(1), Federal Employee Retirement Income Security
3815 Act of 1974, or health maintenance organization as defined in Section 31A-8-101, is prohibited
3816 from considering the availability or eligibility for medical assistance in this or any other state under
3817 Medicaid, when considering eligibility for coverage or making payments under its plan for eligible
3818 enrollees, subscribers, policyholders, or certificate holders.

3819 (3) To the extent that payment for covered expenses has been made under the state
3820 Medicaid program for health care items or services furnished to an individual in any case when a
3821 third party has a legal liability to make payments, the state is considered to have acquired the rights
3822 of the individual to payment by any other party for those health care items or services.

3823 (4) Title 26, Chapter 19, Medical Benefits Recovery Act, applies to reimbursement of
3824 insurers of Medicaid benefits.

3825 Section 83. Section **31A-22-605** is amended to read:

3826 **31A-22-605. Accident and health insurance standards.**

3827 (1) The purposes of this section include:

3828 (a) reasonable standardization and simplification of terms and coverages of individual and
3829 franchise [~~disability~~] accident and health insurance policies, including [~~disability~~] accident and
3830 health insurance contracts of insurers licensed under Chapters 7 and 8, to facilitate public
3831 understanding and comparison in purchasing;

3832 (b) elimination of provisions contained in individual and franchise [~~disability~~] accident
3833 and health insurance contracts [~~which~~] that may be misleading or confusing in connection with
3834 either the purchase of those types of coverages or the settlement of claims; and

3835 (c) full disclosure in the sale of individual and franchise [~~disability~~] accident and health
3836 insurance contracts.

3837 (2) As used in this section:

3838 (a) "Direct response insurance policy" means an individual insurance policy solicited and

3839 sold without the policyholder having direct contact with a natural person intermediary.
3840 (b) "Medicare" is defined in Subsection 31A-22-620(1)(e).
3841 (c) "Medicare supplement policy" is defined in Subsection 31A-22-620(1)(f).
3842 (3) This section applies to all individual and franchise [~~disability~~] accident and health
3843 policies.
3844 (4) The commissioner shall adopt rules relating to the following matters:
3845 (a) standards for the manner and content of policy provisions, and disclosures to be made
3846 in connection with the sale of policies covered by this section, dealing with at least the following
3847 matters:
3848 (i) terms of renewability;
3849 (ii) initial and subsequent conditions of eligibility;
3850 (iii) nonduplication of coverage provisions;
3851 (iv) coverage of dependents;
3852 (v) preexisting conditions;
3853 (vi) termination of insurance;
3854 (vii) probationary periods;
3855 (viii) limitations;
3856 (ix) exceptions;
3857 (x) reductions;
3858 (xi) elimination periods;
3859 (xii) requirements for replacement;
3860 (xiii) recurrent conditions;
3861 (xiv) coverage of persons eligible for Medicare; and
3862 (xv) definition of terms;
3863 (b) minimum standards for benefits under each of the following categories of coverage in
3864 policies covered in this section:
3865 (i) basic hospital expense coverage;
3866 (ii) basic medical-surgical expense coverage;
3867 (iii) hospital confinement indemnity coverage;
3868 (iv) major medical expense coverage;
3869 (v) [~~disability~~] income [~~protection~~] replacement coverage;

3870 (vi) accident only coverage;
3871 (vii) specified disease or specified accident coverage;
3872 (viii) limited benefit health coverage; and
3873 (ix) nursing home and long-term care coverage;
3874 (c) the content and format of the outline of coverage, in addition to that required under
3875 Subsection (6); [~~and~~]
3876 (d) the method of identification of policies and contracts based upon coverages
3877 provided[~~.~~]; and
3878 (e) rating practices.
3879 (5) Nothing in Subsection (4)(b) precludes the issuance of policies that combine categories
3880 of coverage in that subsection provided that any combination of categories meets the standards of
3881 a component category of coverage.
3882 (6) The commissioner may adopt rules relating to the following matters:
3883 (a) establishing disclosure requirements for insurance policies covered in this section,
3884 designed to adequately inform the prospective insured of the need for and extent of the coverage
3885 offered, and requiring that this disclosure be furnished to the prospective insured with the
3886 application form, unless it is a direct response insurance policy;
3887 (b) (i) prescribing caption or notice requirements designed to inform prospective insureds
3888 that particular insurance coverages are not Medicare Supplement coverages;
3889 (ii) the requirements of Subsection (6)(b)(i) apply to all [~~disability~~] insurance policies and
3890 certificates sold to persons eligible for Medicare; and
3891 (c) requiring the disclosures or information brochures to be furnished to the prospective
3892 insured on direct response insurance policies, upon his request or, in any event, no later than the
3893 time of the policy delivery.
3894 (7) A policy covered by this section may be issued only if it meets the minimum standards
3895 established by the commissioner under Subsection (4), an outline of coverage accompanies the
3896 policy or is delivered to the applicant at the time of the application, and, except with respect to
3897 direct response insurance policies, an acknowledged receipt is provided to the insurer. The outline
3898 of coverage shall include:
3899 (a) a statement identifying the applicable categories of coverage provided by the policy as
3900 prescribed under Subsection (4);

3901 (b) a description of the principal benefits and coverage;
3902 (c) a statement of the exceptions, reductions, and limitations contained in the policy;
3903 (d) a statement of the renewal provisions, including any reservation by the insurer of a
3904 right to change premiums;
3905 (e) a statement that the outline is a summary of the policy issued or applied for and that
3906 the policy should be consulted to determine governing contractual provisions; and
3907 (f) any other contents the commissioner prescribes.
3908 (8) If a policy is issued on a basis other than that applied for, the outline of coverage shall
3909 accompany the policy when it is delivered and it shall clearly state that it is not the policy for
3910 which application was made.
3911 (9) (a) Notwithstanding Subsection 31A-22-609(2), and except as provided under
3912 Subsection (9)(b), an insurer that elects to use an application form without questions concerning
3913 the insured's health history or medical treatment history, shall provide coverage under the policy
3914 for any loss which occurs more than 12 months after the effective date of the policy due to a
3915 preexisting condition which is not specifically excluded from coverage.
3916 (b) (i) An insurer that issues a specified disease policy, regardless of whether the basis of
3917 issuance is a detailed application form, a simplified application form, or an enrollment form, may
3918 not deny a claim for loss due to a preexisting condition which occurs more than six months after
3919 the effective date of coverage.
3920 (ii) A specified disease policy may not define a preexisting condition more restrictively
3921 than a condition which first manifested itself within six months prior to the effective date of
3922 coverage or which was diagnosed by a physician at any time prior to the effective date of coverage.
3923 (iii) A specified disease policy may not include wording that provides a defense based
3924 upon a preexisting condition except as allowed under this Subsection (9).
3925 (10) Notwithstanding Subsection 31A-22-606(1), limited accident and health policies or
3926 certificates issued to persons eligible for Medicare shall contain a notice prominently printed on
3927 or attached to the cover or front page which states that the policyholder or certificate holder has
3928 the right to return the policy for any reason within 30 days after its delivery and to have the
3929 premium refunded.
3930 Section 84. Section **31A-22-606** is amended to read:
3931 **31A-22-606. Policy examination period.**

3932 (1) (a) Except as provided in Subsection (2), all [~~disability~~] accident and health policies
3933 shall contain a notice prominently printed on or attached to the cover or front page stating that the
3934 policyholder has the right to return the policy for any reason within ten days after its delivery.
3935 (b) "Return" means delivery to the insurer or its agent or mailing of the policy to either,
3936 properly addressed and stamped for first class handling, with a written statement on the policy or
3937 an accompanying communication that it is being returned for termination of coverage. A policy
3938 returned under Subsection (1) is void from the beginning and a policyholder returning his policy
3939 is entitled to a refund of any premium paid.
3940 (2) This section does not apply to:
3941 (a) group policies;
3942 (b) policies issued to persons entitled to a 30-day examination period under Subsection
3943 31A-22-605(10);
3944 (c) single premium nonrenewable policies issued for terms not longer than 60 days;
3945 (d) policies covering accidents only or accidental bodily injury only; and
3946 (e) other classes of policies which the commissioner by rule specifies after a finding that
3947 a right to return those policies would be impracticable or unnecessary to protect the policyholder's
3948 interests.
3949 Section 85. Section **31A-22-607** is amended to read:
3950 **31A-22-607. Grace period.**
3951 (1) Every individual or franchise [~~disability~~] accident and health insurance policy shall
3952 contain clauses providing for a grace period of at least seven days for weekly premium policies,
3953 ten days for monthly premium policies and 30 days for all other policies, for each premium after
3954 the first. During the grace period, the policy continues in force.
3955 (2) Every group or blanket [~~disability~~] accident and health policy shall provide for a grace
3956 period of at least 30 days, unless the policyholder gives written notice of discontinuance prior to
3957 the date of discontinuance, in accordance with the policy terms. In group or blanket policies, the
3958 policy may provide for payment of a pro rata premium for the period the policy is in effect during
3959 the grace period under this [~~subsection~~] Subsection (2).
3960 (3) If the insurer has not guaranteed the insured a right to renew [~~a disability~~] an accident
3961 and health policy, any grace period beyond the expiration or anniversary date may, if provided in
3962 the policy, be cut off by compliance with the notice provision under Subsection 31A-21-303(4)(b).

3963 Section 86. Section **31A-22-608** is amended to read:

3964 **31A-22-608. Reinstatement of individual or franchise accident and health insurance**
3965 **policies.**

3966 (1) Every individual or franchise [~~disability~~] accident and health insurance policy shall
3967 contain a provision which reads as follows:

3968 "REINSTATEMENT: If any renewal premium is not paid within the time granted the
3969 insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly
3970 authorized by the insurer to accept the premium, without also requiring an application for
3971 reinstatement, shall reinstate the policy. However, if the insurer or agent requires an application
3972 for reinstatement and issues a conditional receipt for the premium tendered, the policy shall be
3973 reinstated upon approval of this application from the insurer or, lacking this approval, upon the
3974 45th day following the date of the conditional receipt, unless the insurer has previously notified
3975 the insured in writing of its disapproval of the application. The reinstated policy shall cover only
3976 loss resulting from such accidental injury as may be sustained after the date of reinstatement and
3977 loss due to such sickness as may begin more than ten days after that date. In all other respects the
3978 insured and insurer have the same rights under the reinstated policy as they had under the policy
3979 immediately before the due date of the defaulted premium, subject to any provisions endorsed on
3980 or attached to this policy in connection with the reinstatement. Any premium accepted in
3981 connection with a reinstatement shall be applied to a period for which premium has not been
3982 previously paid, but not to any period more than 60 days prior to the date of reinstatement."

3983 (2) The last sentence of the provision set forth in Subsection (1) may be omitted from any
3984 policy [~~which~~] that the insured has the right to continue in force subject to its terms by the timely
3985 payment of premiums until at least age 50, or in the case of a policy issued after age 44, for at least
3986 five years from its date of issue.

3987 Section 87. Section **31A-22-609** is amended to read:

3988 **31A-22-609. Incontestability for accident and health insurance.**

3989 (1) [~~No~~] (a) A statement made by an applicant in the application for individual or
3990 franchise [~~disability~~] accident and health insurance coverage [~~and no~~] or statement made relating
3991 to the person's insurability by a person insured under a group policy, except fraudulent
3992 misrepresentation, [~~is~~] may not be a basis for avoidance of the policy or denial of a claim for loss
3993 incurred or disability commencing after the coverage has been in effect for two years.

3994 (b) The insurer has the burden of proving fraud by clear and convincing evidence.
3995 (c) The policy may provide for incontestability even for fraudulent misstatements.
3996 (2) Except as otherwise provided under Subsection 31A-22-605(9), [~~no~~] a claim for loss
3997 incurred or disability commencing after two years from the date of issue of the policy may not be
3998 reduced or denied on the ground that a disease or physical condition existed prior to the effective
3999 date of coverage, unless the condition was excluded from coverage by name or specific description
4000 in a provision [~~which~~] that was in effect on the date of loss.
4001 Section 88. Section **31A-22-610** is amended to read:
4002 **31A-22-610. Dependent coverage from moment of birth or adoption.**
4003 (1) As used in this section:
4004 (a) "Child" means, in connection with any adoption, or placement for adoption of the child,
4005 an individual who is younger than 18 years of age as of the date of the adoption or placement for
4006 adoption.
4007 (b) "Placement for adoption" means the assumption and retention by a person of a legal
4008 obligation for total or partial support of a child in anticipation of the adoption of the child.
4009 (2) (a) If any [~~disability~~] accident and health insurance policy provides coverage for any
4010 members of the policyholder's or certificate holder's family, the policy shall also provide that any
4011 health insurance benefits applicable to dependents of the insured are applicable on the same basis
4012 to a newly born child from the moment of birth, and to an adopted child:
4013 (i) beginning from the moment of birth if placement for adoption occurs within 30 days
4014 of the child's birth; or
4015 (ii) beginning from the date of placement if placement for adoption occurs 30 days or more
4016 after the child's birth.
4017 (b) This coverage is not subject to any preexisting conditions, and includes any injury or
4018 sickness, including the necessary care and treatment of medically diagnosed congenital defects and
4019 birth abnormalities or prematurity.
4020 (c) If the payment of a specific premium is required to provide coverage for a child of the
4021 policyholder or certificate holder, the policy may require that the insurer be notified of the birth
4022 or placement for the purpose of adoption, and that the required premium be paid within 30 days
4023 after the date of birth or placement for the purpose of adoption, in order to have the coverage
4024 extend beyond that 30-day period.

4025 (3) The coverage required by Subsection (2) as to children placed for the purpose of
4026 adoption with a policyholder or certificate holder continues in the same manner as it would with
4027 respect to a child of the policyholder or certificate holder unless the placement is disrupted prior
4028 to legal adoption and the child is removed from placement. The coverage requirement ends if the
4029 child is removed from placement prior to being legally adopted.
4030 (4) The provisions of this section apply to employee welfare benefit plans as defined in
4031 Section 26-19-2.
4032 Section 89. Section **31A-22-610.2** is amended to read:
4033 **31A-22-610.2. Maternity stay minimum limits.**
4034 (1) (a) If an insured has coverage for maternity benefits, the policy may not be limited to
4035 a less than a 48-hour benefit for both mother and newborn with a normal vaginal delivery.
4036 (b) If an insured has coverage for maternity benefits, the policy may not be limited to a less
4037 than 96-hour benefit for both mother and newborn with a caesarean section delivery.
4038 (2) Subsection (1) applies to [~~a disability~~] an accident and health insurer who offers
4039 maternity coverage.
4040 Section 90. Section **31A-22-610.5** is amended to read:
4041 **31A-22-610.5. Dependent coverage.**
4042 (1) As used in this section, "child" has the same meaning as defined in Section 78-45-2.
4043 (2) (a) Any individual or group health insurance policy or health maintenance organization
4044 contract that provides coverage for a policyholder's or certificate holder's dependent shall not
4045 terminate coverage of an unmarried dependent by reason of the dependent's age before the
4046 dependent's 26th birthday and shall, upon application, provide coverage for all unmarried
4047 dependents up to age 26.
4048 (b) The cost of coverage for unmarried dependents 19 to 26 years of age shall be included
4049 in the premium on the same basis as other dependent coverage.
4050 (c) This section does not prohibit the employer from requiring the employee to pay all or
4051 part of the cost of coverage for unmarried dependents.
4052 (3) An individual or group health insurance policy or health maintenance organization
4053 contract shall reinstate dependent coverage, and for purposes of all exclusions and limitations,
4054 shall treat the dependent as if the coverage had been in force since it was terminated; if:
4055 (a) the dependent has not reached the age of 26 by July 1, 1995;

4056 (b) the dependent had coverage prior to July 1, 1994;
4057 (c) prior to July 1, 1994, the dependent's coverage was terminated solely due to the age of
4058 the dependent; and
4059 (d) the policy has not been terminated since the dependent's coverage was terminated.
4060 (4) (a) When a parent is required by a court or administrative order to provide health
4061 insurance coverage for a child, [~~a disability~~] an accident and health insurer may not deny
4062 enrollment of a child under the [~~disability~~] accident and health insurance plan of the child's parent
4063 on the grounds the child:
4064 (i) was born out of wedlock and is entitled to coverage under Subsection (6);
4065 (ii) was born out of wedlock and the custodial parent seeks enrollment for the child under
4066 the custodial parent's policy;
4067 (iii) is not claimed as a dependent on the parent's federal tax return; or
4068 (iv) does not reside with the parent or in the insurer's service area.
4069 (b) [~~A disability~~] An accident and health insurer providing enrollment under Subsection
4070 (4)(a)(iv) is subject to the requirements of Subsection (5).
4071 (5) A health maintenance organization or a preferred provider organization may use
4072 alternative delivery systems or indemnity insurers to provide coverage under Subsection (4)(a)(iv)
4073 outside its service area. [~~The provisions of~~] Section 31A-8-408 [~~do~~] does not apply to this
4074 Subsection (5).
4075 (6) When a child has [~~disability~~] accident and health coverage through an insurer of a
4076 noncustodial parent the insurer shall:
4077 (a) provide information to the custodial parent as necessary for the child to obtain benefits
4078 through that coverage, but the insurer or employer, or the agents or employees of either of them,
4079 are not civilly or criminally liable for providing information in compliance with this Subsection
4080 (6)(a), whether the information is provided pursuant to a verbal or written request;
4081 (b) permit the custodial parent or the service provider, with the custodial parent's approval,
4082 to submit claims for covered services without the approval of the noncustodial parent; and
4083 (c) make payments on claims submitted in accordance with Subsection (6)(b) directly to
4084 the custodial parent, the provider, or the state Medicaid agency.
4085 (7) When a parent is required by a court or administrative order to provide health coverage
4086 for a child, and the parent is eligible for family health coverage, the insurer shall:

4087 (a) permit the parent to enroll, under the family coverage, a child who is otherwise eligible
4088 for the coverage without regard to an enrollment season restrictions;
4089 (b) if the parent is enrolled but fails to make application to obtain coverage for the child,
4090 enroll the child under family coverage upon application of the child's other parent, the state agency
4091 administering the Medicaid program, or the state agency administering 42 U.S.C. 651 through 669,
4092 the child support enforcement program; and
4093 (c) not disenroll or eliminate coverage of the child unless the insurer is provided
4094 satisfactory written evidence that:
4095 (i) the court or administrative order is no longer in effect; or
4096 (ii) the child is or will be enrolled in comparable [~~disability~~] accident and health coverage
4097 through another insurer which will take effect not later than the effective date of disenrollment.
4098 (8) An insurer may not impose requirements on a state agency [~~which~~] that has been
4099 assigned the rights of an individual eligible for medical assistance under Medicaid and covered for
4100 [~~disability~~] accident and health benefits from the insurer that are different from requirements
4101 applicable to an agent or assignee of any other individual so covered.
4102 (9) Insurers may not reduce their coverage of pediatric vaccines below the benefit level
4103 in effect on May 1, 1993.
4104 (10) When a parent is required by a court or administrative order to provide health
4105 coverage, which is available through an employer doing business in this state, the employer shall:
4106 (a) permit the parent to enroll under family coverage any child who is otherwise eligible
4107 for coverage without regard to any enrollment season restrictions;
4108 (b) if the parent is enrolled but fails to make application to obtain coverage of the child,
4109 enroll the child under family coverage upon application by the child's other parent, by the state
4110 agency administering the Medicaid program, or the state agency administering 42 U.S.C. 651
4111 through 669, the child support enforcement program;
4112 (c) not disenroll or eliminate coverage of the child unless the employer is provided
4113 satisfactory written evidence that:
4114 (i) the court order is no longer in effect;
4115 (ii) the child is or will be enrolled in comparable coverage which will take effect no later
4116 than the effective date of disenrollment; or
4117 (iii) the employer has eliminated family health coverage for all of its employees; and

4118 (d) withhold from the employee's compensation the employee's share, if any, of premiums
4119 for health coverage and to pay this amount to the insurer.
4120 (11) An order issued under Section 62A-11-326.1 may be considered a "qualified medical
4121 support order" for the purpose of enrolling a dependent child in a group [~~disability~~] accident and
4122 health insurance plan as defined in Section 609(a), Federal Employee Retirement Income Security
4123 Act of 1974.
4124 (12) This section does not affect any insurer's ability to require as a precondition of any
4125 child being covered under any policy of insurance that:
4126 (a) the parent continues to be eligible for coverage;
4127 (b) the child shall be identified to the insurer; and
4128 (c) the premium shall be paid when due.
4129 (13) The provisions of this section apply to employee welfare benefit plans as defined in
4130 Section 26-19-2.
4131 Section 91. Section **31A-22-611** is amended to read:
4132 **31A-22-611. Policy extension for handicapped children.**
4133 (1) Every [~~disability~~] accident and health insurance policy or contract that provides that
4134 coverage of a dependent child of a person insured under the policy shall terminate upon reaching
4135 a limiting age as specified in the policy, shall also provide that the age limitation does not
4136 terminate the coverage of a dependent child while the child is and continues to be both:
4137 (a) incapable of self-sustaining employment because of mental retardation or physical
4138 handicap; and
4139 (b) chiefly dependent upon the person insured under the policy for support and
4140 maintenance.
4141 (2) The insurer may require proof of the incapacity and dependency be furnished by the
4142 person insured under the policy within 30 days of the date the child attains the limiting age, and
4143 at any time thereafter, except that the insurer may not require proof more often than annually after
4144 the two-year period immediately following attainment of the limiting age by the child.
4145 Section 92. Section **31A-22-612** is amended to read:
4146 **31A-22-612. Conversion privileges for insured former spouse.**
4147 (1) [~~No disability~~] An accident and health insurance policy, which in addition to covering
4148 the insured also provides coverage to the spouse of the insured, may not contain a provision for

4149 termination of coverage of a spouse covered under the policy, except by entry of a valid decree of
4150 divorce or annulment between the parties.
4151 (2) Every policy which contains this type of provision shall provide that upon the entry of
4152 the divorce decree the spouse is entitled to have issued an individual policy of [disability] accident
4153 and health insurance without evidence of insurability, upon application to the company and
4154 payment of the appropriate premium. The policy shall provide the coverage being issued which
4155 is most nearly similar to the terminated coverage. Probationary or waiting periods in the policy
4156 are considered satisfied to the extent the coverage was in force under the prior policy.
4157 (3) When the insurer receives actual notice that the coverage of a spouse is to be
4158 terminated because of a divorce or annulment, the insurer shall promptly provide the spouse
4159 written notification of the right to obtain individual coverage as provided in Subsection (2), the
4160 premium amounts required, and the manner, place, and time in which premiums may be paid. The
4161 premium is determined in accordance with the insurer's table of premium rates applicable to the
4162 age and class of risk of the persons to be covered and to the type and amount of coverage provided.
4163 If the spouse applies and tenders the first monthly premium to the insurer within 30 days after
4164 receiving the notice provided by this subsection, the spouse shall receive individual coverage that
4165 commences immediately upon termination of coverage under the insured's policy.
4166 (4) This section does not apply to [disability] accident and health insurance policies
4167 offered on a group blanket basis.
4168 Section 93. Section **31A-22-613** is amended to read:
4169 **31A-22-613. Permitted provisions for accident and health insurance policies.**
4170 The following provisions may be contained in [a disability] an accident and health
4171 insurance policy, but if they are in that policy, they shall conform to at least the [following]
4172 minimum requirements for the policyholder [:] in this section.
4173 (1) Any provision respecting change of occupation may provide only for a lower maximum
4174 benefit payment and for reduction of loss payments proportionate to the change in appropriate
4175 premium rates, if the change is to a higher rated occupation, and this provision shall provide for
4176 retroactive reduction of premium rates from the date of change of occupation or the last policy
4177 anniversary date, whichever is the more recent, if the change is to a lower rated occupation.
4178 (2) Section 31A-22-405 applies to misstatement of age in [disability] accident and health
4179 policies, with the appropriate modifications of terminology.

4180 (3) Any policy which contains a provision establishing, as an age limit or otherwise, a date
4181 after which the coverage provided by the policy is not effective, and if that date falls within a
4182 period for which a premium is accepted by the insurer or if the insurer accepts a premium after that
4183 date, the coverage provided by the policy continues in force, subject to any right of cancellation,
4184 until the end of the period for which the premium was accepted. This Subsection (3) does not
4185 apply if the acceptance of premium would not have occurred but for a misstatement of age by the
4186 insured.
4187 (4) Any provision dealing with preexisting conditions shall be consistent with Subsections
4188 31A-22-605(9)(a) and 31A-22-609(2), and any applicable rule adopted by the commissioner.
4189 (5) (a) If an insured is otherwise eligible for maternity benefits, a policy may not contain
4190 language which requires an insured to obtain any additional preauthorization or preapproval for
4191 customary and reasonable maternity care expenses or for the delivery of the child after an initial
4192 preauthorization or preapproval has been obtained from the insurer for prenatal care. A
4193 requirement for notice of admission for delivery is not a requirement for preauthorization or
4194 preapproval, however, the maternity benefit may not be denied or diminished for failure to provide
4195 admission notice. The policy may not require the provision of admission notice by only the
4196 insured patient.
4197 (b) This Subsection (5) does not prohibit an insurer from:
4198 (i) requiring a referral before maternity care can be obtained;
4199 (ii) specifying a group of providers or a particular location from which an insured is
4200 required to obtain maternity care; or
4201 (iii) limiting reimbursement for maternity expenses and benefits in accordance with the
4202 terms and conditions of the insurance contract so long as such terms do not conflict with
4203 Subsection (5)(a).
4204 (6) An insurer may only represent that a policy:
4205 (a) offers a vision benefit if the policy:
4206 (i) charges a premium for the benefit; and
4207 (ii) provides reimbursement for materials or services provided under the policy; and
4208 (b) covers laser vision correction, whether photorefractive keratectomy, laser assisted
4209 in-situ keratomelusis, or related procedure, if the policy:
4210 (i) charges a premium for the benefit; and

4211 (ii) the procedure is at least a partially covered benefit.
4212 Section 94. Section **31A-22-613.5** is amended to read:
4213 **31A-22-613.5. Price and value comparisons of health insurance.**
4214 (1) This section applies generally to all health insurance policies and health maintenance
4215 organization contracts.
4216 (2) (a) Immediately after the effective date of this section, the commissioner shall appoint
4217 a Health Benefit Plan Committee.
4218 (b) The committee shall be composed of representatives of carriers, employers, employees,
4219 health care providers, consumers, and producers.
4220 (c) A member of the committee shall be appointed to a four-year term.
4221 (d) Notwithstanding the requirements of Subsection (2)(c), the commissioner shall, at the
4222 time of appointment or reappointment, adjust the length of terms to ensure that the terms of
4223 committee members are staggered so that approximately half of the committee is appointed every
4224 two years.
4225 (3) When a vacancy occurs in the membership for any reason, the replacement shall be
4226 appointed for the unexpired term.
4227 (4) (a) Members shall receive no compensation or benefits for their services, but may
4228 receive per diem and expenses incurred in the performance of the member's official duties at the
4229 rates established by the Division of Finance under Sections 63A-3-106 and 63A-3-107.
4230 (b) Members may decline to receive per diem and expenses for their service.
4231 (5) [~~(a)~~] The committee shall[~~: (i)~~] serve as an advisory committee to the commissioner[~~;~~
4232 ~~and~~]<u>.</u>
4233 [~~(ii) recommend for two or more designated health care plans to be marketed in the state:~~]
4234 [~~(A) services to be covered;~~]
4235 [~~(B) copays;~~]
4236 [~~(C) deductibles;~~]
4237 [~~(D) levels of coinsurance;~~]
4238 [~~(E) annual out-of-pocket maximums;~~]
4239 [~~(F) exclusions; and~~]
4240 [~~(G) limitations.~~]
4241 [~~(b) The plans recommended by the committee may include reasonable benefit differentials~~

4242 ~~applicable to participating and nonparticipating providers.~~]
4243 [~~(c) The plans recommended by the committee may not prohibit the use of the following~~
4244 ~~cost management techniques by an insurer:~~]
4245 [~~(i) preauthorization of health care services;~~]
4246 [~~(ii) concurrent review of health care services;~~]
4247 [~~(iii) case management of health care services;~~]
4248 [~~(iv) retrospective review of medical appropriateness;~~]
4249 [~~(v) selective contracting with hospitals, physicians, and other health care providers to the~~
4250 ~~extent permitted by law; and~~]
4251 [~~(vi) other reasonable techniques intended to manage health care costs.~~]
4252 [~~(d) The committee shall submit the plans to the commissioner within 180 days after the~~
4253 ~~appointment of the committee in accordance with this section.~~]
4254 [~~(e) The commissioner shall adopt two or more health benefit plans within 60 days after~~
4255 ~~the committee submits recommendations.~~]
4256 [~~(f) (i) If the committee fails to submit recommendations to the commissioner within 180~~
4257 ~~days after appointment, the commissioner shall, within 90 days, develop two or more designated~~
4258 ~~health benefit plans.~~]
4259 [~~(ii) The commissioner shall, after notice and hearing, adopt two or more designated health~~
4260 ~~benefit plans.~~]
4261 [~~(iii) The commissioner shall provide incentives for personal management of health care~~
4262 ~~expenses by adopting:~~]
4263 [~~(A) one plan that applies deductibles in the amount of $1,500; and~~]
4264 [~~(B) another plan that applies deductibles in the amount of $2,500.~~]
4265 [~~(iv) The plans described in Subsection (5)(f)(iii) may include:~~]
4266 [~~(A) illustrations and explanations showing the premium savings generated by the high~~
4267 ~~deductibles being applied to a medical savings account for the insured that can be used to pay:~~]
4268 [~~(I) medical expenses up to the plan deductible;~~]
4269 [~~(II) any other medical expenses not covered by the insurance; or~~]
4270 [~~(III) both the medical expenses described in Subsections (5)(f)(iv)(A)(I) and (II); and~~]
4271 [~~(B) an explanation that any funds in the savings account belong to the insured.~~]
4272 [~~(g) The commissioner may reconvene a Health Benefit Plan Committee in accordance~~

4273 ~~with Subsections (2) and (5) to recommend revisions to the designated benefit plans adopted by~~
4274 ~~the commissioner.~~]
4275 [~~(6) (a) Within 180 days after the adoption of the designated benefit plans by the~~
4276 ~~commissioner, or any changes in the designated plans, an insurer offering health insurance policies~~
4277 ~~for sale in this state shall, at the request of a potential buyer, offer the current designated plans at~~
4278 ~~a premium based on factors such as that buyer's previous claims experience, group size,~~
4279 ~~demographic characteristics, and health status.~~]
4280 [~~(b) This section does not prohibit an insurer from refusing to insure, under any plan, a~~
4281 ~~person or group. However, if the insurer offers any policy or contract to that person or group, the~~
4282 ~~insurer shall offer the designated plans.~~]
4283 [~~(7) The designated benefit plans, described in Subsection (5) are intended to facilitate~~
4284 ~~price and value comparisons by consumers. The designated benefit plans are not minimum~~
4285 ~~standards for health insurance policies. An insurer offering the designated benefit plans may offer~~
4286 ~~policies that provide more or less coverage than the designated benefit plans.~~]
4287 [~~(8)~~] (6) (a) The commissioner shall convene or reconvene a Health Benefit Plan
4288 Committee for the purpose of developing a Basic Health Care Plan to be offered under the open
4289 enrollment provisions of Chapter 30.
4290 (b) The commissioner shall adopt a Basic Health Care Plan within 60 days after the
4291 committee submits recommendations, or if the committee fails to submit recommendations to the
4292 commissioner within 180 days after appointment, the commissioner shall, within 90 days, adopt
4293 a Basic Health Care Plan.
4294 (c) (i) Before adoption of a plan under Subsection [~~(8)~~](6)(b), the commissioner shall
4295 submit the proposed Basic Health Care Plan to the Health and Human Services Interim Committee
4296 for review and recommendations.
4297 (ii) After the commissioner adopts the Basic Health Care Plan, the Health and Human
4298 Services Interim Committee:
4299 (A) shall provide legislative oversight of the Basic Health Care Plan; and
4300 (B) may recommend legislation to modify the Basic Health Care Plan adopted by the
4301 commissioner.
4302 (d) The committee's recommendations for the Basic Health Care Plan shall be advisory
4303 to the commissioner.

4304 [(9)] (7) (a) The commissioner shall promote informed consumer behavior and responsible
4305 health insurance and health plans by requiring an insurer issuing health insurance policies or health
4306 maintenance organization contracts to provide to all enrollees, prior to enrollment in the health
4307 benefit plan or health insurance policy, written disclosure of:
4308 (i) restrictions or limitations on prescription drugs and biologics including the use of a
4309 formulary and generic substitution; and
4310 (ii) coverage limits under the plan.
4311 (b) In addition to the requirements of Subsections [(9)] (7)(a) and (d), an insurer described
4312 in Subsection [(9)] (7)(a) shall submit the written disclosure required by this Subsection [(9)] (7)
4313 to the commissioner:
4314 (i) [annually] upon commencement of operations in the state; and
4315 (ii) anytime the insurer amends any of the following described in Subsection [(9)] (7)(a):
4316 (A) treatment policies;
4317 (B) practice standards;
4318 (C) restrictions; or
4319 (D) coverage limits of the insurer's health benefit plan or health insurance policy.
4320 (c) The commissioner may adopt rules to implement the disclosure requirements of this
4321 Subsection [(9)] (7), taking into account:
4322 (i) business confidentiality of the insurer;
4323 (ii) definitions of terms; and
4324 (iii) the method of disclosure to enrollees.
4325 (d) If under Subsection [(9)] (7)(a)(i) a formulary is used, the insurer shall make available
4326 to prospective enrollees and maintain evidence of the fact of the disclosure of:
4327 (i) the drugs included;
4328 (ii) the patented drugs not included; and
4329 (iii) any conditions that exist as a precedent to coverage.
4330 [(10) (a) The commissioner shall annually publish a table comparing the rates charged by
4331 insurers for the designated health plans and other health insurance plans in this state.]
4332 [(b) The comparison required by Subsection (10)(a) shall list:]
4333 [(i) the top 20 insurers writing the greatest volume by premium dollar per calendar year;
4334 and]

4335 [~~(ii) others requesting inclusion in the comparison.~~]

4336 [~~(c) In conjunction with the rate comparison described in this Subsection (10), the~~
4337 ~~commissioner shall publish for each of the listed health insurers a table comparing the complaints~~
4338 ~~filed and the combined loss and expense ratio as described in Subsections 31A-2-208.5(2) and (3).~~]

4339 Section 95. Section **31A-22-614** is amended to read:

4340 **31A-22-614. Claims under accident and health policies.**

4341 (1) Section 31A-21-312 applies generally to claims under [~~disability~~] <u>accident and health</u>
4342 policies.

4343 (2) (a) Subject to Subsection (1), [~~no disability~~] <u>an accident and health</u> insurance policy
4344 may <u>not</u> contain a claim notice requirement less favorable to the insured than one which requires
4345 written notice of the claim within 20 days after the occurrence or commencement of any loss
4346 covered by the policy. The policy shall specify to whom claim notices may be given.

4347 (b) If a loss of time benefit under a policy may be paid for a period of at least two years,
4348 an insurer may require periodic notices that the insured continues to be disabled, unless the insured
4349 is legally incapacitated. The insured's delay in giving that notice does not impair the insured's or
4350 beneficiary's right to any indemnity which would otherwise have accrued during the six months
4351 preceding the date on which that notice is actually given.

4352 (3) [~~No disability~~] <u>An accident and health</u> insurance policy may <u>not</u> contain a time limit
4353 on proof of loss which is more restrictive to the insured than a provision requiring written proof
4354 of loss, delivered to the insurer, within the following time:

4355 (a) for a claim where periodic payments are contingent upon continuing loss, within 90
4356 days after the termination of the period for which the insurer is liable;

4357 (b) for any other claim, within 90 days after the date of the loss.

4358 (4) (a) (i) Section 31A-26-301 applies generally to the payment of claims.

4359 (ii) Indemnity for loss of life is paid in accordance with the beneficiary designation
4360 effective at the time of payment. If no valid beneficiary designation exists, the indemnity is paid
4361 to the insured's estate. Any other accrued indemnities unpaid at the insured's death are paid to the
4362 insured's estate.

4363 (b) Reasonable facility of payment clauses, specified by the commissioner by rule or in
4364 approving the policy form, are permitted. Payment made in good faith and in accordance with
4365 those clauses discharges the insurer's obligation to pay those claims.

4366 (c) All or a portion of any indemnities provided under [a disability] an accident and health
4367 policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option,
4368 be paid directly to the hospital or person rendering the services.
4369 Section 96. Section **31A-22-617** is amended to read:
4370 **31A-22-617. Preferred provider contract provisions.**
4371 Health insurance policies may provide for insureds to receive services or reimbursement
4372 under the policies in accordance with preferred health care provider contracts as follows:
4373 (1) Subject to restrictions under this section, any insurer or third party administrator may
4374 enter into contracts with health care providers as defined in Section 78-14-3 under which the health
4375 care providers agree to supply services, at prices specified in the contracts, to persons insured by
4376 an insurer. [The]
4377 (a) A health care provider contract may require the health care provider to accept the
4378 specified payment as payment in full, relinquishing the right to collect additional amounts from
4379 the insured person.
4380 (b) The insurance contract may reward the insured for selection of preferred health care
4381 providers by:
4382 (i) reducing premium rates[,];
4383 (ii) reducing deductibles[,];
4384 (iii) coinsurance[, or];
4385 (iv) other copayments[,]; or
4386 (v) in any other reasonable manner.
4387 (c) If the insurer is a managed care organization, as defined in Subsection
4388 31A-27-311.5(1)(f):
4389 (i) the insurance contract shall provide that in the event the managed care organization
4390 becomes insolvent, the rehabilitator or liquidator may:
4391 (A) require the health care provider to continue to provide health care services under the
4392 contract until the later of:
4393 (I) 90 days from the date of the filing of a petition for rehabilitation or the petition for
4394 liquidation; or
4395 (II) the date the term of the contract ends; and
4396 (B) subject to Subsection (1)(c)(v), reduce the fees the provider is otherwise entitled to

4397 receive from the managed care organization during the time period described in Subsection
4398 (1)(c)(i)(A);
4399 (ii) the provider is required to:
4400 (A) accept the reduced payment under Subsection (1)(c)(i)(B) as payment in full; and
4401 (B) relinquish the right to collect additional amounts from the insolvent managed care
4402 organization's enrollee, as defined in Section 31A-27-311.5(1)(b);
4403 (iii) if the contract between the health care provider and the managed care organization has
4404 not been reduced to writing, or the contract fails to contain the language required by Subsection
4405 (1)(c)(i), the provider may not collect or attempt to collect from the enrollee:
4406 (A) sums owed by the managed care organization; or
4407 (B) the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B);
4408 (iv) the following may not bill or maintain any action at law against an enrollee to collect
4409 sums owed by the managed care organization or the amount of the regular fee reduction authorized
4410 under Subsection (1)(c)(i)(B):
4411 (A) a provider;
4412 (B) an agent;
4413 (C) a trustee; or
4414 (D) an assignee of a person described in Subsections (1)(c)(iv)(A) through (C); and
4415 (v) notwithstanding Subsection (1)(c)(i):
4416 (A) a rehabilitator or liquidator may not reduce a fee by less than 75% of the provider's
4417 regular fee set forth in the contract; and
4418 (B) the enrollee shall continue to pay the copayments, deductibles, and other payments for
4419 services received from the provider that the enrollee was required to pay before the filing of:
4420 (I) a petition for rehabilitation; or
4421 (II) a petition for liquidation.
4422 (2) (a) Subject to Subsections (2)(b) through (2)(f), an insurer using preferred health care
4423 provider contracts shall pay for the services of health care providers not under the contract, unless
4424 the illnesses or injuries treated by the health care provider are not within the scope of the insurance
4425 contract. As used in this section, "class of health care providers" means all health care providers
4426 licensed or licensed and certified by the state within the same professional, trade, occupational, or
4427 facility licensure or licensure and certification category established pursuant to Titles 26 and 58.

4428 (b) When the insured receives services from a health care provider not under contract, the
4429 insurer shall reimburse the insured for at least 75% of the average amount paid by the insurer for
4430 comparable services of preferred health care providers who are members of the same class of
4431 health care providers. The commissioner may adopt a rule dealing with the determination of what
4432 constitutes 75% of the average amount paid by the insurer for comparable services of preferred
4433 health care providers who are members of the same class of health care providers.
4434 (c) When reimbursing for services of health care providers not under contract, the insurer
4435 may make direct payment to the insured.
4436 (d) Notwithstanding Subsection (2)(b), an insurer using preferred health care provider
4437 contracts may impose a deductible on coverage of health care providers not under contract.
4438 (e) When selecting health care providers with whom to contract under Subsection (1), an
4439 insurer may not unfairly discriminate between classes of health care providers, but may
4440 discriminate within a class of health care providers, subject to Subsection (7).
4441 (f) For purposes of this section, unfair discrimination between classes of health care
4442 providers shall include:
4443 (i) refusal to contract with class members in reasonable proportion to the number of
4444 insureds covered by the insurer and the expected demand for services from class members; and
4445 (ii) refusal to cover procedures for one class of providers that are:
4446 (A) commonly utilized by members of the class of health care providers for the treatment
4447 of illnesses, injuries, or conditions;
4448 (B) otherwise covered by the insurer; and
4449 (C) within the scope of practice of the class of health care providers.
4450 (3) Before the insured consents to the insurance contract, the insurer shall fully disclose
4451 to the insured that it has entered into preferred health care provider contracts. The insurer shall
4452 provide sufficient detail on the preferred health care provider contracts to permit the insured to
4453 agree to the terms of the insurance contract. The insurer shall provide at least the following
4454 information:
4455 (a) a list of the health care providers under contract and if requested their business
4456 locations and specialties;
4457 (b) a description of the insured benefits, including any deductibles, coinsurance, or other
4458 copayments;

4459 (c) a description of the quality assurance program required under Subsection (4); and
4460 (d) a description of the grievance procedures required under Subsection (5).
4461 (4) (a) An insurer using preferred health care provider contracts shall maintain a quality
4462 assurance program for assuring that the care provided by the health care providers under contract
4463 meets prevailing standards in the state.
4464 (b) The commissioner in consultation with the executive director of the Department of
4465 Health may designate qualified persons to perform an audit of the quality assurance program. The
4466 auditors shall have full access to all records of the organization and its health care providers,
4467 including medical records of individual patients.
4468 (c) The information contained in the medical records of individual patients shall remain
4469 confidential. All information, interviews, reports, statements, memoranda, or other data furnished
4470 for purposes of the audit and any findings or conclusions of the auditors are privileged. The
4471 information is not subject to discovery, use, or receipt in evidence in any legal proceeding except
4472 hearings before the commissioner concerning alleged violations of this section.
4473 (5) An insurer using preferred health care provider contracts shall provide a reasonable
4474 procedure for resolving complaints and grievances initiated by the insureds and health care
4475 providers.
4476 (6) An insurer may not contract with a health care provider for treatment of illness or
4477 injury unless the health care provider is licensed to perform that treatment.
4478 (7) (a) [~~No~~] A health care provider or insurer may not discriminate against a preferred
4479 health care provider for agreeing to a contract under Subsection (1).
4480 (b) Any health care provider licensed to treat any illness or injury within the scope of the
4481 health care provider's practice, who is willing and able to meet the terms and conditions established
4482 by the insurer for designation as a preferred health care provider, shall be able to apply for and
4483 receive the designation as a preferred health care provider. Contract terms and conditions may
4484 include reasonable limitations on the number of designated preferred health care providers based
4485 upon substantial objective and economic grounds, or expected use of particular services based
4486 upon prior provider-patient profiles.
4487 (8) Upon the written request of a provider excluded from a provider contract, the
4488 commissioner may hold a hearing to determine if the insurer's exclusion of the provider is based
4489 on the criteria set forth in Subsection (7)(b).

4490 (9) Insurers are subject to the provisions of Sections 31A-22-613.5, 31A-22-614.5, and
4491 31A-22-618.
4492 (10) Nothing in this section is to be construed as to require an insurer to offer a certain
4493 benefit or service as part of a health benefit plan.
4494 (11) This section does not apply to catastrophic mental health coverage provided in
4495 accordance with Section 31A-22-625.
4496 Section 97. Section **31A-22-619** is amended to read:
4497 **31A-22-619. Coordination of benefits.**
4498 (1) The commissioner shall adopt rules concerning the coordination of benefits between
4499 [~~disability~~] accident and health insurance policies.
4500 (2) Rules adopted by the commissioner under Subsection (1):
4501 (a) may not prohibit coordination of benefits with individual [~~disability~~] accident and
4502 health insurance policies; and
4503 (b) shall apply equally to all [~~disability~~] accident and health insurance policies without
4504 regard to whether the policies are group or individual policies.
4505 Section 98. Section **31A-22-620** is amended to read:
4506 **31A-22-620. Medicare Supplement Insurance Minimum Standards Act.**
4507 (1) As used in this section:
4508 (a) "Applicant" means:
4509 (i) in the case of an individual Medicare supplement policy, the person who seeks to
4510 contract for insurance benefits; and
4511 (ii) in the case of a group Medicare supplement policy, the proposed certificate holder.
4512 (b) "Certificate" means any certificate delivered or issued for delivery in this state under
4513 a group Medicare supplement policy.
4514 (c) "Certificate form" means the form on which the certificate is delivered or issued for
4515 delivery by the issuer.
4516 (d) "Issuer" includes insurance companies, fraternal benefit societies, health care service
4517 plans, health maintenance organizations, and any other entity delivering, or issuing for delivery in
4518 this state, Medicare supplement policies or certificates.
4519 (e) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social
4520 Security Amendments of 1965, as then constituted or later amended.

4521 (f) "Medicare Supplement Policy" means a group or individual policy of disability
4522 insurance, other than a policy issued pursuant to a contract under Section 1876 of the federal Social
4523 Security Act, 42 U.S.C. Section 1395 et seq., or an issued policy under a demonstration project
4524 specified in 41 U.S.C. Section 1395ss(g)(1), that is advertised, marketed, or designed primarily as
4525 a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses
4526 of persons eligible for Medicare.
4527 (g) "Policy Form" means the form on which the policy is delivered or issued for delivery
4528 by the issuer.
4529 (2) (a) Except as otherwise specifically provided, this section applies to:
4530 (i) all Medicare supplement policies delivered or issued for delivery in this state on or after
4531 the effective date of this section;
4532 (ii) all certificates issued under group Medicare supplement policies, that have been
4533 delivered or issued for delivery in this state on or after the effective date of this section; and
4534 (iii) policies or certificates that were in force prior to the effective date of this section, with
4535 respect to requirements for benefits, claims payment, and policy reporting practice under
4536 Subsection (3)(d), and loss ratios under Subsection (4).
4537 (b) This section does not apply to a policy of one or more employers or labor
4538 organizations, or of the trustees of a fund established by one or more employers or labor
4539 organizations, or a combination of employers and labor unions, for employees or former employees
4540 or a combination of employees and former employees, or for members or former members of the
4541 labor organizations, or a combination of members and former members of labor organizations.
4542 (c) This section does not prohibit, nor does it apply to insurance policies or health care
4543 benefit plans, including group conversion policies, provided to Medicare eligible persons that are
4544 not marketed or held out to be Medicare supplement policies or benefit plans.
4545 (3) (a) A Medicare supplement policy or certificate in force in the state may not contain
4546 benefits that duplicate benefits provided by Medicare.
4547 (b) Notwithstanding any other provision of law of this state, a Medicare supplement policy
4548 or certificate may not exclude or limit benefits for loss incurred more than six months from the
4549 effective date of coverage because it involved a preexisting condition. The policy or certificate
4550 may not define a preexisting condition more restrictively than: "A condition for which medical
4551 advice was given or treatment was recommended by or received from a physician within six

4552 months before the effective date of coverage."

4553 (c) The commissioner shall adopt rules to establish specific standards for policy provisions
4554 of Medicare supplement policies and certificates. The standards adopted shall be in addition to
4555 and in accordance with applicable laws of this state. A requirement of this title relating to
4556 minimum required policy benefits, other than the minimum standards contained in this section,
4557 may not apply to Medicare supplement policies and certificates. The standards may include:

4558 (i) terms of renewability;

4559 (ii) initial and subsequent conditions of eligibility;

4560 (iii) nonduplication of coverage;

4561 (iv) probationary periods;

4562 (v) benefit limitations, exceptions, and reductions;

4563 (vi) elimination periods;

4564 (vii) requirements for replacement;

4565 (viii) recurrent conditions; and

4566 (ix) definitions of terms.

4567 (d) The commissioner shall adopt rules establishing minimum standards for benefits,
4568 claims payment, marketing practices, compensation arrangements, and reporting practices for
4569 Medicare supplement policies and certificates.

4570 (e) The commissioner may adopt such rules as are necessary to conform Medicare
4571 supplement policies and certificates to the requirements of federal law and regulations promulgated
4572 thereunder, including:

4573 (i) requiring refunds or credits if the policies do not meet loss ratio requirements;

4574 (ii) establishing a uniform methodology for calculating and reporting loss ratios;

4575 (iii) assuring public access to policies, premiums, and loss ratio information of issuers of
4576 Medicare supplement insurance;

4577 (iv) establishing a process for approving or disapproving policy forms and certificate forms
4578 and proposed premium increases;

4579 (v) establishing a policy for holding public hearings prior to approval of premium
4580 increases; and

4581 (vi) establishing standards for Medicare select policies and certificates.

4582 (f) The commissioner may adopt rules that prohibit policy provisions not otherwise

4583 specifically authorized by statute that, in the opinion of the commissioner, are unjust, unfair, or
4584 unfairly discriminatory to any person insured or proposed to be insured under a Medicare
4585 supplement policy or certificate.
4586 (4) Medicare supplement policies shall return to policyholders benefits that are reasonable
4587 in relation to the premium charged. The commissioner shall make rules to establish minimum
4588 standards for loss ratios of Medicare supplement policies on the basis of incurred claims
4589 experience, or incurred health care expenses where coverage is provided by a health maintenance
4590 organization on a service basis rather than on a reimbursement basis, and earned premiums in
4591 accordance with accepted actuarial principles and practices.
4592 (5) (a) To provide for full and fair disclosure in the sale of Medicare supplement policies,
4593 a Medicare supplement policy or certificate may not be delivered in this state unless an outline of
4594 coverage is delivered to the applicant at the time application is made.
4595 (b) The commissioner shall prescribe the format and content of the outline of coverage
4596 required by Subsection (5)(a).
4597 (c) For purposes of this section, "format" means style arrangements and overall
4598 appearance, including such items as the size, color, and prominence of type and arrangement of
4599 text and captions. The outline of coverage shall include:
4600 (i) a description of the principal benefits and coverage provided in the policy;
4601 (ii) a statement of the renewal provisions, including any reservation by the issuer of a right
4602 to change premiums; and disclosure of the existence of any automatic renewal premium increases
4603 based on the policyholder's age; and
4604 (iii) a statement that the outline of coverage is a summary of the policy issued or applied
4605 for and that the policy should be consulted to determine governing contractual provisions.
4606 <u>(d) The commissioner may make rules for captions or notice if the commissioner finds that</u>
4607 <u>the rules are:</u>
4608 <u>(i) in the public interest; and</u>
4609 <u>(ii) designed to inform prospective insureds that particular insurance coverages are not</u>
4610 <u>Medicare supplement coverages, for all accident an health insurance policies sold to person</u>
4611 <u>eligible for Medicare, other than:</u>
4612 <u>(A) a medicare supplement policy; or</u>
4613 <u>(B) a disability income policy.</u>

4614 [(d)] (e) The commissioner may prescribe by rule a standard form and the contents of an
4615 informational brochure for persons eligible for Medicare, that is intended to improve the buyer's
4616 ability to select the most appropriate coverage and improve the buyer's understanding of Medicare.
4617 Except in the case of direct response insurance policies, the commissioner may require by rule that
4618 the informational brochure be provided concurrently with delivery of the outline of coverage to
4619 any prospective insureds eligible for Medicare. With respect to direct response insurance policies,
4620 the commissioner may require by rule that the prescribed brochure be provided upon request to any
4621 prospective insureds eligible for Medicare, but in no event later than the time of policy delivery.
4622 [(e)] (f) The commissioner may adopt reasonable rules to govern the full and fair
4623 disclosure of the information in connection with the replacement of [disability] accident and health
4624 policies, subscriber contracts, or certificates by persons eligible for Medicare.
4625 (6) Notwithstanding Subsection (1), Medicare supplement policies and certificates shall
4626 have a notice prominently printed on the first page of the policy or certificate, or attached to the
4627 front page, stating in substance that the applicant has the right to return the policy or certificate
4628 within 30 days of its delivery and to have the premium refunded if, after examination of the policy
4629 or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this
4630 section shall be paid directly to the applicant by the issuer in a timely manner.
4631 (7) Every issuer of Medicare supplement insurance policies or certificates in this state shall
4632 provide a copy of any Medicare supplement advertisement intended for use in this state, whether
4633 through written or broadcast medium, to the commissioner for review.
4634 Section 99. Section **31A-22-623** is amended to read:
4635 **31A-22-623. Coverage of inborn metabolic errors.**
4636 (1) As used in this section:
4637 (a) "Dietary products" means medical food or a low protein modified food product that:
4638 (i) is specifically formulated to treat inborn errors of amino acid or urea cycle metabolism;
4639 (ii) is not a natural food that is naturally low in protein; and
4640 (iii) is used under the direction of a physician.
4641 (b) "Inborn errors of amino acid or urea cycle metabolism" means a disease caused by an
4642 inherited abnormality of body chemistry which is treatable by the dietary restriction of one or more
4643 amino acid.
4644 (2) The commissioner shall establish, by rule, minimum standards of coverage for dietary

4645 products used for the treatment of inborn errors of amino acid or urea cycle metabolism at levels
4646 consistent with the major medical benefit provided under [~~a disability~~] an accident and health
4647 insurance policy.
4648 Section 100. Section **31A-22-624** is amended to read:
4649 **31A-22-624. Primary care physician.**
4650 [~~A disability~~] An accident and health insurance policy that requires an insured to select a
4651 primary care physician to receive optimum coverage:
4652 (1) shall permit an insured to select a participating provider who is an
4653 obstetrician/gynecologist and is qualified and willing to provide primary care services, as defined
4654 by the health care plan, as the insured's provider from whom primary care services are received;
4655 (2) shall clearly state in literature explaining the policy the option available to female
4656 insureds under Subsection (1); and
4657 (3) may not impose a higher premium, higher copayment requirement, or any other
4658 additional expense on an insured by virtue of the insured selecting a primary care physician in
4659 accordance with Subsection (1).
4660 Section 101. Section **31A-22-626** is amended to read:
4661 **31A-22-626. Coverage of diabetes.**
4662 (1) As used in this section, "diabetes" includes individuals with:
4663 (a) complete insulin deficiency or type 1 diabetes;
4664 (b) insulin resistant with partial insulin deficiency or type 2 diabetes; and
4665 (c) elevated blood glucose levels induced by pregnancy or gestational diabetes.
4666 (2) The commissioner shall establish, by rule, minimum standards of coverage for diabetes
4667 for [~~disability~~] accident and health insurance policies that provide a health insurance benefit before
4668 July 1, 2000.
4669 (3) In making rules under Subsection (2), the commissioner shall require rules:
4670 (a) with durational limits, amount limits, deductibles, and coinsurance for the treatment
4671 of diabetes equitable or identical to coverage provided for the treatment of other illnesses or
4672 diseases; and
4673 (b) that provide coverage for:
4674 (i) diabetes self-management training and patient management, including medical nutrition
4675 therapy as defined by rule, provided by an accredited or certified program and referred by an

4676 attending physician within the plan and consistent with the health plan provisions for
4677 self-management education:
4678 (A) recognized by the federal Health Care Financing [~~Agency~~] Administration; or
4679 (B) certified by the Department of Health; and
4680 (ii) the following equipment, supplies, and appliances to treat diabetes when medically
4681 necessary:
4682 (A) blood glucose monitors, including those for the legally blind;
4683 (B) test strips for blood glucose monitors;
4684 (C) visual reading urine and ketone strips;
4685 (D) lancets and lancet devices;
4686 (E) insulin;
4687 (F) injection aides, including those adaptable to meet the needs of the legally blind, and
4688 infusion delivery systems;
4689 (G) syringes;
4690 (H) prescriptive oral agents for controlling blood glucose levels; and
4691 (I) glucagon kits.
4692 (4) (a) Before October 1, 2003, the commissioner shall report to the Health and Human
4693 Services Interim Committee on the effects of Section 31A-22-626. The report shall be based on
4694 three years of data and shall include, to the extent possible:
4695 (i) a review of the rules established under Subsection (3);
4696 (ii) the change in availability of coverage resulting from this section;
4697 (iii) the extent to which persons have been benefitted by the provisions of this section; and
4698 (iv) the impact of this section on premiums.
4699 (b) The Legislature shall consider the results of the report under Subsection (4)(a) when
4700 determining whether to reauthorize the provisions of this section.
4701 Section 102. Section **31A-22-630** is amended to read:
4702 **31A-22-630. Mastectomy coverage.**
4703 (1) If an insured has coverage that provides medical and surgical benefits with respect to
4704 a mastectomy, it shall provide coverage, with consultation of the attending physician and the
4705 patient, for:
4706 (a) reconstruction of the breast on which the mastectomy has been performed;

4707 (b) surgery and reconstruction of the breast on which the mastectomy was not performed
4708 to produce symmetrical appearance; and
4709 (c) prostheses and physical complications with regards to all stages of mastectomy,
4710 including lymphedemas.
4711 (2) (a) This section does not prevent [~~a disability~~] an accident and health insurer from
4712 imposing cost-sharing measures for health benefits relating to this coverage, if cost-sharing
4713 measures are not greater than those imposed on any other medical condition.
4714 (b) For purposes of this Subsection (2), cost-sharing measures include imposing a
4715 deductible or coinsurance requirement.
4716 (3) Written notice of the availability of the coverage described in Subsection (1) shall be
4717 delivered to the participant:
4718 (a) upon enrollment; and
4719 (b) annually after the enrollment.
4720 Section 103. Section **31A-22-631** is enacted to read:
4721 **31A-22-631. Policy summary or illustration.**
4722 (1) (a) Except as provided in Subsection (1)(b), at the time a life insurance policy is
4723 delivered, a policy summary or illustration shall be delivered for the life insurance policy if:
4724 (i) the life insurance policy includes riders or supplemental benefits, including accelerated
4725 benefits; and
4726 (ii) receipt of benefits under the life insurance policy is contingent upon morbidity
4727 requirements.
4728 (b) In the case of a direct response solicitation, the insurer shall deliver the policy summary
4729 or illustration at the sooner of:
4730 (i) the applicant's request; or
4731 (ii) at the time of policy delivery regardless of whether the applicant requests a policy
4732 summary or illustration.
4733 (2) In addition to complying with all applicable requirements, the policy summary or
4734 illustration shall include:
4735 (a) a clear and prominent disclosure of how the rider or supplemental benefit interacts with
4736 other components of the policy, including deductions from death benefits and policy values;
4737 (b) an illustration for each covered person of:

4738 (i) the amount of benefits;
4739 (ii) the length of benefits; and
4740 (iii) the guaranteed lifetime benefits, if any;
4741 (c) a disclosure of the maximum premiums for the rider or supplemental benefit;
4742 (d) any exclusions, reductions, or limitations on the benefits of the rider or supplemental
4743 benefit; and
4744 (e) if applicable to the policy type:
4745 (i) a disclosure of the effects of exercising other rights under the policy; and
4746 (ii) guaranteed maximum lifetime benefits.
4747 Section 104. Section **31A-22-632** is enacted to read:
4748 **31A-22-632. Report to policy holder.**
4749 (1) An insurer shall provide the policyholder a monthly report if an accident and health
4750 rider or supplemental benefit is:
4751 (a) funded through a life insurance vehicle by acceleration of the death benefit; and
4752 (b) in benefit payment status.
4753 (2) The report required by Subsection (1) shall include:
4754 (a) any rider or supplemental benefits paid out during the month;
4755 (b) an explanation of any changes in the policy due to rider or supplemental benefits being
4756 paid out such as:
4757 (i) death benefits; or
4758 (ii) cash values; and
4759 (c) the amount of the rider or supplemental benefits existing or remaining.
4760 Section 105. Section **31A-22-701** is amended to read:
4761 **Part VII. Group Accident and Health Insurance**
4762 **31A-22-701. Groups eligible for group or blanket insurance.**
4763 (1) A group or blanket [~~disability~~] accident and health insurance policy may be issued to:
4764 (a) any group to which a group life insurance policy may be issued under Sections
4765 31A-22-502 through 31A-22-507;
4766 (b) a policy issued pursuant to a conversion privilege under Part VII; or
4767 (c) a group specifically authorized by the commissioner upon a finding that:
4768 (i) authorization is not contrary to the public interest;

4769 (ii) the proposed group is actuarially sound;
4770 (iii) formation of the proposed group may result in economies of scale in administrative,
4771 marketing, and brokerage costs; and
4772 (iv) the health insurance policy, certificate, or other indicia of coverage that will be offered
4773 to the proposed group is substantially equivalent to policies that are otherwise available to similar
4774 groups.
4775 (2) Blanket policies may also be issued to:
4776 (a) any common carrier or any operator, owner, or lessee of a means of transportation, as
4777 policyholder, covering persons who may become passengers as defined by reference to their travel
4778 status;
4779 (b) an employer, as policyholder, covering any group of employees, dependents, or guests,
4780 as defined by reference to specified hazards incident to any activities of the policyholder;
4781 (c) an institution of learning, including a school district, school jurisdictional units, or the
4782 head, principal, or governing board of any of those units, as policyholder, covering students,
4783 teachers, or employees;
4784 (d) any religious, charitable, recreational, educational, or civic organization, or branch of
4785 those organizations, as policyholder, covering any group of members or participants as defined by
4786 reference to specified hazards incident to the activities sponsored or supervised by the
4787 policyholder;
4788 (e) a sports team, camp, or sponsor of the team or camp, as policyholder, covering
4789 members, campers, employees, officials, or supervisors;
4790 (f) any volunteer fire department, first aid, civil defense, or other similar volunteer
4791 organization, as policyholder, covering any group of members or participants as defined by
4792 reference to specified hazards incident to activities sponsored, supervised, or participated in by the
4793 policyholder;
4794 (g) a newspaper or other publisher, as policyholder, covering its carriers;
4795 (h) an association, including a labor union, which has a constitution and bylaws and which
4796 has been organized in good faith for purposes other than that of obtaining insurance, as
4797 policyholder, covering any group of members or participants as defined by reference to specified
4798 hazards incident to the activities or operations sponsored or supervised by the policyholder;
4799 (i) a health insurance purchasing association organized and controlled solely by

4800 participating employers as defined in Section 31A-34-103; and
4801 (j) any other class of risks which, in the judgment of the commissioner, may be properly
4802 eligible for blanket [disability] accident and health insurance.
4803 (3) The judgment of the commissioner may be exercised on the basis of:
4804 (a) individual risks [or];
4805 (b) class of risks; or
4806 (c) both Subsections (3)(a) and (b).
4807 Section 106. Section **31A-22-702** is amended to read:
4808 **31A-22-702. Adjustment of premium rate and application of dividends or rate**
4809 **reductions.**
4810 Any group [disability] accident and health insurance policy may provide for the adjustment
4811 of the rate of premium based upon the experience under the contract. If a policy dividend is
4812 declared or a reduction in rate is made or continued for the first or any subsequent year of
4813 insurance under any policy of group [disability] accident and health insurance, the excess, if any,
4814 of the aggregate dividends or rate reductions under the policy and all other group insurance policies
4815 of the policyholder over the aggregate expenditure for insurance under those policies made from
4816 funds contributed by the policyholder, including expenditures made in connection with the
4817 administration of the policies, shall be applied by the policyholder for the sole benefit of insured
4818 employees or members unless the insured employee or member explicitly elects otherwise.
4819 Section 107. Section **31A-22-703** is amended to read:
4820 **31A-22-703. Conversion rights on termination of group accident and health**
4821 **insurance coverage.**
4822 (1) Except as provided in Subsections (2) through (5), all policies of [disability] accident
4823 and health insurance offered on a group basis under this title or Title 49, Chapter 8, Group
4824 Insurance Program Act, shall provide that a person whose insurance under the group policy has
4825 been terminated for any reason, and who has been continuously insured under the group policy or
4826 its predecessor for at least six months immediately prior to termination, is entitled to choose
4827 [either] a converted individual [or group] policy of [disability] accident and health insurance from
4828 the insurer which conforms to Section 31A-22-708 or an extension of benefits under the group
4829 policy as provided in Section 31A-22-714.
4830 (2) Subsection (1) does not apply if the policy:

4831 (a) provides catastrophic, aggregate stop loss, or specific stop loss benefits;
4832 (b) provides benefits for specific diseases or for accidental injuries only, or for dental
4833 service; or
4834 (c) is [a disability] an income replacement policy.
4835 (3) An employee or group member does not have conversion rights under Subsection (1)
4836 if:
4837 (a) termination of the group coverage occurred because of failure of the group member to
4838 pay any required individual contribution;
4839 (b) the individual group member acquires other group coverage covering all preexisting
4840 conditions including maternity, if the coverage existed under the replaced group coverage; or
4841 (c) the person [who would be covered is or could be covered by Medicare] has:
4842 (i) performed an act or practice that constitutes fraud; or
4843 (ii) made an intentional misrepresentation of material fact under the terms of the coverage.
4844 (4) Notwithstanding Subsections (1), (2), and (3), an employee or group member does not
4845 have conversion rights under Subsection (1) if the individual or group member qualifies to
4846 continue coverage under his existing group policy in accordance with the terms of his policy.
4847 (5) (a) Notwithstanding Subsection 31A-22-613(1), an insurer may reduce benefits under
4848 a converted [disability] policy covering any person to the extent the benefits provided or available
4849 to that person under one or more of the sources listed under Subsection (5)(b), together with the
4850 benefits provided by the converted policy, would result in [overinsurance according to the insurer's
4851 standards. The insurer's standards shall bear a reasonable relationship to actual health care costs
4852 in the area in which the insured lives at the time of conversion and shall be filed with the
4853 commissioner prior to their use in denying coverage] duplicate coverage.
4854 (b) The benefits sources referred to under Subsection (5)(a) include:
4855 (i) benefits under another insurance policy; and
4856 (ii) benefits under any arrangement of coverage for individuals in a group, whether on an
4857 insured or an uninsured basis[; and].
4858 [(iii) benefits provided for or available to that person, in accordance with the requirements
4859 of any state or federal law.]
4860 (6) (a) The conversion policy shall provide maternity benefits equal to the maternity
4861 benefits of the group policy until termination of pregnancy that exists on the date of conversion

4862 if:
4863 (i) one of the following is pregnant on the date of the conversion:
4864 (A) the insured;
4865 (B) a spouse of the insured; or
4866 (C) a dependent of the insured; and
4867 (ii) the accident and health policy had maternity benefits.
4868 (b) The requirements of this Subsection (6) do not apply to a pregnancy that occurs after
4869 the date of conversion.
4870 Section 108. Section **31A-22-704** is amended to read:
4871 **31A-22-704. Conversion rules and procedures.**
4872 (1) Written application for the converted policy shall be made and the first premium paid
4873 to the insurer no later than 60 days after termination of the group [~~disability~~] accident and health
4874 insurance.
4875 (2) The converted policy shall be issued without evidence of insurability.
4876 (3) (a) The initial premium for the converted policy for the first 12 months and subsequent
4877 renewal premiums shall be determined in accordance with premium rates applicable to age, class
4878 of risk of the person, and the type and amount of insurance provided[~~.~~]; and
4879 (b) the initial premium for the first 12 months may not be raised based on pregnancy of
4880 a covered insured.
4881 (4) Conditions pertaining to health are not an acceptable basis for classification under this
4882 section.
4883 (5) The premium for converted [~~disability~~] policies shall be payable monthly or quarterly
4884 as required by the insurer for the policy form and plan selected, unless another mode of premium
4885 payment is mutually agreed upon.
4886 (6) The converted policy becomes effective at the time the insurance under the group
4887 policy terminates.
4888 (7) The converted policy covers the employee or member and the dependents who were
4889 covered by the group policy on the date of termination of insurance. At the option of the insurer,
4890 a separate converted policy may be issued to cover any dependent.
4891 Section 109. Section **31A-22-705** is amended to read:
4892 **31A-22-705. Provisions in conversion policies.**

4893 (1) A converted policy may include a provision under which the insurer may request from
4894 the person covered, information in advance of any premium due date as to whether there is other
4895 coverage as specified under Subsection 31A-22-703(4).
4896 (2) The converted policy may provide that the insurer may refuse to renew the policy or
4897 the coverage of any person insured:
4898 [(a) if the insured could be covered by Medicare;]
4899 [(b) the converted policy creates an unreasonable over-insurance position;]
4900 [(c)] (a) for fraud or [material] intentional misrepresentation of a material fact in applying
4901 for any benefits under the converted policy; or
4902 [(d)] (b) for any other reason approved by the commissioner by rule or order.
4903 (3) [No] An insurer may not be required to issue a converted policy which provides
4904 benefits in excess of those provided under the group policy from which conversion is made.
4905 (4) [No] A converted policy may not exclude a preexisting condition not excluded under
4906 the group policy.
4907 (5) During the first policy year, the converted policy may provide that the benefits payable
4908 under the converted policy, together with the benefits paid for the individual under the group
4909 policy, do not exceed those that would have been payable had the individual's insurance under the
4910 group policy remained in force and effect.
4911 Section 110. Section **31A-22-715** is amended to read:
4912 **31A-22-715. Optional rider for alcohol and drug dependency treatment.**
4913 Each group [disability] accident and health insurance policy shall contain an optional rider
4914 allowing certificate holders to obtain coverage for alcohol or drug dependency treatment in
4915 programs licensed by the Department of Human Services, under Title 62A, Chapter 2, inpatient
4916 hospitals accredited by the joint commission on the accreditation of hospitals, or facilities licensed
4917 by the Department of Health.
4918 Section 111. Section **31A-22-716** is amended to read:
4919 **31A-22-716. Required provision for notice of termination.**
4920 (1) Every policy for group or blanket [disability] accident and health coverage issued or
4921 renewed after July 1, 1990, shall include a provision that obligates the policyholder to give 30 days
4922 prior written notice of termination to each employee or group member and to notify each employee
4923 or group member of his rights to continue coverage upon termination.

4924 (2) An insurer's monthly notice to the policyholder of premium payments due shall include
4925 a statement of the policyholder's obligations as set forth in Subsection (1). Insurers shall provide
4926 a sample notice to the policyholder at least once a year.
4927 Section 112. Section **31A-22-717** is amended to read:
4928 **31A-22-717. Provisions pertaining to service members and their families affected by**
4929 **Operation Desert Shield and Operation Desert Storm.**
4930 For any group or blanket [~~disability~~] <u>accident and health</u> coverage, an insurer:
4931 (1) may not refuse to reinstate an insured or his family whose coverage lapsed due to the
4932 insured's participation in Operation Desert Shield or Operation Desert Storm provided application
4933 is made within 180 days of release from active duty;
4934 (2) shall reinstate an insured in full upon payment of the first premium without the
4935 requirement of a waiting period or exclusion for preexisting conditions or any other underwriting
4936 requirements that were covered previously; and
4937 (3) may not increase the insured's premium in excess of what it would have been increased
4938 in the normal course of time had the insured not participated in Operation Desert Shield or
4939 Operation Desert Storm.
4940 Section 113. Section **31A-22-720** is amended to read:
4941 **31A-22-720. Mental health parity.**
4942 (1) (a) A group [~~disability~~] <u>accident and health</u> plan offered by an insurer shall comply
4943 with Subsection (1)(b) if the group disability plan:
4944 (i) applies an aggregate lifetime limit to plan payments for medical or surgical services
4945 covered by the group [~~disability~~] <u>accident and health</u> plan; and
4946 (ii) provides a mental health benefit.
4947 (b) A group [~~disability~~] <u>accident and health</u> plan described in Subsection (1)(a) shall:
4948 (i) include in the aggregate lifetime limit for medical or surgical services covered by the
4949 group [~~disability~~] <u>accident and health</u> plan the payments made under the plan for mental health
4950 services; or
4951 (ii) establish a separate aggregate lifetime limit to plan payments for mental health services
4952 covered by the group [~~disability~~] <u>accident and health</u> plan, but only if the dollar amount of the
4953 aggregate lifetime limit for mental health services covered by that plan is equal to or greater than
4954 the dollar amount of the aggregate lifetime limit for medical or surgical services covered by that

4955 plan.
4956 (2) (a) A group [~~disability~~] <u>accident and health</u> plan offered by an insurer shall comply
4957 with Subsection (2)(b) if the group [~~disability~~] <u>accident and health</u> plan:
4958 (i) applies an annual limit to plan payments for medical or surgical services covered by the
4959 group [~~disability~~] <u>accident and health</u> plan; and
4960 (ii) provides a mental health benefit.
4961 (b) A group [~~disability~~] <u>accident and health</u> plan described in Subsection (2)(a) shall:
4962 (i) include in the annual limit for medical or surgical services covered by the group
4963 [~~disability~~] <u>accident and health</u> plan the payments made under the plan for mental health services;
4964 or
4965 (ii) establish a separate annual limit to plan payments for mental health services covered
4966 by the group [~~disability~~] <u>accident and health</u> plan, but only if the dollar amount of the annual limit
4967 for mental health services covered by that plan is equal to or greater than the dollar amount of the
4968 annual limit for medical or surgical services covered by that plan.
4969 (3) This section does not prohibit a group [~~disability~~] <u>accident and health</u> plan offered by
4970 an insurer from:
4971 (a) using other forms of cost containment not prohibited under Subsection (1); or
4972 (b) applying requirements that make distinctions between acute care and chronic care.
4973 (4) This section does not apply to:
4974 (a) benefits for:
4975 (i) substance abuse; or
4976 (ii) chemical dependency; or
4977 (b) [~~disability~~] <u>accident and health</u> benefits or plans paid under Title XVII or XIX of the
4978 Social Security Act.
4979 (5) (a) This section does not apply to plans maintained by employers that employ less than
4980 50 employees.
4981 (b) For purposes of determining whether an employer is exempt under Subsection (5)(a):
4982 (i) if the employer was not in existence throughout the preceding calendar year, the number
4983 of employees of the employer is determined based on the average number of employees that the
4984 employer is reasonably expected to employ on business days in the calendar year for which the
4985 determination is made; and

4986 (ii) as used in this Subsection (5), "employer" includes a predecessor of the employer.
4987 Section 114. Section **31A-22-801** is amended to read:
4988 **31A-22-801. Scope of part.**
4989 (1) Except as provided under Subsection (2), all life insurance and [~~disability~~] accident and
4990 health insurance in connection with loans or other credit transactions are subject to this part.
4991 (2) (a) Insurance in connection with a loan or other credit transaction of more than ten
4992 years duration is not subject to this part, but is subject to other provisions of this title.
4993 (b) Isolated transactions on the part of an insurer [~~which~~] that are not related to an
4994 agreement or plan for insuring debtors of the creditor are not subject to this part.
4995 Section 115. Section **31A-22-802** is amended to read:
4996 **31A-22-802. Definitions.**
4997 As used in Part VIII:
4998 (1) "Credit [~~disability~~] accident and health insurance" means [~~disability~~] insurance on a
4999 debtor to provide indemnity for payments coming due on a specific loan or other credit transaction
5000 while the debtor is disabled.
5001 (2) "Credit life insurance" means life insurance on the life of a debtor in connection with
5002 a specific loan or credit transaction.
5003 (3) "Credit transaction" means any transaction under which the payment for money loaned
5004 or for goods, services, or properties sold or leased is to be made on future dates.
5005 (4) "Creditor" means the lender of money or the vendor or lessor of goods, services, or
5006 property, for which payment is arranged through a credit transaction, or any successor to the right,
5007 title, or interest of any lender or vendor.
5008 (5) "Debtor" means a borrower of money or a purchaser, including a lessee under a lease
5009 intended as security, of goods, services, or property, for which payment is arranged through a credit
5010 transaction.
5011 (6) "Indebtedness" means the total amount payable by a debtor to a creditor in connection
5012 with a credit transaction, including principal finance charges and interest.
5013 (7) "Net indebtedness" means the total amount required to liquidate the indebtedness,
5014 exclusive of any unearned interest, any insurance on the monthly outstanding balance coverage,
5015 or any finance charge.
5016 (8) "Net written premiums" means gross written premiums minus refunds on termination.

5017 Section 116. Section **31A-22-803** is amended to read:

5018 **31A-22-803. Forms of insurance permitted.**

5019 Credit life insurance and credit [~~disability~~] accident and health insurance may be issued
5020 only in the following forms:

5021 (1) individual policies of term life insurance issued to debtors;

5022 (2) individual policies of term [~~disability~~] accident and health insurance issued to debtors,
5023 or [~~disability~~] accident and health benefit provisions in individual policies of credit life insurance;

5024 (3) group policies of term life insurance issued to creditors, providing insurance upon the
5025 lives of debtors;

5026 (4) group policies of term [~~disability~~] accident and health insurance issued to creditors
5027 insuring debtors, or [~~disability~~] accident and health benefit provisions in group credit life insurance
5028 policies.

5029 Section 117. Section **31A-22-804** is amended to read:

5030 **31A-22-804. Limitations on amounts of insurance.**

5031 (1) Except as provided under Subsection (2), the initial amount of credit life insurance on
5032 the life of any one debtor may not exceed the total amount repayable under the contract of
5033 indebtedness. Where an indebtedness is repayable in substantially equal periodic installments,
5034 the amount of insurance may not exceed the scheduled or actual amount of unpaid indebtedness,
5035 whichever is greater.

5036 (2) Subsection (1) does not apply to:

5037 (a) insurance on agricultural credit transaction commitments not exceeding the
5038 commitment period, which may be written for the amount of the commitment on a nondecreasing
5039 or level term plan;

5040 (b) insurance on educational credit transaction commitments, which may be written to
5041 include the portion of the commitment that has not been advanced by the creditor;

5042 (c) insurance on preauthorized lines of credit not exceeding the commitment period which
5043 may be written for the preauthorized amount on a nondecreasing or level term plan, whether
5044 secured or unsecured[~~.~~]; and

5045 (d) insurance on any other class of lawful credit transaction or commitment, which in the
5046 commissioner's opinion does not require the application of the restrictions under Subsection (1),
5047 in which case the commissioner may authorize by rule a class exception to Subsection (1).

5048 (3) The total amount of indemnity payable by credit [disability] accident and health
5049 insurance in the event of disability, as defined in the policy, may not exceed the aggregate of the
5050 periodic scheduled unpaid installments of the indebtedness. The amount of each periodic
5051 indemnity payment may not exceed the total amount repayable under the contract of indebtedness
5052 divided by the number of periodic installments.

5053 Section 118. Section **31A-22-805** is amended to read:

5054 **31A-22-805. Beginning date of insurance.**

5055 (1) Except as provided under Subsection (2), any credit life insurance or credit [disability]
5056 accident and health insurance, subject to acceptance by the insurer, commences on the date when
5057 the debtor becomes obligated to the creditor.

5058 (2) (a) Where a group policy provides coverage for existing obligations, the insurance on
5059 a debtor with respect to that indebtedness commences on the effective date of the policy.

5060 (b) Where evidence of insurability is required and the evidence is furnished more than 30
5061 days after the debtor becomes obligated to the creditor, the insurance may commence when the
5062 insurance company determines the evidence of insurability to be satisfactory. In this event, the
5063 insurer shall make an appropriate refund or adjustment of any charge to the debtor for insurance.

5064 (3) The insurance may not extend more than 15 days beyond the scheduled maturity date
5065 of the indebtedness, unless it does so at no additional cost to the debtor.

5066 (4) If the indebtedness is discharged due to renewal or refinancing prior to the scheduled
5067 maturity date, the insurance in force shall terminate before any new insurance may be issued in
5068 connection with the renewed or refinanced indebtedness. In all cases of termination prior to
5069 scheduled maturity, a refund shall be paid or credited as provided in Section 31A-22-808.

5070 Section 119. Section **31A-22-806** is amended to read:

5071 **31A-22-806. Provisions of policies and certificates.**

5072 (1) All credit life insurance and credit [disability] accident and health insurance shall be
5073 evidenced by an individual policy, or, in the case of group insurance, by a certificate of insurance
5074 delivered to the debtor.

5075 (2) Each of these types of policies or certificates shall, in addition to satisfying the
5076 requirements of Chapter 21, set forth:

5077 (a) the name and home office address of the insurer;

5078 (b) the identity, by name or otherwise, of the persons insured;

5079 (c) the rate, premium, or amount of payment by the debtor, if any, given separately for
5080 credit life insurance and credit [~~disability~~] accident and health insurance;
5081 (d) a description of the amount, term, and coverage, including any exceptions, limitations,
5082 and restrictions;
5083 (e) that the benefits shall be paid to the creditor to reduce or extinguish the unpaid
5084 indebtedness; and
5085 (f) that whenever the amount of insurance exceeds the unpaid indebtedness, that excess
5086 is payable to a beneficiary, other than the creditor, named by the debtor or to the debtor's estate.
5087 (3) Except as provided in Subsection (4), the policy or certificate shall be delivered to the
5088 debtor within 30 days after the date when the indebtedness is incurred.
5089 (4) (a) If the policy or certificate is not delivered to the debtor within 30 days after the date
5090 the indebtedness is incurred, a copy of the application for the policy or a notice of proposed
5091 insurance shall be delivered to the debtor.
5092 (b) The application or the notice shall be signed by the debtor and shall set forth:
5093 (i) the name and home office address of the insurer;
5094 (ii) the name of the debtor;
5095 (iii) the premium or amount of payment by the debtor, if any, separately for credit life
5096 insurance and credit [~~disability~~] accident and health insurance; and
5097 (iv) the amount, term, and a brief description of the coverage provided.
5098 (c) The copy of the application for or notice of proposed insurance, shall also refer
5099 exclusively to insurance coverage, and shall be separate from the loan, sale, or other credit
5100 statement of account or instrument, unless the information required by this Subsection (4)(c) is
5101 prominently set forth therein.
5102 (d) Upon acceptance of the insurance by the insurer and within 60 days after the later of
5103 the date on which the indebtedness is incurred or the date on which the credit life or credit
5104 [~~disability~~] accident and health policy was purchased, the insurer shall deliver the individual policy
5105 or group certificate of insurance to the debtor.
5106 (e) The application or notice shall state that upon acceptance by the insurer, the insurance
5107 is effective as provided in Section 31A-22-805.
5108 (5) If the named insurer does not accept the risk, the debtor shall receive a policy or
5109 certificate of insurance setting forth the name and home office address of the substituted insurer

5110 and the amount of the premium to be charged. If the premium is less than that set forth in the
5111 notice of proposed insurance, an appropriate refund shall be made.
5112 (6) If a creditor makes available to the debtors more than one plan of credit life or credit
5113 [~~disability~~] accident and health insurance, all debtors must be informed of the plans applicable to
5114 the specific type of loan transaction for which the debtor is applying.
5115 Section 120. Section **31A-22-807** is amended to read:
5116 **31A-22-807. Filing and approval of forms -- Loss ratio standards.**
5117 (1) All forms of policies, certificates of insurance, statements of insurance, endorsements,
5118 and riders intended for use in Utah are subject to Section 31A-21-201.
5119 (2) In addition to the grounds for disapproval under Subsection 31A-21-201(3), it is a
5120 ground for disapproval that the benefits provided in the form are not reasonable in relation to the
5121 premium charge.
5122 (3) In ascertaining whether the benefits are reasonable in relation to the premium charged,
5123 the commissioner shall consider the mortality cost of the life insurance and the morbidity cost of
5124 the [~~disability~~] accident and health insurance, and the reserves set up for the payment of claims
5125 unreported or in the process of settlement. The benefits are considered reasonable in relation to
5126 the premium charged if the premium rate charged develops or may reasonably be expected to
5127 develop a loss ratio of not less than 50% for credit life insurance and not less than 55% for credit
5128 [~~disability~~] accident and health insurance given the above costs.
5129 (4) Benefits are considered reasonable in relation to premium charged if the ratio of claims
5130 incurred to premium earned during the most recent four-year period at the rates in use produces
5131 a loss ratio that is equal to or exceeds the minimum loss ratio standard specified in Subsection (3).
5132 (5) If the minimum loss ratio test produces a loss ratio that exceeds Subsection (4)'s
5133 minimum loss ratio standard by five percentage points or more, the insurer may file for approval
5134 and use rates that are higher than prima facie rates, if it can be expected that the use of those higher
5135 rates will continue to produce a loss ratio for the accounts to which they are applied that will
5136 satisfy the minimum loss ratio test.
5137 (6) If the minimum loss ratio test produces a loss ratio that is lower than Subsection (4)'s
5138 minimum loss standard by five percentage points or more, the commissioner may require that the
5139 insurer file adjusted rates that can be expected to produce a loss ratio that will satisfy the minimum
5140 loss ratio test, or to submit reasons acceptable to the commissioner why the insurer should not be

5141 required to file these adjusted rates.

5142 Section 121. Section **31A-22-808** is amended to read:

5143 **31A-22-808. Premiums and refunds.**

5144 (1) Each policy, certificate, or statement of insurance shall provide that in the event of
5145 termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund
5146 of an amount paid by the debtor for insurance shall be paid or credited promptly to the person
5147 entitled to it. The formula used in computing the refund shall be filed with and approved by the
5148 commissioner under Chapter 21, Part II. No refund is required if it would be less than $5.

5149 (2) If a creditor requires a debtor to make any payment for credit life or credit [~~disability~~]
5150 accident and health insurance and an individual policy, certificate, or statement of insurance is not
5151 issued, the creditor shall immediately give written notice to the debtor and credit the account.

5152 (3) The amount charged the debtor for credit life or [~~disability~~] accident and health
5153 insurance may not exceed the premiums charged by the insurer as computed at the time the charge
5154 to the debtor is determined.

5155 Section 122. Section **31A-22-809** is amended to read:

5156 **31A-22-809. Right of debtor to choose insurer.**

5157 When credit life insurance or credit [~~disability~~] accident and health insurance is required
5158 as security for any indebtedness, the creditor shall inform the debtor of the debtor's option to
5159 furnish the required insurance through existing policies of insurance owned or controlled by the
5160 debtor or to procure and furnish the required coverage through any insurer authorized to transact
5161 life or [~~disability~~] accident and health insurance in Utah.

5162 Section 123. Section **31A-22-1002** is amended to read:

5163 **31A-22-1002. Duration of coverage.**

5164 (1) Any insurer assuming a workers' compensation risk shall carry it until the policy is
5165 canceled, either:

5166 (a) by agreement between the Division of Industrial Accidents in the Labor Commission,
5167 the insurer, and the employer; or

5168 (b) after:

5169 (i) [~~30 days~~] notice by the insurer to the employer as provided in Section 31A-21-303; and

5170 (ii) notice to the Division of Industrial Accidents in the Labor Commission as provided
5171 in Section 34A-2-205.

5172 (2) Subsection (1) does not affect the requirements of Section 31A-22-1001.

5173 Section 124. Section **31A-22-1101** is amended to read:

5174 **31A-22-1101. Combination of lines.**

5175 (1) Legal expense insurance may be transacted alone or together with life insurance,
5176 [~~disability~~] <u>accident and health</u> insurance, or casualty insurance.

5177 (2) [~~No~~] <u>An</u> insurer may <u>not</u> transact liability insurance and also issue legal expense
5178 insurance policies providing coverage for the expense of enforcing claims against third persons,
5179 unless the requirements of Subsection (3) are met and the commissioner is satisfied that the
5180 interests of policyholders of legal expense insurance policies are not endangered by potential
5181 conflicts of interest within the insurer.

5182 (3) Adequate precautions shall be taken to make sure that the handling of an insured's
5183 claim for legal assistance in enforcing a claim against a third person is not affected by the insurer's
5184 actual or potential obligation as a liability insurer to pay the claim for the third person. These
5185 precautions may include:

5186 (a) a provision in the policy that claims against third persons shall be handled exclusively
5187 by attorneys selected by the insureds themselves rather than by the insurer, that no information
5188 about the case other than the name of the defendant and the nature of the claim may be made
5189 available to the insurer, and that the insurer may not interfere with the handling of the case; or

5190 (b) organizational separation between the legal expense and the liability insurance
5191 departments with respect to management, accounting, record keeping, and claims handling, with
5192 appropriate rules and procedures, satisfactory to the commissioner, to prevent the exchange of
5193 information between the two departments about details of cases.

5194 Section 125. Section **31A-22-1401** is amended to read:

5195 **31A-22-1401. Application.**

5196 (1) The requirements of this part apply to individual policies and to group policies and
5197 certificates marketed in this state on or after July 1, [~~1991~~] <u>2001</u>, other than employee and labor
5198 union group policies and certificates.

5199 (2) Entities subject to this part shall comply with other applicable insurance laws and rules
5200 unless they are in conflict with this part.

5201 (3) The laws, regulations, and rules designed and intended to apply to Medicare
5202 supplement insurance policies may not be applied to long-term care insurance.

5203 (4) Any policy or rider advertised, marketed, or offered as long-term care or nursing home
5204 insurance shall comply with the provisions of this part.
5205 Section 126. Section **31A-22-1402** is amended to read:
5206 **31A-22-1402. Definitions.**
5207 Unless the context requires otherwise, the following definitions apply in this part:
5208 (1) "Applicant" means:
5209 (a) in the case of an individual long-term care insurance policy, the person who seeks to
5210 contract for benefits; and
5211 (b) in the case of a group long-term care insurance policy, the proposed certificate holder.
5212 [~~(2) (a) "Long-term care insurance" means any insurance policy or rider advertised,~~
5213 ~~marketed, offered, or designed to provide coverage:~~]
5214 [~~(i) for not less than 12 consecutive months for each covered person on an expense~~
5215 ~~incurred, indemnity, prepaid, or other basis;~~]
5216 [~~(ii) for one or more necessary or medically necessary diagnostic, preventive, therapeutic,~~
5217 ~~rehabilitative, maintenance, or personal care service, provided in a setting other than an acute care~~
5218 ~~unit of a hospital.~~]
5219 [~~(b) The term includes group and individual annuities and life insurance policies or riders~~
5220 ~~which provide directly or supplement long-term care insurance. The term also includes a policy~~
5221 ~~or rider which provides for payment of benefits based upon cognitive impairment or the loss of~~
5222 ~~functional capacity.~~]
5223 [~~(c) Long-term care insurance does not include any insurance policy which is offered~~
5224 ~~primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic~~
5225 ~~medical-surgical expense coverage, hospital confinement indemnity coverage, major medical~~
5226 ~~expense coverage, disability income or related asset-protection coverage, accident only coverage,~~
5227 ~~specified disease or specified accident coverage, or limited benefit health coverage.~~]
5228 (2) Notwithstanding Section 31A-1-301,"certificate" means a certificate issued under a
5229 group long-term care insurance policy if the group long-term care insurance policy is delivered or
5230 issued for delivery in this state.
5231 (3) Notwithstanding Section 31A-1-301, "policy" means a policy, contract subscriber
5232 agreement, rider, or endorsement, if the policy, contract subscriber agreement, rider, or
5233 endorsement is delivered or issued:

5234 (a) in this state; and
5235 (b) by:
5236 (i) an insurer;
5237 (ii) a fraternal benefit society;
5238 (iii) a nonprofit health, hospital, or medical service corporation;
5239 (iv) a prepaid health plan;
5240 (v) a health maintenance organization; or
5241 (vi) an entity similar to an entity described in Subsections (4)(b)(i) through (v).
5242 Section 127. Section **31A-22-1407** is amended to read:
5243 **31A-22-1407. Restricted conditional terms.**
5244 (1) A long-term care insurance policy may not contain a provision that conditions
5245 eligibility:
5246 (a) [conditions eligibility] for any benefits on a prior hospitalization requirement; [or]
5247 (b) [conditions eligibility] for benefits provided in an institutional care setting on the
5248 receipt of a higher level of institutional care[.]; or
5249 (c) for any benefits on a prior institutionalization requirement except for eligibility for:
5250 (i) waiver of premium;
5251 (ii) post confinement;
5252 (iii) post-acute care; or
5253 (iv) recuperative benefits.
5254 (2) A long-term care insurance policy containing [any limitations or conditions for
5255 eligibility other than those prohibited in Subsection (1)] post confinement, post-acute care, or
5256 recuperative benefits shall clearly label the limitations or conditions, including any required
5257 number of days of confinement in a separate paragraph of the policy or certificate that is entitled
5258 "Limitations or Conditions on Eligibility for Benefits."
5259 [(3) A long-term care insurance policy containing a benefit advertised, marketed, or
5260 offered as a home health care benefit may not condition receipt of benefits on a prior
5261 institutionalization.]
5262 [(4) A long-term care insurance policy or rider that provides benefits only following
5263 institutionalization may not condition the benefits upon admission to a facility for the same or
5264 related conditions within a period of less than 30 days after discharge from the institution.]

5265 (3) A long-term care insurance policy or rider that conditions eligibility of noninstitutional
5266 benefits on the prior receipt of institutional care may not require a prior institutional stay of more
5267 than 30 days.
5268 Section 128. Section **31A-22-1409** is amended to read:
5269 **31A-22-1409. Statements of coverage.**
5270 (1) An outline of coverage shall be delivered to a prospective applicant for long-term care
5271 insurance at the time of initial solicitation through means which prominently direct the attention
5272 of the applicant to the document and its purpose.
5273 (2) The commissioner may prescribe a standard format of an outline of coverage, including
5274 style, arrangement, and overall appearance, and the content.
5275 (3) In the case of agent solicitations an agent must deliver the outline of coverage prior to
5276 the presentation of any application or enrollment form.
5277 (4) In the case of direct response solicitations, the outline of coverage must be presented
5278 in conjunction with any application or enrollment form.
5279 (5) An outline of coverage under this section shall include:
5280 (a) a description of the principal benefits and coverage provided in the policy;
5281 (b) a statement of the principal exclusions, reductions, and limitations contained in the
5282 policy;
5283 (c) a statement of the terms under which the policy or certificate, or both, may be
5284 continued in force or discontinued, including any reservation in the policy of a right to change
5285 premium;
5286 (d) a specific description of continuation or conversion provisions of group coverage;
5287 (e) a statement that the outline of coverage is not a contract of insurance but a summary
5288 only and that the policy or group master policy contains governing contractual provisions;
5289 (f) a description of the terms under which the policy or certificate may be returned and
5290 premium refunded; [~~and~~]
5291 (g) a brief description of the relationship of cost of care and benefits[~~.~~]; and
5292 (h) a statement that discloses to the policyholder or certificate holder whether the policy
5293 is intended to be a federally tax-qualified, long-term care insurance contract under Section
5294 7702B(b), Internal Revenue Code.
5295 (6) A certificate issued pursuant to a group long-term care insurance policy, which policy

5296 is delivered or issued for delivery in this state, shall include:
5297 (a) a description of the principal benefits and coverage provided in the policy;
5298 (b) a statement of the principal exclusions, reductions, and limitations contained in the
5299 policy; [~~and~~]
5300 (c) a statement that the group master policy determines governing contractual
5301 provisions[~~.~~]<u>; and</u>
5302 <u>(d) a statement that any long-term care inflation protection option required by rule is not</u>
5303 <u>available under the policy.</u>
5304 <u>(7) If an application for a long-term care contract or certificate is approved, the issuer shall</u>
5305 <u>deliver the contract or certificate of insurance to the applicant no later than 30 days after the date</u>
5306 <u>of approval.</u>
5307 [~~(7)~~] <u>(8)</u> At the time of policy delivery, a policy summary shall be delivered for an
5308 individual life insurance policy which provides long-term care benefits within the policy or by
5309 rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon
5310 the applicant's request. However, the insurer shall deliver the summary to the applicant no later
5311 than at the time of policy delivery regardless of request. In addition to complying with all
5312 applicable requirements, the summary shall also include:
5313 (a) an explanation of how the long-term care benefit interacts with other components of
5314 the policy, including deductions from death benefits;
5315 (b) an illustration for each covered person of the amount of benefits, the length of benefit,
5316 and the guaranteed lifetime benefits if any;
5317 (c) any exclusions, reductions, and limitations on benefits of long-term care; and
5318 (d) if applicable to the policy type, the summary shall also include:
5319 (i) a disclosure of the effects of exercising other rights under the policy;
5320 (ii) a disclosure of guarantees related to long-term care costs of insurance charges; and
5321 (iii) current and projected maximum lifetime benefits.
5322 <u>(9) The provisions of the policy summary required under Subsection (8) may be</u>
5323 <u>incorporated into:</u>
5324 <u>(a) a basic illustration; or</u>
5325 <u>(b) the life insurance policy summary required to be delivered in accordance with rule.</u>
5326 Section 129. Section **31A-22-1411** is amended to read:

5327 **31A-22-1411. Incontestability period.**
5328 (1) For a policy or certificate that has been in force for less than six months, an insurer may
5329 rescind a long-term care insurance policy or certificate upon a showing of misrepresentation that
5330 is material to the acceptance for coverage.
5331 (2) For a policy or certificate that has been in force for at least six months but less than two
5332 years, an insurer may rescind a long-term care insurance policy or certificate upon a showing of
5333 misrepresentation that:
5334 (a) is material to the acceptance for coverage; and
5335 (b) pertains to the condition for which benefits are sought.
5336 (3) If an insurer has paid benefits under a long-term care insurance policy or certificate,
5337 the benefit payments may not be recovered by the insurer if the policy or certificate is rescinded.
5338 (4) (a) In the event of the death of the insured:
5339 (i) this section may not apply to the remaining death benefit of a life insurance policy or
5340 certificate that accelerates benefits for long-term care; and
5341 (ii) the remaining death benefits under the policy or certificate shall be governed by
5342 Section 31A-22-403 or 31A-22-514.
5343 (b) In a situation other than a situation described in Subsection (4)(a), this section shall
5344 apply to life insurance policies or certificates that accelerate benefits for long-term care.
5345 Section 130. Section **31A-22-1412** is amended to read:
5346 **31A-22-1412. Nonforfeiture benefits.**
5347 (1) (a) A long-term care insurance policy or certificate may not be delivered or issued for
5348 delivery in this state unless the [issuer of the policy or certificate offers nonforfeiture benefits to
5349 the defaulting or surrendering policyholder or certificate holder] policyholder or certificate holder
5350 has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit.
5351 (b) The offer of a nonforfeiture benefit under Subsection (1)(a) may be in the form of a
5352 rider that is attached to the policy.
5353 (c) If the policyholder or certificate holder declines the nonforfeiture benefit offered under
5354 this Subsection (1), the insurer shall provide a contingent benefit upon lapse of the policy or
5355 certificate that is available for a specified period of time following a substantial increase in
5356 premium rates.
5357 (d) (i) Except as provided in Subsection (1)(d)(ii), if a group long-term care insurance

5358 policy is issued, the offer required in this Subsection (1) shall be made to the group policyholder.
5359 (ii) If the policy is issued to a group authorized under Section 31A-22-509, the offer
5360 required under this Subsection (1) shall be made to each proposed certificate holder.
5361 (2) The commissioner shall make rules:
5362 (a) specifying the types of nonforfeiture benefits [and] to be offered as part of a long-term
5363 care insurance policy or certificate;
5364 (b) specifying the standards for [the] nonforfeiture benefits [to be included in the policies
5365 and certificates.]; and
5366 (c) regarding contingent benefits upon lapse, including a determination of:
5367 (i) the specified period of time during which a contingent benefit upon lapse will be
5368 available as provided in Subsection (1); and
5369 (ii) the substantial premium rate increase that triggers a contingent benefit upon lapse as
5370 provided in Subsection (1).
5371 Section 131. Section **31A-22-1413** is enacted to read:
5372 **31A-22-1413. Claim information.**
5373 If a claim under a long-term care insurance contract is denied, within 60 days of the date
5374 a written request by the policyholder or a representative of a policyholder is filed with the insurer,
5375 the insurer shall:
5376 (1) provide a written explanation of the reason for the denial; and
5377 (2) make available all information directly related to the denial.
5378 Section 132. Section **31A-22-1414** is enacted to read:
5379 **31A-22-1414. Marketing.**
5380 A policy or rider shall comply with this part if it is advertised, marketed, or offered as:
5381 (1) long-term care insurance; or
5382 (2) nursing home insurance.
5383 Section 133. Section **31A-23-101** is amended to read:
5384 **31A-23-101. Purposes.**
5385 The purposes of this chapter include:
5386 (1) promoting the professional competence of insurance agents, brokers, and consultants;
5387 (2) providing maximum freedom of marketing methods for insurance, consistent with the
5388 interests of the Utah public;

5389 (3) preserving and encouraging competition at the consumer level; [~~and~~]
5390 (4) regulating insurance marketing practices in conformity with the general purposes of
5391 [~~the Insurance Code.~~] this title; and
5392 (5) governing the qualifications and procedures for the licensing of insurance producers.
5393 Section 134. Section **31A-23-102** is amended to read:
5394 **31A-23-102. Definitions.**
5395 As used in this chapter:
5396 [~~(1) Except as provided in Subsection (2):~~]
5397 [~~(a) "Escrow" is a license category that allows a person to conduct escrows, settlements,~~
5398 ~~or closings on behalf of a title insurance agency or a title insurer.~~]
5399 [~~(b) "Limited license" means a license that is issued for a specific product of insurance and~~
5400 ~~limits an individual or agency to transact only for those products.~~]
5401 [~~(c) "Search" is a license category that allows a person to issue title insurance~~
5402 ~~commitments or policies on behalf of a title insurer.~~]
5403 [~~(d) "Title marketing representative" means a person who:~~]
5404 [~~(i) represents a title insurer in soliciting, requesting, or negotiating the placing of:~~]
5405 [~~(A) title insurance; or~~]
5406 [~~(B) escrow, settlement, or closing services; and~~]
5407 [~~(ii) does not have a search or escrow license.~~]
5408 [~~(2) The following persons are not acting as agents, brokers, title marketing~~
5409 ~~representatives, or consultants when acting in the following capacities:~~]
5410 [~~(a) any regular salaried officer, employee, or other representative of an insurer or licensee~~
5411 ~~under this chapter who devotes substantially all of the officer's, employee's, or representative's~~
5412 ~~working time to activities other than those described in Subsection (1) and Subsections~~
5413 ~~31A-1-301(51), (52), and (54) including the clerical employees of persons required to be licensed~~
5414 ~~under this chapter;~~]
5415 [~~(b) a regular salaried officer or employee of a person seeking to purchase insurance, who~~
5416 ~~receives no compensation that is directly dependent upon the amount of insurance coverage~~
5417 ~~purchased;~~]
5418 [~~(c) a person who gives incidental advice in the normal course of a business or professional~~
5419 ~~activity, other than insurance consulting, if neither that person nor that person's employer receives~~

5420 direct or indirect compensation on account of any insurance transaction that results from that
5421 advice;]
5422 [(d) a person who, without special compensation, performs incidental services for another
5423 at the other's request, without providing advice or technical or professional services of a kind
5424 normally provided by an agent, broker, or consultant;]
5425 [(e) a holder of a group insurance policy, or any other person involved in mass marketing,
5426 but only:]
5427 [(i) with respect to administrative activities in connection with that type of policy,
5428 including the collection of premiums; and]
5429 [(ii) if the person receives no compensation for the activities described in Subsection
5430 (2)(e)(i) beyond reasonable expenses including a fair payment for the use of capital; and]
5431 [(f) a person who gives advice or assistance without direct or indirect compensation or any
5432 expectation of direct or indirect compensation.]
5433 [(3)] (1) "Actuary" means a person who is a member in good standing of the American
5434 Academy of Actuaries.
5435 [(4)] (2) "Agency" means a person other than an individual, and includes a sole
5436 proprietorship by which a natural person does business under an assumed name.
5437 [(5)] (3) "Broker" means an insurance broker or any other person, firm, association, or
5438 corporation that for any compensation, commission, or other thing of value acts or aids in any
5439 manner in soliciting, negotiating, or procuring the making of any insurance contract on behalf of
5440 an insured other than itself.
5441 [(6)] (4) "Bail bond agent" means [any] an individual:
5442 (a) appointed by an authorized bail bond surety insurer or appointed by a licensed bail
5443 bond surety company to execute or countersign undertakings of bail in connection with judicial
5444 proceedings; and
5445 (b) who receives or is promised money or other things of value for this service.
5446 [(7)] (5) "Captive insurer" means:
5447 (a) an insurance company owned by another organization whose exclusive purpose is to
5448 insure risks of the parent organization and affiliated companies; or
5449 (b) in the case of groups and associations, an insurance organization owned by the insureds
5450 whose exclusive purpose is to insure risks of member organizations, group members, and their

5451 affiliates.

5452 [(8)] (6) "Controlled insurer" means a licensed insurer that is either directly or indirectly
5453 controlled by a broker.

5454 [(9)] (7) "Controlling broker" means a broker who either directly or indirectly controls an
5455 insurer.

5456 [(10)] (8) "Controlling person" means any person, firm, association, or corporation that
5457 directly or indirectly has the power to direct or cause to be directed, the management, control, or
5458 activities of a reinsurance intermediary.

5459 (9) "Escrow" means a license category that allows a person to conduct escrows,
5460 settlements, or closings on behalf of:

5461 (a) a title insurance agency; or

5462 (b) a title insurer.

5463 (10) "Home state" means any state or territory of the United States or the District of
5464 Columbia in which an insurance producer:

5465 (a) maintains the insurance producer's principal:

5466 (i) place of residence; or

5467 (ii) place of business; and

5468 (b) is licensed to act as an insurance producer.

5469 (11) "Insurer" is as defined in Section 31A-1-301, except the following persons or similar
5470 persons are not insurers for purposes of Part 6, Broker Controlled Insurers:

5471 (a) all risk retention groups as defined in:

5472 (i) the Superfund Amendments and Reauthorization Act of 1986, Pub. L. No. 99-499;

5473 (ii) the Risk Retention Act, 15 U.S.C. Sec. 3901 et seq.; and

5474 (iii) [Title 31A,] Chapter 15, Part II, Risk Retention Groups Act;

5475 (b) all residual market pools and joint underwriting authorities or associations; and

5476 (c) all captive insurers.

5477 (12) "License" is defined in Section 31A-1-301.

5478 (13) "Limited license" means a license that:

5479 (a) is issued for a specific product of insurance; and

5480 (b) limits an individual or agency to transact only for that product or insurance.

5481 (14) "Limited line insurance" includes:

5482 (a) bail bond;
5483 (b) credit life;
5484 (c) credit disability;
5485 (d) credit property;
5486 (e) credit unemployment;
5487 (f) involuntary unemployment;
5488 (g) legal expense;
5489 (h) mortgage life;
5490 (i) mortgage guaranty;
5491 (j) mortgage disability;
5492 (k) motor club;
5493 (l) rental car-related;
5494 (m) travel insurance; and
5495 (n) any other form of limited insurance or insurance offered in connection with an
5496 extension of credit that:
5497 (i) is limited to partially or wholly extinguishing that credit obligation; and
5498 (ii) the commissioner determines should be designated a form of limited line insurance.
5499 [(12)] (15) (a) "Managing general agent" means any person, firm, association, or
5500 corporation that:
5501 (i) manages all or part of the insurance business of an insurer, including the management
5502 of a separate division, department, or underwriting office;
5503 (ii) acts as an agent for the insurer whether it is known as a managing general agent,
5504 manager, or other similar term;
5505 (iii) with or without the authority, either separately or together with affiliates, directly or
5506 indirectly produces and underwrites an amount of gross direct written premium equal to, or more
5507 than 5% of, the policyholder surplus as reported in the last annual statement of the insurer in any
5508 one quarter or year; and
5509 (iv) [either] (A) adjusts or pays claims in excess of an amount determined by the
5510 commissioner[,]; or [that]
5511 (B) negotiates reinsurance on behalf of the insurer.
5512 (b) Notwithstanding Subsection [(12)] (15)(a), the following persons may not be

5513 considered as managing general agent for the purposes of this chapter:
5514 (i) an employee of the insurer;
5515 (ii) a [~~U.S.~~] United States manager of the United States branch of an alien insurer;
5516 (iii) an underwriting manager that, pursuant to contract:
5517 (A) manages all the insurance operations of the insurer;
5518 (B) is under common control with the insurer;
5519 (C) is subject to [~~Title 31A,~~] Chapter 16, Insurance Holding Companies; and
5520 (D) is not compensated based on the volume of premiums written; and
5521 (iv) the attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer
5522 or inter-insurance exchange under powers of attorney.
5523 (16) "Negotiate" means the act of conferring directly with or offering advice directly to a
5524 purchaser or prospective purchaser of a particular contract of insurance concerning any of the
5525 substantive benefits, terms or conditions of the contract if the person engaged in that act:
5526 (a) sells insurance; or
5527 (b) obtains insurance from insurers for purchasers.
5528 [~~(13)~~] (17) "Producer" [~~is~~] means a person [~~who arranges for insurance coverages between~~
5529 ~~insureds and insurers~~] required to be licensed under the laws of this state to sell, solicit, or
5530 negotiate insurance.
5531 [~~(14)~~] (18) "Qualified [~~U.S.~~] United States financial institution" means an institution that:
5532 (a) is organized or, in the case of a [~~U.S.~~] United States office of a foreign banking
5533 organization licensed, under the laws of the United States or any state;
5534 (b) is regulated, supervised, and examined by [~~U.S.~~] United States federal or state
5535 authorities having regulatory authority over banks and trust companies; and
5536 (c) [~~has been determined by either the commissioner, or the Securities Valuation Office~~
5537 ~~of the National Association of Insurance Commissioners, to meet~~] meets the standards of financial
5538 condition and standing that are considered necessary and appropriate to regulate the quality of
5539 financial institutions whose letters of credit will be acceptable to the commissioner[~~.~~] as
5540 determined by:
5541 (i) the commissioner; or
5542 (ii) the Securities Valuation Office of the National Association of Insurance
5543 Commissioners.

5544 [(15)] (19) "Reinsurance intermediary" means a reinsurance intermediary-broker or a
5545 reinsurance intermediary-manager as these terms are defined in Subsections [(16)] (20) and [(17)]
5546 (21).
5547 [(16)] (20) "Reinsurance intermediary-broker" means a person other than an officer or
5548 employee of the ceding insurer, firm, association, or corporation who solicits, negotiates, or places
5549 reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power
5550 to bind reinsurance on behalf of the insurer.
5551 [(17)] (21) (a) "Reinsurance intermediary-manager" means a person, firm, association, or
5552 corporation who:
5553 (i) has authority to bind or who manages all or part of the assumed reinsurance business
5554 of a reinsurer, including the management of a separate division, department, or underwriting
5555 office; and
5556 (ii) acts as an agent for the reinsurer whether the person, firm, association, or corporation
5557 is known as a reinsurance intermediary-manager, manager, or other similar term.
5558 (b) Notwithstanding Subsection [(17)] (21)(a), the following persons may not be
5559 considered reinsurance intermediary-managers for the purpose of this chapter with respect to the
5560 reinsurer:
5561 (i) an employee of the reinsurer;
5562 (ii) a [U.S.] United States manager of the United States branch of an alien reinsurer;
5563 (iii) an underwriting manager that, pursuant to contract:
5564 (A) manages all the reinsurance operations of the reinsurer;
5565 (B) is under common control with the reinsurer;
5566 (C) is subject to [Title 31A,] Chapter 16, Insurance Holding Companies; and
5567 (D) is not compensated based on the volume of premiums written; and
5568 (iv) the manager of a group, association, pool, or organization of insurers that:
5569 (A) engage in joint underwriting or joint reinsurance; and
5570 (B) are subject to examination by the insurance commissioner of the state in which the
5571 manager's principal business office is located.
5572 [(18)] (22) "Reinsurer" means any person, firm, association, or corporation duly licensed
5573 in this state as an insurer with the authority to assume reinsurance.
5574 (23) "Search" means a license category that allows a person to issue title insurance

5575 commitments or policies on behalf of a title insurer.
5576 (24) "Sell" means to exchange a contract of insurance:
5577 (a) by any means;
5578 (b) for money or its equivalent; and
5579 (c) on behalf of an insurance company.
5580 (25) "Solicit" means:
5581 (a) attempting to sell insurance; or
5582 (b) asking or urging a person to apply:
5583 (i) for a particular kind of insurance; and
5584 (ii) from a particular insurance company.
5585 [~~(19)~~] (26) "Surplus lines broker" means a person licensed under Subsection
5586 31A-23-204(5) to place insurance with unauthorized insurers in accordance with Section
5587 31A-15-103.
5588 (27) "Terminate" means:
5589 (a) the cancellation of the relationship between:
5590 (i) an insurance producer; and
5591 (ii) a particular insurer; or
5592 (b) the termination of the producer's authority to transact insurance on behalf of a
5593 particular insurance company.
5594 (28) "Title marketing representative" means a person who:
5595 (a) represents a title insurer in soliciting, requesting, or negotiating the placing of:
5596 (i) title insurance; or
5597 (ii) escrow, settlement, or closing services; and
5598 (b) does not have a search or escrow license.
5599 [~~(20)~~] (29) "Underwrite" means the authority to accept or reject risk on behalf of the
5600 insurer.
5601 (30) "Uniform application" means the version of the National Association of Insurance
5602 Commissioner's uniform application for resident and nonresident producer licensing at the time
5603 the application is filed.
5604 (31) "Uniform business entity application" means the version of the National Association
5605 of Insurance Commissioner's uniform business entity application for resident and nonresident

5606 business entities at the time the application is filed.

5607 Section 135. Section **31A-23-201** is amended to read:

5608 **31A-23-201. Requirement of license.**

5609 (1) (a) Unless exempted from the licensing requirement under [Subsection (2) or] Section

5610 31A-23-201.5 or 31A-23-214, a person may not perform, offer to perform, or advertise any service

5611 as an agent, broker, or consultant in Utah, without a valid license under Section 31A-23-203.

5612 (b) A person may not utilize the services of another as an agent, broker, or consultant if

5613 [he] that person knows or should know that the other does not have a license as required by law.

5614 [(2) The commissioner may by rule exempt certain classes of persons from the license

5615 requirement of Subsection (1) if either of these circumstances exist:]

5616 [(a) the functions they perform do not require special competence, trustworthiness, or the

5617 regulatory surveillance made possible by licensing; or]

5618 [(b) other existing safeguards make regulation unnecessary.]

5619 (2) This part may not be construed to require an insurer to obtain an insurance producer

5620 license.

5621 (3) [No] An insurance contract is not invalid as a result of a violation of this section.

5622 Section 136. Section **31A-23-201.5** is enacted to read:

5623 **31A-23-201.5. Exceptions to licensing.**

5624 (1) The commissioner may not require a license as an insurance producer of:

5625 (a) an officer, director, or employee of an insurer or of an insurance producer if:

5626 (i) the officer, director, or employee does not receive any commission on a policy written

5627 or sold to insure risks residing, located, or to be performed in this state; and

5628 (ii) (A) the officer's, director's, or employee's activities are:

5629 (I) executive, administrative, managerial, clerical, or a combination of these activities; and

5630 (II) only indirectly related to the sale, solicitation, or negotiation of insurance;

5631 (B) the officer's, director's, or employee's function relates to:

5632 (I) underwriting;

5633 (II) loss control;

5634 (III) inspection; or

5635 (IV) the processing, adjusting, investigating or settling of a claim on a contract of

5636 insurance; or

5637 (C) (I) the officer, director, or employee is acting in the capacity of a special agent or
5638 agency supervisor assisting an insurance producer;
5639 (II) the officer's, director's, or employee's activities are limited to providing technical
5640 advice and assistance to a licensed insurance producer; and
5641 (III) the officer's, director's, or employee's activities do not include the sale, solicitation,
5642 or negotiation of insurance;
5643 (b) a person who:
5644 (i) is paid no commission for the services described in Subsection (1)(b)(ii); and
5645 (ii) secures and furnishes information for the purpose of:
5646 (A) group life insurance;
5647 (B) group property and casualty insurance;
5648 (C) group annuities;
5649 (D) group or blanket accident and health insurance;
5650 (E) enrolling individuals under plans;
5651 (F) issuing certificates under plans; or
5652 (G) otherwise assisting in administering plans;
5653 (c) a person who:
5654 (i) is paid no commission for the services described in Subsection (1)(c)(ii); and
5655 (ii) performs administrative services related to mass marketed property and casualty
5656 insurance;
5657 (d) (i) any of the following if the conditions of Subsection (1)(d)(ii) are met:
5658 (A) an employer or association; or
5659 (B) an officer, director, employee, or trustee of an employee trust plan;
5660 (ii) a person listed in Subsection (1)(d)(i):
5661 (A) to the extent that the employer, officer, employee, director, or trustee is engaged in the
5662 administration or operation of a program of employee benefits for:
5663 (I) the employer's or association's own employees; or
5664 (II) the employees of a subsidiary or affiliate of an employer or association;
5665 (B) the program involves the use of insurance issued by an insurer; and
5666 (C) the employer, association, officer, director, employee, or trustee is not in any manner
5667 compensated, directly or indirectly, by the company issuing the contract;

5668 (e) an employee of an insurer or organization employed by an insurer who:
5669 (i) is engaging in:
5670 (A) the inspection, rating, or classification of risks; or
5671 (B) the supervision of the training of insurance producers; and
5672 (ii) is not individually engaged in the sale, solicitation, or negotiation of insurance;
5673 (f) a person whose activities in this state are limited to advertising:
5674 (i) without the intent to solicit insurance in this state;
5675 (ii) through communications in mass media including:
5676 (A) a printed publication; or
5677 (B) a form of electronic mass media;
5678 (iii) that is distributed to residents outside of the state; and
5679 (iv) if the person does not sell, solicit, or negotiate insurance that would insure risks
5680 residing, located, or to be performed in this state;
5681 (g) a person who:
5682 (i) is not a resident of this state;
5683 (ii) sells, solicits, or negotiates a contract of insurance:
5684 (A) for commercial property and casualty risks to an insured with risks located in more
5685 than one state insured under that contract; and
5686 (B) insures risks located in a state in which the person is licensed as provided in
5687 Subsection (1)(g)(iii); and
5688 (iii) is licensed as an insurance producer to sell, solicit, or negotiate that insurance in the
5689 state where the insured maintains its principal place of business;
5690 (h) if the employee does not sell, solicit, or receive a commission for a contract of
5691 insurance, a salaried full-time employee who counsels or advises the employee's employer relating
5692 to the insurance interests of:
5693 (i) the employer; or
5694 (ii) a subsidiary or business affiliate of the employer; or
5695 (i) an employee of an insurer or of an insurance producer if the employee:
5696 (i) responds to requests from existing policyholders on existing policies;
5697 (ii) is not directly compensated based on the volume of premiums that may result from the
5698 services; and

5699 (iii) does not otherwise sell, solicit, or negotiate insurance.
5700 (2) The commissioner may by rule exempt a class of persons from the license requirement
5701 of Subsection 31A-23-201(1) if:
5702 (a) the functions performed by the class of persons does not require:
5703 (i) special competence;
5704 (ii) special trustworthiness; or
5705 (iii) regulatory surveillance made possible by licensing; or
5706 (b) other existing safeguards make regulation unnecessary.
5707 Section 137. Section **31A-23-202** is amended to read:
5708 **31A-23-202. Application for license.**
5709 (1) [The] (a) Subject to Subsection (2) the application for a resident license as an agent,
5710 a broker, or a consultant shall be:
5711 (i) made to the commissioner on forms and in a manner [he] the commissioner prescribes[.
5712 The]; and
5713 (ii) accompanied by an applicable fee that is not refunded if the application is denied; and
5714 (b) the application for a nonresident license as an agent, a broker, or a consultant shall be:
5715 (i) made on the uniform application; and
5716 (ii) accompanied by an applicable fee that is not refunded if the application is denied.
5717 (2) An application described in Subsection (1) shall provide:
5718 (a) information about the applicant's identity[,];
5719 (b) the applicant's:
5720 (i) social security number[,]; or
5721 (ii) federal employer identification number;
5722 (c) the applicant's personal history, experience, education, and business record[, and];
5723 (d) if the applicant is a natural person, whether the applicant is 18 years of age or older;
5724 (e) whether the applicant has committed an act that is a ground for denial, suspension, or
5725 revocation as set forth in Section 31A-23-216; and
5726 (f) any other information the commissioner reasonably requires.
5727 (3) The commissioner may require any documents reasonably necessary to verify the
5728 information contained in an application.
5729 [(2)] (4) [An applicant's social security number is a] The following are private [record]

5730 records under Subsection 63-2-302(1)(g)[.] an applicant's:
5731 (a) social security number; or
5732 (b) federal employer identification number.
5733 Section 138. Section **31A-23-203** is amended to read:
5734 **31A-23-203. General requirements for license issuance and renewal.**
5735 (1) The commissioner shall issue or renew a license to act as an agent, broker, or
5736 consultant to any person who, as to the license classification applied for under Section
5737 31A-23-204:
5738 (a) has satisfied the character requirements under Section 31A-23-205;
5739 (b) has satisfied any applicable continuing education requirements under Section
5740 31A-23-206;
5741 (c) has satisfied any applicable examination requirements under Section 31A-23-207;
5742 (d) has satisfied any applicable training period requirements under Section 31A-23-208;
5743 (e) if a nonresident:
5744 (i) has complied with Section 31A-23-209; and
5745 (ii) holds an active similar license in that person's state of residence;
5746 (f) as to applicants for licenses to act as title insurance agents, has satisfied the
5747 requirements of Section 31A-23-211; and
5748 (g) has paid the applicable fees under Section 31A-3-103.
5749 (2) (a) This Subsection (2) applies to the following persons:
5750 (i) an applicant for a pending producer's license; or
5751 (ii) a licensed producer.
5752 (b) A person described in Subsection (2)(a) shall report to the commissioner:
5753 (i) any administrative action taken against the person:
5754 (A) in another jurisdiction; or
5755 (B) by another regulatory agency in this state; and
5756 (ii) any criminal prosecution taken against the person in any jurisdiction.
5757 (c) The report required by Subsection (2)(b) shall:
5758 (i) be filed:
5759 (A) at the time the person files the application for a producer's license; or
5760 (B) within 30 days of the initiation of an action or prosecution described in Subsection

5761 (2)(b); and
5762 (ii) include a copy of the complaint or other relevant legal documents related to the action
5763 or prosecution described in Subsection (2)(b).
5764 [(2)] (3) (a) The department may request:
5765 (i) criminal background information maintained pursuant to Title 53, Chapter 10, Part 2,
5766 from the Bureau of Criminal Identification; and
5767 (ii) complete Federal Bureau of Investigation criminal background checks through the
5768 national criminal history system.
5769 (b) Information obtained by the department from the review of criminal history records
5770 received under Subsection [(2)] (3)(a) shall be used by the department for the purposes of:
5771 (i) determining if a person satisfies the character requirements under Section 31A-23-205
5772 for issuance or renewal of a license;
5773 (ii) determining if a person has failed to maintain the character requirements under Section
5774 31A-23-205; and
5775 (iii) preventing persons who violate the federal Violent Crime Control and Law
5776 Enforcement Act of 1994, 18 U.S.C. Secs. 1033 and 1034, from engaging in the business of
5777 insurance in the state.
5778 (c) If the department requests the criminal background information, the department shall:
5779 (i) pay to the Department of Public Safety the costs incurred by the Department of Public
5780 Safety in providing the department criminal background information under Subsection [(2)]
5781 (3)(a)(i);
5782 (ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau of
5783 Investigation in providing the department criminal background information under Subsection[(2)]
5784 (3)(a)(ii); and
5785 (iii) charge the person applying for a license or for renewal of a license a fee equal to the
5786 aggregate of Subsections [(2)] (3)(c)(i) and (ii).
5787 Section 139. Section **31A-23-204** is amended to read:
5788 **31A-23-204. License classifications.**
5789 [Licenses] A resident or nonresident license issued under this chapter shall be issued under
5790 the classifications described under Subsections (1) through (6). These classifications are intended
5791 to describe the matters to be considered under any education, examination, and training required

5792 of license applicants under Sections 31A-23-206 through 31A-23-208.
5793 (1) [Agent] An agent and broker license [classifications include] classification includes:
5794 (a) life insurance, including nonvariable [annuities] contracts;
5795 (b) variable [annuities] contracts;
5796 (c) [disability] accident and health insurance, including contracts issued to policyholders
5797 under Chapter 7 or 8;
5798 (d) property/liability insurance, which includes:
5799 (i) property insurance;
5800 (ii) liability insurance;
5801 (iii) surety and other bonds; and
5802 (iv) policies containing any combination of these coverages;
5803 (e) title insurance under one of the following categories:
5804 (i) search, including authority to act as a title marketing representative;
5805 (ii) escrow, including authority to act as a title marketing representative;
5806 (iii) search and escrow, including authority to act as a title marketing representative; and
5807 (iv) title marketing representative only; and
5808 (f) workers' compensation insurance.
5809 (2) [Limited] A limited license [product] classification includes:
5810 (a) credit life and credit [disability] accident and health insurance;
5811 (b) travel insurance;
5812 (c) motor club insurance;
5813 (d) car rental related insurance;
5814 (e) credit involuntary unemployment insurance [and];
5815 (f) credit property insurance;
5816 [(f)] (g) bail bond agent; and
5817 [(g)] (h) customer service representative.
5818 (3) [Consultant] A consultant license classification includes:
5819 (a) life insurance, including nonvariable [annuities] contracts;
5820 (b) variable [annuities] contracts;
5821 (c) [disability] accident and health insurance, including contracts issued to policyholders
5822 under Chapter 7 or 8;

5823 (d) property/liability insurance, which includes:
5824 (i) property insurance;
5825 (ii) liability insurance;
5826 (iii) surety and other bonds; and
5827 (iv) policies containing any combination of these coverages; and
5828 (e) workers' compensation insurance.
5829 (4) A holder of licenses under Subsections (1)(a) and (1)(c) has all qualifications necessary
5830 to act as a holder of a license under Subsection (2)(a).
5831 (5) (a) Upon satisfying the additional applicable requirements, a holder of a brokers license
5832 may obtain a license to act as a surplus lines broker.
5833 (b) A license to act as a surplus lines broker gives the holder the authority to arrange
5834 insurance contracts with unauthorized insurers under Section 31A-15-103, but only as to the types
5835 of insurance under Subsection (1) for which the broker holds a brokers license.
5836 (6) The commissioner may by rule recognize other agent, broker, limited license, or
5837 consultant license classifications as to kinds of insurance not listed under Subsections (1), (2), and
5838 (3).
5839 Section 140. Section **31A-23-206** is amended to read:
5840 **31A-23-206. Continuing education requirements -- Regulatory authority.**
5841 (1) The commissioner shall by rule prescribe the continuing education requirements for
5842 each class of agent's license under Subsection 31A-23-204(1), except that the commissioner may
5843 not impose a continuing education requirement on a holder of a license under:
5844 (a) Subsection 31A-23-204(2); or
5845 (b) a license classification other than under Subsection 31A-23-204(2) that is recognized
5846 by the commissioner by rule as provided in Subsection 31A-23-204(6).
5847 (2) (a) The commissioner may not state a continuing education requirement in terms of
5848 formal education.
5849 (b) The commissioner may state a continuing education requirement in terms of classroom
5850 hours, or their equivalent, of insurance-related instruction received.
5851 (c) Insurance-related formal education may be a substitute, in whole or in part, for
5852 classroom hours, or their equivalent, required under Subsection (2)(b).
5853 (3) (a) The commissioner shall impose continuing education requirements in accordance

5854 with a two-year licensing period in which the licensee meets the requirements of this Subsection
5855 (3).
5856 (b) Except as provided in Subsection (3)(c), for a two-year licensing period described in
5857 Subsection (3)(a) the commissioner shall require that the licensee for each line of authority held
5858 by the licensee:
5859 (i) receive six hours of continuing education; or
5860 (ii) pass a line of authority continuing education examination.
5861 (c) Notwithstanding Subsection (3)(b):
5862 (i) the commissioner may not require continuing education for more than four lines of
5863 authority held by the licensee;
5864 (ii) the commissioner shall require:
5865 (A) a minimum of:
5866 (I) 12 hours of continuing education;
5867 (II) passage of two line of authority continuing education examinations; or
5868 (III) a combination of Subsections (3)(c)(ii)(A)(I) and (II);
5869 (B) that the minimum continuing education requirement of Subsection (3)(c)(ii)(A)
5870 include:
5871 (I) at least six hours or one line of authority continuing education examination for each line
5872 of authority held by the licensee not to exceed four lines of authority held by the licensee; and
5873 (II) three hours of ethics training, which may be taken in place of three hours of the hours
5874 required for a line of authority.
5875 (d) (i) If a licensee completes the licensee's continuing education requirement without
5876 taking a line of authority continuing education examination, the licensee shall complete at least 1/2
5877 of the required hours through classroom hours of insurance-related instruction.
5878 (ii) The hours not completed through classroom hours in accordance with Subsection
5879 (3)(d)(i) may be obtained through:
5880 (A) home study;
5881 (B) video tape;
5882 (C) experience credit; or
5883 (D) other method provided by rule.
5884 (e) (i) A licensee may obtain continuing education hours at any time during the two-year

5885 licensing period.
5886 (ii) The licensee may not take a line of authority continuing education examination more
5887 than 90 calendar days before the date on which the licensee's license is renewed.
5888 (f) The commissioner shall make rules for the content and procedures for line of authority
5889 continuing education examinations.
5890 (g) (i) Beginning May 3, 1999, a licensee is exempt from continuing education
5891 requirements under this section if:
5892 (A) as of April 1, 1990, the licensee has completed 20 years of licensure in good standing;
5893 (B) the licensee requests an exemption from the department; and
5894 (C) the department approves the exemption.
5895 (ii) If the department approves the exemption under Subsection (3)(g)(i), the licensee is
5896 not required to apply again for the exemption.
5897 (h) A licensee with a variable [~~annuity~~] contract line of authority is exempt from the
5898 requirement for continuing education for that line of authority so long as the:
5899 (i) National Association of Securities Dealers requires continuing education for licensees
5900 having a securities license; and
5901 (ii) licensee complies with the National Association of Securities Dealers' continuing
5902 education requirements for securities licensees.
5903 (i) The commissioner shall, by rule:
5904 (i) publish a list of insurance professional designations whose continuing education
5905 requirements can be used to meet the requirements for continuing education under Subsection
5906 (3)(c); and
5907 (ii) authorize professional agent associations to:
5908 (A) offer qualified programs for all classes of licenses on a geographically accessible basis;
5909 and
5910 (B) collect reasonable fees for funding and administration of the continuing education
5911 program, subject to the review and approval of the commissioner.
5912 (j) (i) The fees permitted under Subsection (3)(i)(ii) that are charged to fund and administer
5913 the program shall reasonably relate to the costs of administering the program.
5914 (ii) Nothing in this section prohibits a provider of continuing education programs or
5915 courses from charging fees for attendance at courses offered for continuing education credit.

5916 (iii) The fees permitted under Subsection (3)(i)(ii) that are charged for attendance at a
5917 professional agent association program may be less for an association member, based on the
5918 member's affiliation expense, but shall preserve the right of a nonmember to attend without
5919 affiliation.
5920 (4) The commissioner shall designate courses, including those presented by insurers,
5921 which satisfy the requirements of this section.
5922 (5) The requirements of this section apply only to applicants who are natural persons.
5923 [(6) The commissioner may waive the requirements of this section as to any person who
5924 has been an active insurance agent or broker in another state for two years immediately prior to
5925 applying for a license in this state, but only if the applicant's state of residence has imposed upon
5926 the applicant education requirements which are substantially as rigorous as those of this state.]
5927 (6) A nonresident producer is considered to have satisfied this state's continuing education
5928 requirements if:
5929 (a) the nonresident producer satisfies the nonresident producer's home state's continuing
5930 education requirements for a licensed insurance producer; and
5931 (b) on the same basis as under this Subsection (6) the nonresident producer's home state
5932 considers satisfaction of Utah's continuing education requirements for a producer as satisfying the
5933 continuing education requirements of the home state.
5934 Section 141. Section **31A-23-207** is amended to read:
5935 **31A-23-207. Examination requirements.**
5936 (1) (a) The commissioner may require applicants for any particular class of license under
5937 Section 31A-23-204 to pass an examination as a requirement for a license, except that [no] an
5938 examination may not be required of applicants for:
5939 (i) licenses under Subsection 31A-23-204(2); or
5940 (ii) other license classifications recognized by the commissioner by rule as provided in
5941 Subsection 31A-23-204(6).
5942 (b) The examination described in Subsection (1)(a):
5943 (i) shall reasonably relate to the specific classes for which it is prescribed[. The
5944 examination]; and
5945 (ii) may be administered by the commissioner or as otherwise specified by rule.
5946 (2) The commissioner [may] shall waive the requirement of an examination for a

5947 nonresident applicant who [~~has held a similar license in his home state for the two years~~
5948 ~~immediately preceding application in this state, but only if the applicant's state of residence has~~
5949 ~~imposed upon the applicant examination requirements which are substantially as rigorous as those~~
5950 ~~of this state.~~]:
5951 (a) applies for an insurance producer license in this state;
5952 (b) has been licensed for the same line of authority in another state; and
5953 (c) (i) is licensed in the state described in Subsection (2)(b) at the time the applicant
5954 applies for an insurance producer license in this state; or
5955 (ii) if the application is received within 90 days of the cancellation of the applicant's
5956 previous license:
5957 (A) the prior state certifies that at the time of cancellation, the applicant was in good
5958 standing in that state; or
5959 (B) the state's producer database records maintained by the National Association of
5960 Insurance Commissioners or the National Association of Insurance Commissioner's affiliates or
5961 subsidiaries, indicates that the producer is or was licensed in good standing for the line of authority
5962 requested.
5963 (3) (a) To become a resident licensee in accordance with Sections 31A-23-202 and
5964 31A-23-203, a person licensed as an insurance producer in another state who moves to this state
5965 shall make application within 90 days of establishing legal residence in this state.
5966 (b) A person who becomes a resident licensee under Subsection (3)(a) may not be required
5967 to meet prelicensing education or examination requirements to obtain any line of authority
5968 previously held in the prior state unless:
5969 (i) the prior state would require a prior resident of this state to meet the prior state's
5970 prelicensing education or examination requirements to become a resident licensee; or
5971 (ii) the commissioner imposes the requirements by rule.
5972 [~~(3)~~] (4) This section's requirement may only be applied to applicants who are natural
5973 persons.
5974 Section 142. Section **31A-23-209** is amended to read:
5975 **31A-23-209. Nonresident jurisdictional agreement.**
5976 (1) (a) [~~Nonresident applicants for licenses under this chapter shall~~] If a nonresident
5977 license applicant has a valid license from the nonresident license applicant's home state and the

5978 conditions of Subsection (1)(b) are met, the commissioner shall:
5979 (i) waive any license requirement for a license under this chapter; and
5980 (ii) issue the nonresident license applicant a nonresident producer license.
5981 (b) Subsection (1)(a) applies if:
5982 (i) the nonresident license applicant:
5983 (A) is licensed as a resident in the nonresident license applicant's home state at the time
5984 the nonresident license applicant applies for a nonresident producer license;
5985 (B) has submitted the proper request for licensure;
5986 (C) has submitted to the commissioner:
5987 (I) the application for licensure that the nonresident license applicant submitted to the
5988 applicant's home state; or
5989 (II) a completed uniform application; and
5990 (D) has paid the applicable fees under Section 31A-3-103;
5991 (ii) the nonresident license applicant's license in the applicant's home state is in good
5992 standing; and
5993 (iii) the nonresident license applicant's home state awards nonresident producer licenses
5994 to residents of this state on the same basis as this state awards licenses to residents of that home
5995 state.
5996 (2) A nonresident applicant shall execute, in a form acceptable to the commissioner, an
5997 agreement to be subject to the jurisdiction of the Utah commissioner and courts on any matter
5998 related to the applicant's insurance activities in this state, on the basis of:
5999 (a) service of process under Sections 31A-2-309 and 31A-2-310; or [other]
6000 (b) service authorized:
6001 (i) in the Utah Rules of Civil Procedure; or
6002 (ii) under Section 78-27-25.
6003 (3) The commissioner may verify the producer's licensing status through the producer
6004 database maintained by:
6005 (a) the National Association of Insurance Commissioners; or
6006 (b) an affiliate or subsidiary of the National Association of Insurance Commissioners.
6007 (4) The commissioner may not assess a greater fee for an insurance license or related
6008 service to a person not residing in this state solely on the fact that the person does not reside in this

6009 state.

6010 Section 143. Section **31A-23-211.7** is amended to read:

6011 **31A-23-211.7. Special requirements for variable annuity line of authority.**

6012 (1) Before applying for a variable [~~annuity~~] contracts line of authority, an agent, broker,
6013 or consultant shall be licensed under Section 61-1-3 as a:

6014 (a) broker-dealer; or

6015 (b) agent.

6016 (2) An agent's, broker's, or consultant's variable [~~annuity~~] contracts line of authority is
6017 revoked on the day on which an agent's, broker's, or consultant's license under Section 61-1-3 is
6018 no longer valid.

6019 Section 144. Section **31A-23-212** is amended to read:

6020 **31A-23-212. Form and contents of license.**

6021 (1) Licenses issued under this chapter shall be in the form the commissioner prescribes and
6022 shall set forth:

6023 (a) the name, address, and telephone number of the licensee;

6024 (b) the license classifications under Section 31A-23-204;

6025 (c) the date of license issuance; and

6026 (d) any other information the commissioner considers necessary.

6027 (2) An insurance producer doing business under any other name than the producer's legal
6028 name shall notify the commissioner prior to using the assumed name in this state.

6029 [~~(2)~~] (3) (a) An agency shall be licensed as an agency if the agency acts as:

6030 (i) an agent;

6031 (ii) a broker;

6032 (iii) a surplus lines broker;

6033 (iv) a managing general agent; or

6034 (v) a consultant.

6035 (b) The agency license [~~required~~] issued under [~~Subsections (2)~~] Subsection (3)(a) shall
6036 set forth the names of all natural persons licensed under this chapter who are authorized to act in
6037 those capacities for the agency in this state.

6038 [~~(3)~~] (4) (a) So far as is practicable, the commissioner shall issue a single license to each
6039 agent, broker, or consultant for a single fee.

6040 (b) For purposes of the fee described in Subsection (4)(a), the less expensive license is
6041 included within the most expensive license.
6042 Section 145. Section **31A-23-216** is amended to read:
6043 **31A-23-216. Termination of license.**
6044 (1) A license issued under this chapter remains in force until:
6045 (a) revoked, suspended, or limited under Subsection (2);
6046 (b) lapsed under Subsection (3);
6047 (c) surrendered to and accepted by the commissioner; or
6048 (d) the licensee dies or is adjudicated incompetent as defined under Title 75, Chapter 5,
6049 Part 3, Guardians of Incapacitated Persons or Part 4, Protection of Property of Persons Under
6050 Disability and Minors.
6051 [(2) (a) After an adjudicative proceeding under Title 63, Chapter 46b, Administrative
6052 Procedures Act, the commissioner may revoke, suspend, or limit in whole or in part the license of
6053 any agent, broker, surplus lines broker, or consultant who is found:]
6054 [(i) to be unqualified;]
6055 [(ii) to have violated an insurance statute, valid rule under Subsection 31A-2-201(3), or
6056 a valid order under Subsection 31A-2-201(4); or]
6057 [(iii) if the licensee's methods and practices in the conduct of business endanger the
6058 legitimate interests of customers and the public.]
6059 [(b) Every order suspending a license issued under this chapter shall specify the period for
6060 which the suspension is effective, but in no event may the period exceed 12 months.]
6061 (2) (a) If the commissioner makes a finding under Subsection (2)(b), after an adjudicative
6062 proceeding under Title 63, Chapter 46b, Administrative Procedures Act, the commissioner may:
6063 (i) revoke a license of an agent, broker, surplus lines broker, or consultant;
6064 (ii) suspend for a specified period of 12 months or less a license of an agent, broker,
6065 surplus lines broker, or consultant; or
6066 (iii) limit in whole or in part the license of any agent, broker, surplus lines broker, or
6067 consultant.
6068 (b) The commissioner may take an action described in Subsection (2)(a) if the
6069 commissioner finds that the licensee:
6070 (i) is unqualified for a license under Section 31A-23-203;

6071 (ii) has violated:
6072 (A) an insurance statute;
6073 (B) a rule that is valid under Subsection 31A-2-201(3); or
6074 (C) an order that is valid under Subsection 31A-2-201(4);
6075 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other
6076 delinquency proceedings in any state;
6077 (iv) fails to pay any final judgment rendered against the person in this state within 60 days
6078 after the day the judgment became final;
6079 (v) fails to meet the same good faith obligations in claims settlement that is required of
6080 admitted insurers;
6081 (vi) is affiliated with and under the same general management or interlocking directorate
6082 or ownership as another insurance producer that transacts business in this state without a license;
6083 (vii) refuses to be examined or to produce its accounts, records, and files for examination;
6084 (viii) has an officer who refuses to:
6085 (A) give information with respect to the administrator's affairs; or
6086 (B) perform any other legal obligation as to an examination;
6087 (ix) provided information in the license application that is:
6088 (A) incorrect;
6089 (B) misleading;
6090 (C) incomplete; or
6091 (D) materially untrue;
6092 (x) has violated any insurance law, valid rule, or valid order of another state's insurance
6093 department;
6094 (xi) has obtained or attempted to obtain a license through misrepresentation or fraud;
6095 (xii) has improperly withheld, misappropriated, or converted any monies or properties
6096 received in the course of doing insurance business;
6097 (xiii) has intentionally misrepresented the terms of an actual or proposed:
6098 (A) insurance contract; or
6099 (B) application for insurance;
6100 (xiv) has been convicted of a felony;
6101 (xv) has admitted or been found to have committed any insurance unfair trade practice or

6102 fraud;
6103 (xvi) in the conduct of business in this state or elsewhere has:
6104 (A) used fraudulent, coercive, or dishonest practices; or
6105 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;
6106 (xvii) has had an insurance license, or its equivalent, denied, suspended, or revoked in any
6107 other state, province, district, or territory;
6108 (xviii) has forged another's name to:
6109 (A) an application for insurance; or
6110 (B) any document related to an insurance transaction;
6111 (xix) has improperly used notes or any other reference material to complete an
6112 examination for an insurance license;
6113 (xx) has knowingly accepted insurance business from an individual who is not licensed;
6114 (xxi) has failed to comply with an administrative or court order imposing a child support
6115 obligation;
6116 (xxii) has failed to:
6117 (A) pay state income tax; or
6118 (B) comply with any administrative or court order directing payment of state income tax;
6119 (xxiii) has violated or permitted others to violate the federal Violent Crime Control and
6120 Law Enforcement Act of 1994, 18 U.S.C. Secs. 1033 and 1034; or
6121 (xxiv) has engaged in methods and practices in the conduct of business that endanger the
6122 legitimate interests of customers and the public.
6123 (3) (a) Any license issued under this chapter shall lapse if the licensee fails to pay when
6124 due a fee under Section 31A-3-103.
6125 (b) A licensee whose license lapses due to military service or some other extenuating
6126 circumstances such as long-term medical disability may request:
6127 (i) reinstatement of the license; and
6128 (ii) waiver of any of the following imposed for failure to comply with renewal procedures:
6129 (A) an examination requirement;
6130 (B) a fine; or
6131 (C) other sanction imposed for failure to comply with renewal procedures.
6132 (c) The commissioner shall by rule prescribe the license renewal and reinstatement

6133 procedures, in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act.
6134 (4) A licensee under this chapter whose license is suspended, revoked, or lapsed, but who
6135 continues to act as a licensee, is subject to the penalties for acting as a licensee without a license.
6136 (5) Any person licensed in this state shall immediately report to the commissioner:
6137 (a) a suspension or revocation of that person's license in any other state, District of
6138 Columbia, or territory of the United States;
6139 (b) the imposition of a disciplinary sanction imposed on that person by any other state,
6140 District of Columbia, or territory of the United States; and
6141 (c) a judgment or injunction entered against that person on the basis of conduct involving
6142 fraud, deceit, misrepresentation, or violation of an insurance law or rule.
6143 (6) An order revoking a license under Subsection (2) may specify a time, not to exceed five
6144 years, within which the former licensee may not apply for a new license. If no time is specified,
6145 the former licensee may not apply for a new license for five years without express approval by the
6146 commissioner.
6147 (7) Any person whose license is suspended or revoked under Subsection (2) shall, when
6148 the suspension ends or a new license is issued, pay all fees that would have been payable if the
6149 license had not been suspended or revoked, unless the commissioner by order waives the payment
6150 of the interim fees. If a new license is issued more than three years after the revocation of a similar
6151 license, this subsection applies only to the fees that would have accrued during the three years
6152 immediately following the revocation.
6153 (8) The division shall promptly withhold, suspend, restrict, or reinstate the use of a license
6154 issued under this part if so ordered by a court.
6155 Section 146. Section **31A-23-218** is amended to read:
6156 **31A-23-218. Temporary insurance producer license -- Trustee for terminated**
6157 **licensee's business.**
6158 (1) (a) [~~Upon the request of the spouse, guardian, conservator, or personal representative~~
6159 ~~of a deceased or disabled agent or broker, or upon the request of a person whose license has been~~
6160 ~~terminated under Section 31A-23-216, the commissioner may appoint a trustee to provide~~
6161 ~~continuing service to the insureds who procured insurance through the deceased, disabled, or~~
6162 ~~unlicensed person.~~] The commissioner may issue a temporary insurance producer license:
6163 (i) to a person listed in Subsection (1)(b):

6164 (A) if the commissioner considers that the temporary license is necessary:
6165 (I) for the servicing of an insurance business in the public interest; and
6166 (II) to provide continued service to the insureds who procured insurance in a circumstance
6167 described in Subsection (1)(b);
6168 (B) for a period not to exceed 180 days; and
6169 (C) without requiring an examination; or
6170 (ii) in any other circumstance:
6171 (A) if the commissioner considers the public interest will best be served by issuing the
6172 temporary license;
6173 (B) for a period not to exceed 180 days; and
6174 (C) without requiring an examination.
6175 (b) The commissioner may issue a temporary insurance producer license in accordance
6176 with Subsection (1)(a) to:
6177 (i) the surviving spouse or court-appointed personal representative of a licensed insurance
6178 producer who dies or becomes mentally or physically disabled to allow adequate time for:
6179 (A) the sale of the insurance business owned by the producer;
6180 (B) recovery or return of the producer to the business; or
6181 (C) the training and licensing of new personnel to operate the producer's business;
6182 (ii) to a member or employee of a business entity licensed as an insurance producer upon
6183 the death or disability of an individual designated in:
6184 (A) the business entity application; or
6185 (B) the license; or
6186 (iii) the designee of a licensed insurance producer entering active service in the armed
6187 forces of the United States of America.
6188 (2) If a person's license is terminated under Section 31A-23-216, the commissioner may
6189 appoint a trustee to provide in the public interest continuing service to the insureds who procured
6190 insurance through the person whose license is terminated:
6191 (a) at the request of the person whose license is terminated; or
6192 (b) upon the commissioner's own initiative.
6193 (3) This section does not apply if the deceased or disabled agent or broker [~~owned or owns~~
6194 ~~no~~] does not or did not own any ownership interest in the accounts and associated expiration lists

6195 [which] that were previously serviced by the agent or broker. [Any]
6196 (4) (a) A person issued a temporary license under Subsection (1) receives the license and
6197 shall perform the duties under the license subject to the commissioner's authority to:
6198 (i) require a temporary licensee to have a suitable sponsor who:
6199 (A) is a licensed producer; and
6200 (B) assumes responsibility for all acts of the temporary licensee; or
6201 (ii) impose other requirements that are:
6202 (A) designed to protect the insureds and the public; and
6203 (B) similar to the condition described in Subsection (4)(a)(i).
6204 (b) A trustee appointed under [this section] Subsection (2) shall [receive his appointment]
6205 be appointed and perform [his] the trustee's duties subject to the [following] terms and
6206 conditions[:] described in Subsections (4)(b)(i) through (vi).
6207 [(1) Trustees] (i) (A) A trustee appointed under [this section] Subsection (2) shall be
6208 licensed under this chapter to perform the services required by the trustor's clients.
6209 (B) When possible, the commissioner shall appoint a trustee who is no longer actively
6210 engaged on [his] the trustee's own behalf in business as an agent or broker.
6211 (C) The commissioner shall only select [persons] a person to act as trustee who [are] is
6212 trustworthy and competent to perform the necessary services.
6213 [(2)] (ii) (A) If the deceased, disabled, or unlicensed person for whom the trustee is acting
6214 was an agent, the insurers through which the former agent's business was written shall cooperate
6215 with the trustee in allowing [him] the trustee to service the policies written through the insurer.
6216 (B) The trustee shall abide by the terms of the agency agreement between the former agent
6217 and the issuing insurer, except that terms in those agreements terminating the agreement upon the
6218 death, disability, or license termination of the former agent do not bar the trustee from continuing
6219 to act under the agreement.
6220 [(3)] (iii) (A) The commissioner shall set the trustee's compensation, which:
6221 (I) may be stated in terms of a percentage of commissions[, but which is required to]; and
6222 (II) shall be equitable.
6223 (B) The compensation shall be paid exclusively from:
6224 (I) the commissions generated by the former agent or broker's insurance accounts serviced
6225 by the trustee; and [from]

6226 (II) other funds the former agent or broker or [his] the agent's or broker's successor in
6227 interest agree to pay.
6228 (C) The trustee has no special priority to commissions over the former agent or broker's
6229 creditors.
6230 [(4) Neither the] (iv) (A) The commissioner [nor] or the state [of Utah] may not be held
6231 liable for errors or omissions of:
6232 (I) the former agent or broker; or
6233 (II) the trustee.
6234 (B) The trustee may not be held liable for errors and omissions [which] that were caused
6235 in any material way by the negligence of the former agent or broker.
6236 (C) The trustee may be held liable for errors and omissions which arise solely from the
6237 trustee's negligence.
6238 (D) The trustee's compensation level shall be sufficient to allow the trustee to purchase
6239 errors and omissions coverage, if that coverage is not provided the trustee by:
6240 (I) the former agent or broker; or [his]
6241 (II) the agent's or broker's successor in interest.
6242 [(5)] (v) (A) It is a breach of the trustee's fiduciary duty to capture the accounts of trustor's
6243 clients, either directly or indirectly.
6244 (B) The trustee may not purchase the accounts or expiration lists of the former agent or
6245 broker, unless the commissioner expressly ratifies the terms of the sale.
6246 (C) The commissioner may adopt rules [which] that:
6247 (I) further define the trustee's fiduciary duties; and
6248 (II) explain how the trustee is to carry out [his] the trustee's responsibilities.
6249 [(6)] (vi) (A) The trust may be terminated by:
6250 (I) the commissioner; or [by]
6251 (II) the person that requested the trust be established.
6252 (B) The trust is terminated by written notice being delivered to:
6253 (I) the trustee; and
6254 (II) the commissioner.
6255 (5) (a) The commissioner may by order:
6256 (i) limit the authority of any temporary licensee or trustee in any way the commissioner

6257 considers necessary to protect insureds and the public; and
6258 (ii) revoke a temporary license or trustee's appointment if the commissioner finds that the
6259 insureds or the public are endangered.
6260 (b) A temporary license or trustee's appointment may not continue after the owner or
6261 personal representative disposes of the business.
6262 Section 147. Section **31A-23-302** is amended to read:
6263 **31A-23-302. Unfair marketing practices.**
6264 (1) (a) (i) [~~A person who is or should be licensed under this title, an employee or agent of~~
6265 ~~that licensee or person who should be licensed, a person whose primary interest is as a competitor~~
6266 ~~of a person licensed under this title, and a person on behalf of any of these persons~~] Any of the
6267 following may not make or cause to be made any communication that contains false or misleading
6268 information, relating to an insurance contract, any insurer, or other licensee under this title,
6269 including information that is false or misleading because it is incomplete[~~.~~]:
6270 (A) a person who is or should be licensed under this title;
6271 (B) an employee or agent of a person described in Subsection (1)(a)(i)(A);
6272 (C) a person whose primary interest is as a competitor of a person licensed under this title;
6273 and
6274 (D) a person on behalf of any of the persons listed in this Subsection (1)(a)(i).
6275 (ii) As used in this Subsection (1), "false or misleading information" includes:
6276 (A) assuring the nonobligatory payment of future dividends or refunds of unused
6277 premiums in any specific or approximate amounts, but reporting fully and accurately past
6278 experience is not false or misleading information; and
6279 (B) with intent to deceive a person examining it, filing a report, making a false entry in a
6280 record, or wilfully refraining from making a proper entry in a record.
6281 (iii) An insurer or other licensee under this title may not:
6282 (A) use any business name, slogan, emblem, or related device that is misleading or likely
6283 to cause the insurer or other licensee to be mistaken for another insurer or other licensee already
6284 in business[~~.~~]; or
6285 (B) use any advertisement or other insurance promotional material that would cause a
6286 reasonable person to mistakenly believe that a state or federal government agency:
6287 (I) is responsible for the insurance sales activities of the person;

6288 (II) stands behind the credit of the person;
6289 (III) guarantees any returns on insurance products of or sold by the person; or
6290 (IV) is a source of payment of any insurance obligation of or sold by the person.
6291 (iv) A person who is not an insurer may not assume or use any name that deceptively
6292 implies or suggests that it is an insurer.
6293 (v) A person other than persons licensed as health maintenance organizations under
6294 Chapter 8 may not use the term "Health Maintenance Organization" or "HMO" in referring to
6295 itself.
6296 (b) If an insurance agent or third party administrator distributes cards or documents,
6297 exhibits a sign, or publishes an advertisement that violates Subsection (1) (a), with reference to a
6298 particular insurer that the agent represents, or for whom the third party administrator processes
6299 claims, and if the cards, documents, signs, or advertisements are supplied or approved by that
6300 insurer, the agent's or the third party administrator's violation creates a rebuttable presumption that
6301 the violation was also committed by the insurer.
6302 (2) (a) (i) An insurer or licensee under this chapter, or an officer or employee of either may
6303 not induce any person to enter into or continue an insurance contract or to terminate an existing
6304 insurance contract by offering benefits not specified in the policy to be issued or continued,
6305 including premium or commission rebates.
6306 (ii) An insurer may not make or knowingly allow any agreement of insurance that is not
6307 clearly expressed in the policy to be issued or renewed.
6308 (iii) Subsection (2)(a) does not preclude:
6309 (A) insurers from reducing premiums because of expense savings;
6310 (B) the usual kinds of social courtesies not related to particular transactions; or
6311 (C) an insurer from receiving premiums under an installment payment plan.
6312 (b) An agent, broker, or insurer may not absorb the tax under Section 31A-3-301.
6313 (c) (i) A title insurer or agent or any officer or employee of either may not pay, allow, give,
6314 or offer to pay, allow, or give, directly or indirectly, as an inducement to obtaining any title
6315 insurance business, any rebate, reduction, or abatement of any rate or charge made incident to the
6316 issuance of the insurance, any special favor or advantage not generally available to others, or any
6317 money or other consideration or material inducement.
6318 (ii) "Charge made incident to the issuance of the insurance" includes escrow, settlement,

6319 and closing charges, and any other services that are prescribed by the commissioner.
6320 (iii) An insured or any other person connected, directly or indirectly, with the transaction,
6321 including a mortgage lender, real estate broker, builder, attorney, or any officer, employee, or agent
6322 of any of them, may not knowingly receive or accept, directly or indirectly, any benefit referred
6323 to in Subsection (2)(c)(i).
6324 (3) (a) An insurer may not unfairly discriminate among policyholders by charging different
6325 premiums or by offering different terms of coverage, except on the basis of classifications related
6326 to the nature and the degree of the risk covered or the expenses involved.
6327 (b) Rates are not unfairly discriminatory if they are averaged broadly among persons
6328 insured under a group, blanket, or franchise policy, and the terms of those policies are not unfairly
6329 discriminatory merely because they are more favorable than in similar individual policies.
6330 (4) A person who is or should be licensed under this title, an employee or agent of that
6331 licensee or person who should be licensed, a person whose primary interest is as a competitor of
6332 a person licensed under this title, and one acting on behalf of any of these persons, may not commit
6333 or enter into any agreement to participate in any act of boycott, coercion, or intimidation that tends
6334 to produce an unreasonable restraint of the business of insurance or a monopoly in that business.
6335 (5) (a) A person may not restrict in the choice of an insurer or insurance agent or broker,
6336 another person who is required to pay for insurance as a condition for the conclusion of a contract
6337 or other transaction or for the exercise of any right under a contract. The person requiring the
6338 coverage may, however, reserve the right to disapprove the insurer or the coverage selected on
6339 reasonable grounds.
6340 (b) The form of corporate organization of an insurer authorized to do business in this state
6341 is not a reasonable ground for disapproval, and the commissioner may by rule specify additional
6342 grounds that are not reasonable. This Subsection (5) does not bar an insurer from declining an
6343 application for insurance.
6344 (6) A person may not make any charge other than insurance premiums and premium
6345 financing charges for the protection of property or of a security interest in property, as a condition
6346 for obtaining, renewing, or continuing the financing of a purchase of the property or the lending
6347 of money on the security of an interest in the property.
6348 (7) (a) An agent may not refuse or fail to return promptly all indicia of agency to the
6349 principal on demand.

6350 (b) A licensee whose license is suspended, limited, or revoked under Section 31A-2-308,
6351 31A-23-216, or 31A-23-217 may not refuse or fail to return the license to the commissioner on
6352 demand.
6353 (8) A person may not engage in any other unfair method of competition or any other unfair
6354 or deceptive act or practice in the business of insurance, as defined by the commissioner by rule,
6355 after a finding that they are misleading, deceptive, unfairly discriminatory, provide an unfair
6356 inducement, or unreasonably restrain competition.
6357 Section 148. Section **31A-23-303** is amended to read:
6358 **31A-23-303. Inherent unsuitability.**
6359 [~~In the event~~] (1) If the commissioner finds after a hearing that a certain type of [~~disability~~]
6360 accident and health insurance, life insurance, or annuity product is inherently unsuitable for
6361 persons of certain ages or in certain conditions of health, the commissioner shall [~~promulgate~~]
6362 make a rule declaring [~~this disability~~] the accident and health insurance, life insurance, or annuity
6363 product as inherently unsuitable for persons of certain ages or in certain conditions of health. [~~No~~
6364 ~~disability~~]
6365 (2) An accident and health insurance, life insurance, or annuity product that is subject to
6366 the rule may not be sold to a person for whom the product has been determined as inherently
6367 unsuitable unless that person purchasing the product signs a receipt acknowledging having
6368 received a statement [~~which~~] that expresses that the product has been determined by the
6369 commissioner to be inherently unsuitable for persons of certain ages or in certain conditions of
6370 health.
6371 (3) Unless the insurer or its agent establishes that its sale of coverage [~~which~~] is
6372 inconsistent with the rule made under Subsection (1) is due to excusable neglect, the purchaser
6373 may treat the sale as voidable, if acted upon by the insured within a two-year period from the date
6374 of sale.
6375 Section 149. Section **31A-23-307** is amended to read:
6376 **31A-23-307. Title insurance agents' business.**
6377 A title insurance agent may engage in the escrow, settlement, or closing business, or any
6378 combination of such businesses, and operate as escrow, settlement, or closing agent provided that
6379 all the following exist:
6380 (1) The title insurance agent is properly licensed under this chapter.

6381 (2) (a) (i) All funds deposited with the agent in connection with any escrow, settlement,
6382 or closing are deposited in a federally insured financial institution in separate trust accounts, with
6383 the funds being the property of the persons entitled to them under the provisions of the escrow,
6384 settlement, or closing.
6385 (ii) The funds shall be segregated escrow by escrow, settlement by settlement, or closing
6386 by closing in the records of the agent. [These funds]
6387 (iii) Earnings on funds held in escrow may be paid out of the escrow account to any person
6388 in accordance with the provisions of the escrow agreement if the agreement does not otherwise
6389 provide for payment of the earnings or any portion of the earnings on the escrow funds.
6390 (iv) Funds held in escrow:
6391 (A) are not subject to any debts of the agent; and
6392 (B) may only be used to fulfill the terms of the individual escrow, settlement, or closing
6393 under which the funds were accepted. [None of the funds]
6394 (v) Funds held in escrow may not be used until all conditions of the escrow, settlement,
6395 or closing have been met.
6396 [(b) Any interest received on funds deposited with the agent in connection with any
6397 escrow, settlement, or closing shall be paid over to the depositing party to the escrow, settlement,
6398 or closing and may not be transferred to the account of the agent.]
6399 (b) Assets or property other than escrow funds received by an agent in accordance with an
6400 escrow agreement shall be maintained in a manner that will:
6401 (i) reasonably preserve and protect the asset or property from loss, theft, or damages; and
6402 (ii) otherwise comply with all general duties and responsibilities of a fiduciary or bailee.
6403 (c) [No] A check may not be drawn, executed or dated, or funds otherwise disbursed
6404 unless the segregated escrow account from which funds are to be disbursed contains a sufficient
6405 credit balance consisting of collected or cleared funds at the time the check is drawn, executed or
6406 dated, or funds are otherwise disbursed.
6407 (d) As used in this Subsection (2), funds are considered to be "collected or cleared," and
6408 may be disbursed as follows:
6409 (i) cash may be disbursed on the same day it is deposited;
6410 (ii) wire transfers may be disbursed on the same day they are deposited;
6411 (iii) cashier's checks, certified checks, teller's checks, U.S. Postal Service money orders,

6412 and checks drawn on a Federal Reserve Bank or Federal Home Loan Bank may be disbursed on
6413 the day following the date of deposit; and
6414 (iv) other checks or deposits may be disbursed within the time limits provided under the
6415 Expedited Funds Availability Act, 12 U.S.C. Section 4001 et seq., as amended, and related
6416 regulations of the Federal Reserve System or upon written notification from the financial
6417 institution to which the funds have been deposited, that final settlement has occurred on the
6418 deposited item.
6419 (3) The title insurance agent shall maintain records of all receipts and disbursements of
6420 escrow, settlement, and closing funds.
6421 (4) The title insurance agent shall comply with any rules adopted by the commissioner
6422 governing escrows, settlements, or closings.
6423 Section 150. Section **31A-23-310** is amended to read:
6424 **31A-23-310. Trust obligation for funds collected.**
6425 (1) Every agent or broker is a trustee for all funds received or collected as an agent or
6426 broker for forwarding to insurers or to insureds. Except for amounts necessary to pay bank
6427 charges, and except for funds paid by insureds and belonging in part to the agent or broker as fees
6428 or commissions, an agent or broker may not commingle trust funds with the agent or broker's own
6429 funds or with funds held in any other capacity. Except as provided under Subsection (4), every
6430 agent or broker owes to insureds and insurers the fiduciary duties of a trustee with respect to
6431 money to be forwarded to insurers or insureds through the agent or broker. Unless the funds are
6432 sent to the appropriate payee by the close of the next business day after their receipt, the licensee
6433 shall deposit them in an account authorized under Subsection (2). Funds so deposited shall remain
6434 in an account authorized under Subsection (2) until sent to the appropriate payee.
6435 (2) Funds required to be deposited under Subsection (1) shall be deposited:
6436 (a) in a federally insured trust account with a financial institution located in this state; or
6437 (b) in some other account, approved by the commissioner by rule or order, providing safety
6438 comparable to federally insured trust accounts.
6439 (3) It is not a violation of Subsection (2)(a) if the amounts in the accounts exceed the
6440 amount of the federal insurance on the accounts.
6441 (4) A trust account into which funds are deposited may be interest bearing. [~~Except as~~
6442 ~~provided under Subsection 31A-23-307(2)(b), the~~] The interest accrued on the account may be

6443 paid to the agent or broker, so long as the agent or broker otherwise complies with this section and
6444 with the contract with the insurer.
6445 (5) A financial institution or other organization holding trust funds under this section may
6446 not offset or impound trust account funds against debts and obligations incurred by the agent or
6447 broker.
6448 (6) Any licensee who, not being lawfully entitled thereto, diverts or appropriates any
6449 portion of the funds held under Subsection (1) to the licensee's own use, is guilty of theft under
6450 Title 76, Chapter 6, Part 4. Section 76-6-412 applies in determining the classification of the
6451 offense. Sanctions under Section 31A-2-308 also apply.
6452 Section 151. Section **31A-23-312** is amended to read:
6453 **31A-23-312. Place of business and residence address -- Records.**
6454 (1) (a) All licensees under this chapter shall register with the commissioner the address
6455 and telephone numbers of their principal place of business.
6456 (b) If the licensee is an individual, [~~he~~] in addition to complying with Subsection (1)(a)
6457 the individual shall [~~also~~] provide [~~his~~] to the commissioner the individual's residence address and
6458 telephone number. [~~Licensees~~]
6459 (c) A licensee shall notify the commissioner, in writing, within 30 days of any change of
6460 address or telephone number.
6461 (2) (a) Except as provided under Subsection (3), every licensee under this chapter shall
6462 keep at the principal place of business address registered under Subsection (1), [~~a record~~] separate
6463 and distinct books and records of all transactions consummated under the Utah license. [~~The~~
6464 ~~record~~]
6465 (b) The books and records described in Subsection (2)(a) shall:
6466 (i) be in an organized form;
6467 (ii) be available to the commissioner for inspection upon reasonable notice; and [~~shall~~]
6468 (iii) include all of the following:
6469 [~~(a)~~] (A) if the licensee is an agent or broker:
6470 [~~(i)~~] (I) a record of each insurance contract procured by or issued through the licensee, with
6471 the names of insurers and insureds, the amount of premium and commissions or other
6472 compensation, and the subject of the insurance;
6473 [~~(ii)~~] (II) the names of any other agents or brokers from whom business is accepted, and

6474 of persons to whom commissions or allowances of any kind are promised or paid; and
6475 (III) a record of all consumer complaints forwarded to the licensee by an insurance
6476 regulator;
6477 [(b)] (B) if the licensee is a consultant, a record of each agreement outlining the work
6478 performed and the fee for the work; and
6479 [(c)] (C) any additional information which:
6480 (I) is customary for a similar business[,]; or [which]
6481 (II) may reasonably be required by the commissioner by rule.
6482 (3) Subsection (2) is satisfied if the books and records specified in [that] Subsection (2)
6483 can be obtained immediately from a central storage place or elsewhere by on-line computer
6484 terminals located at the registered address.
6485 (4) An agent who represents only a single insurer satisfies Subsection (2) if the insurer
6486 maintains the books and records pursuant to Subsection (2) at a place satisfying Subsections (1)
6487 and (5).
6488 (5) (a) The books and records maintained [as to a transaction] under Subsection (2) or
6489 Section 31A-23-313 shall be available for the inspection of the commissioner during all business
6490 hours for a period of time after the date of the transaction as specified by the commissioner by rule,
6491 but in no case for less than three years.
6492 (b) Discarding books and records after the applicable record retention period has expired
6493 does not place the licensee in violation of a later-adopted longer record retention period.
6494 Section 152. Section **31A-23-317** is enacted to read:
6495 **31A-23-317. Financial services insurance activities regulation.**
6496 (1) It is the intent of the Legislature that the regulation of insurance activities of any person
6497 in this state be based on functional regulation principles established in the Gramm-Leach-Bliley
6498 Act of 1999, Pub. L. No. 106-102.
6499 (2) The insurance activities of any person in this state shall be functionally regulated by
6500 the commissioner subject to Sections 104, 301-308, 501-507, and 509 of the Gramm-Leach-Bliley
6501 Act of 1999, Pub. L. No. 106-102.
6502 (3) Under Title 63, Chapter 46a, Utah Administrative Rulemaking Act, the commissioner
6503 shall adopt rules consistent with Section 104(d) of the Gramm-Leach-Bliley Act of 1999, Pub. L.
6504 No. 106-102, and the functional regulation of insurance activities of any person otherwise subject

6505 to the jurisdiction of the commissioner in this state described in Subsection (2).
6506 (4) The commissioner shall consult and coordinate with the commissioner of the
6507 Department of Financial Institutions and the director of the Division of Securities for the purpose
6508 of assuring, to the extent possible, that the rules prescribed by the department are consistent and
6509 comparable with federal regulations governing the insurance, banking, and securities industries.
6510 Section 153. Section **31A-23-404** is amended to read:
6511 **31A-23-404. Sharing commissions.**
6512 (1) (a) Except as provided in Subsection 31A-15-103(3), a licensee under this chapter or
6513 an insurer may only pay consideration or reimburse out-of-pocket expenses to a person if the
6514 licensee knows that the person is licensed under this chapter to act as an agent or broker in Utah
6515 as to the particular type of insurance.
6516 (b) A person may only accept commission compensation or other compensation as an
6517 agent, broker, or consultant that is directly or indirectly the result of any insurance transaction if
6518 that person is licensed under this chapter to act as an agent or broker as to the particular type of
6519 insurance.
6520 (2) (a) Except as provided in Section 31A-23-301, a consultant may not pay or receive any
6521 commission or other compensation that is directly or indirectly the result of any insurance
6522 transaction.
6523 (b) A consultant may share a consultant fee or other compensation received for consulting
6524 services performed within Utah only with another consultant licensed under this chapter, and only
6525 to the extent that the other consultant contributed to the services performed.
6526 (3) This section does not prohibit the payment of renewal commissions to former licensees
6527 under this chapter, former Title 31, Chapter 17, or their successors in interest under a deferred
6528 compensation or agency sales agreement.
6529 (4) This section does not prohibit compensation paid to or received by an individual for
6530 referral of a potential customer that seeks to purchase or obtain an opinion or advice on an
6531 insurance product if:
6532 (a) the person is not licensed to sell insurance;
6533 (b) the person sells or provides opinions or advice on the product; and
6534 (c) the compensation does not depend on whether the referral results in a purchase or sale.
6535 [~~(4)~~] (5) In selling any policy of title insurance, no sharing of commissions under

6536 Subsection (1) may occur if it will result in an unlawful rebate, or in compensation in connection
6537 with controlled business, or in payment of a forwarding fee or finder's fee. A person may share
6538 compensation for the issuance of a title insurance policy only to the extent that he contributed to
6539 the search and examination of the title or other services connected with it.
6540 [~~(5)~~] (6) This section does not apply to bail bond agents or bail enforcement agents as
6541 defined in Section 31A-35-102.
6542 Section 154. Section **31A-23-503** is amended to read:
6543 **31A-23-503. Duties of insurers.**
6544 (1) The insurer shall have on file an independent financial examination, in a form
6545 acceptable to the commissioner, of each managing general agent with which it has done business.
6546 (2) If a managing general agent establishes loss reserves, the insurer shall annually obtain
6547 the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred
6548 and outstanding on business produced by the managing general agent. This is in addition to any
6549 other required loss reserve certification.
6550 (3) The insurer shall at least semiannually conduct an on-site review of the underwriting
6551 and claims processing operations of the managing general agent.
6552 (4) Binding authority for all reinsurance contracts or participation in insurance or
6553 reinsurance syndicates shall rest with an officer of the insurer, who may not be affiliated with the
6554 managing general agent.
6555 (5) Within 30 days after entering into or terminating a contract with a managing general
6556 agent, the insurer shall provide written notification of the appointment or termination to the
6557 commissioner. A notice of appointment of a managing general agent shall include:
6558 (a) a statement of duties that the applicant is expected to perform on behalf of the insurer;
6559 (b) the lines of insurance for which the applicant is to be authorized to act; and
6560 (c) any other information the commissioner may request.
6561 (6) An insurer shall review its books and records each quarter to determine if any producer,
6562 as defined by Subsection 31A-23-102[~~(13)~~](20), has become a managing general agent as defined
6563 in Subsection 31A-23-102[~~(12)~~](17). If the insurer determines that a producer has become a
6564 managing general agent, the insurer shall promptly notify the producer and the commissioner of
6565 the determination. The insurer and producer shall fully comply with the provisions of this chapter
6566 within 30 days.

6567 (7) An insurer may not appoint officers, directors, employees, subproducers, or controlling
6568 shareholders of its managing general agents to its board of directors. This Subsection (7) does not
6569 apply to relationships governed by Title 31A, Chapter 16, Insurance Holding Companies, or
6570 Chapter 23, Part 6, Broker Controlled Insurers, if it applies.
6571 Section 155. Section **31A-23-601** is amended to read:
6572 **31A-23-601. Applicability.**
6573 This part applies to licensed insurers, as defined in Subsection 31A-23-102[~~(11)~~](12),
6574 which are either domiciled in this state or domiciled in a state that does not have a substantially
6575 similar law. All provisions of Title 31A, Chapter 16, Insurance Holding Companies, to the extent
6576 they are not superseded by this part, continue to apply to all parties within holding company
6577 systems subject to this part.
6578 Section 156. Section **31A-23-702** is amended to read:
6579 **31A-23-702. Required contract provisions -- Reinsurance intermediary-broker.**
6580 Transactions between a reinsurance intermediary-broker and the insurer it represents in that
6581 capacity may only be entered into pursuant to a written authorization, which specifies the
6582 responsibilities of each party. The authorization shall, at a minimum, provide that the reinsurance
6583 intermediary-broker:
6584 (1) may have his authority terminated by the insurer at any time;
6585 (2) will render accounts to the insurer accurately detailing all material transactions,
6586 including information necessary to support all commissions, charges and other fees received by,
6587 or owing to the reinsurance intermediary-broker, and that he will remit all funds due to the insurer
6588 within 30 days of receipt;
6589 (3) shall hold, in a fiduciary capacity, all funds collected for the insurer's account in a bank,
6590 which is a qualified [~~U.S.~~] United States financial institution;
6591 (4) will comply with Section 31A-23-703;
6592 (5) will comply with the written standards established by the insurer for the cession or
6593 retrocession of all risks; and
6594 (6) will disclose to the insurer any relationship with any reinsurer to which business will
6595 be ceded or retroceded.
6596 Section 157. Section **31A-23-705** is amended to read:
6597 **31A-23-705. Required contract provisions -- Reinsurance intermediary-manager.**

6598 Transactions between a reinsurance intermediary-manager and the reinsurer it represents
6599 in that capacity may only be entered into pursuant to a written contract, which specifies the
6600 responsibilities of each party, and which shall be approved by the reinsurer's board of directors.
6601 At least 30 days before the reinsurer assumes or cedes business through the producer, a true copy
6602 of the approved contract shall be filed with the commissioner for approval. The contract shall, at
6603 a minimum, provide or require the following:
6604 (1) The reinsurer may terminate the contract for cause upon written notice to the
6605 reinsurance intermediary-manager. The reinsurer may immediately suspend the authority of the
6606 reinsurance intermediary-manager to assume or cede business during the pendency of any dispute
6607 regarding the cause for termination.
6608 (2) The reinsurance intermediary-manager will render accounts to the reinsurer accurately
6609 detailing all material transactions, including information necessary to support all commissions,
6610 charges, and other fees received by, or owing to the reinsurance intermediary-manager, and he shall
6611 remit all funds due under the contract to the reinsurer at least monthly.
6612 (3) All funds collected for the reinsurer's account will be held by the reinsurance
6613 intermediary-manager in a fiduciary capacity in a bank which is a qualified [~~U.S.~~] United States
6614 financial institution. The reinsurance intermediary-manager may retain no more than three months
6615 estimated claims payments and allocated loss adjustment expenses. The reinsurance
6616 intermediary-manager shall maintain a separate bank account for each reinsurer that it represents.
6617 (4) For at least ten years after expiration of each contract of reinsurance transacted by the
6618 reinsurance intermediary-manager, he shall keep a complete record for each transactions showing:
6619 (a) the type of contract, limits, underwriting restrictions, classes of risks, and territory;
6620 (b) period of coverage, including effective and expiration dates, cancellation provisions
6621 and notice required of cancellation, and disposition of outstanding reserves on covered risks;
6622 (c) reporting and settlement requirements of balances;
6623 (d) rates used to compute the reinsurance premium;
6624 (e) names and addresses of reinsurers;
6625 (f) rates of all reinsurance commissions, including the commissions on any retrocessions
6626 handled by the reinsurance intermediary-manager;
6627 (g) related correspondence and memoranda;
6628 (h) proof of placement;

6629 (i) details regarding retrocessions handled by the reinsurance intermediary-manager, as
6630 permitted by Subsection 31A-23-707 (4), including the identity of retrocessionaires and percentage
6631 of each contract assumed or ceded;
6632 (j) financial records, including premium and loss accounts; and
6633 (k) when the reinsurance intermediary-manager places a reinsurance contract on behalf of
6634 a ceding insurer:
6635 (i) directly from any assuming reinsurer, written evidence that the assuming reinsurer has
6636 agreed to assume the risk; or
6637 (ii) if placed through a representative of the assuming reinsurer, other than an employee,
6638 written evidence that the reinsurer has delegated binding authority to the representative.
6639 (5) The reinsurer will have access and the right to copy all accounts and records
6640 maintained by the reinsurance intermediary-manager which are related to its business, in a form
6641 usable by the reinsurer.
6642 (6) The contract cannot be assigned in whole or in part by the reinsurance
6643 intermediary-manager.
6644 (7) The reinsurance intermediary-manager will comply with the written underwriting and
6645 rating standards established by the insurer for the acceptance, rejection, or cession of all risks.
6646 (8) The contract shall set forth the rates, terms, and purposes of commissions, charges, and
6647 other fees which the reinsurance intermediary-manager may levy against the reinsurer.
6648 (9) If the contract permits the reinsurance intermediary-manager to settle claims on behalf
6649 of the reinsurer:
6650 (a) All claims will be reported to the reinsurer in a timely manner.
6651 (b) A copy of the claim file will be sent to the reinsurer at its request or as soon as it
6652 becomes known that the claim:
6653 (i) has the potential to exceed the lesser of an amount determined by the commissioner or
6654 the limit set by the reinsurer;
6655 (ii) involves a coverage dispute;
6656 (iii) may exceed the reinsurance intermediary-manager claims settlement authority;
6657 (iv) is open for more than six months; or
6658 (v) is closed by payment of the lesser of an amount set by the commissioner or an amount
6659 set by the reinsurer.

6660 (c) All claim files will be the joint property of the reinsurer and reinsurance
6661 intermediary-manager. However, upon an order of liquidation of the reinsurer the files shall
6662 become the sole property of the reinsurer or its estate. The reinsurance intermediary-manager shall
6663 have reasonable access to and the right to copy the files on a timely basis.
6664 (d) Any settlement authority granted to the reinsurance intermediary-manager may be
6665 terminated for cause upon the reinsurer's written notice to the reinsurance intermediary-manager,
6666 or upon the termination of the contract. The reinsurer may suspend the settlement authority during
6667 the pendency of the dispute regarding the cause of termination.
6668 (10) If the contract provides for a sharing of interim profits by the reinsurance
6669 intermediary-manager, that the contract shall provide interim profits will not be paid until one year
6670 after the end of each underwriting period for property business and five years after the end of each
6671 underwriting period for casualty business, or a later time period set by the commissioner for
6672 specified lines of insurance, and not until the adequacy of reserves on remaining claims has been
6673 verified pursuant to Subsection 31A-23-707 (3).
6674 (11) The reinsurance intermediary-manager will annually provide the reinsurer with a
6675 statement of its financial condition prepared by an independent certified public accountant.
6676 (12) The reinsurer shall at least semi-annually conduct an on-site review of the
6677 underwriting and claims processing operations of the reinsurance intermediary-manager.
6678 (13) The reinsurance intermediary-manager will disclose to the reinsurer any relationship
6679 it has with any insurer prior to ceding or assuming any business with the insurer pursuant to this
6680 contract.
6681 (14) Within the scope of its actual or apparent authority the acts of the reinsurance
6682 intermediary-manager shall be considered to be the acts of the reinsurer on whose behalf it is
6683 acting.
6684 Section 158. Section **31A-25-102** is amended to read:
6685 **31A-25-102. Scope and purposes.**
6686 (1) This chapter applies to all third party administrators.
6687 (2) The purposes of this chapter include:
6688 (a) encouraging disclosure of contracts between insurers and third party administrators,
6689 both to potential insureds and to the commissioner;
6690 (b) promoting the financial responsibility of [~~insurance~~] third party administrators;

6691 (c) subjecting persons administering insurance in Utah to the jurisdiction of the Utah
6692 commissioner and courts; [and]
6693 (d) regulating [insurance] third party administrators' practices in conformity with the
6694 general purposes of [the Insurance Code.] this title; and
6695 (e) governing the qualifications and procedures for the licensing of third party
6696 administrators.
6697 Section 159. Section **31A-25-202** is amended to read:
6698 **31A-25-202. Application for license.**
6699 (1) (a) An application for a license as a third party administrator shall be:
6700 (i) made to the commissioner on forms and in a manner [he] the commissioner
6701 prescribes[,]; and [be]
6702 (ii) accompanied by the applicable fee, which is not refundable if the application is denied.
6703 (b) The application for a license as a third party administrator shall:
6704 (i) state the applicant's:
6705 (A) social security number; or
6706 (B) federal employer identification number;
6707 (ii) provide information about:
6708 (A) the applicant's identity[,];
6709 (B) the applicant's personal history, experience, education, and business record[,];
6710 (C) if the applicant is a natural person, whether the applicant is 18 years of age or older;
6711 and
6712 (D) whether the applicant has committed an act that is a ground for denial, suspension, or
6713 revocation as set forth in Section 31A-25-208; and
6714 (iii) any other information as the commissioner reasonably requires.
6715 (2) The commissioner may require documents reasonably necessary to verify the
6716 information contained in the application.
6717 (3) The following are private records under Subsection 63-2-302(1)(g):
6718 (a) an applicant's social security number; and
6719 (b) an applicant's federal employer identification number.
6720 Section 160. Section **31A-25-203** is amended to read:
6721 **31A-25-203. General requirements for license issuance.**

6722 (1) The commissioner shall issue a license to act as a third party administrator to any
6723 person who has:
6724 (a) satisfied the character requirements under Section 31A-25-204;
6725 (b) satisfied the financial responsibility requirement under Section 31A-25-205;
6726 (c) if a nonresident, complied with Section 31A-25-206; and
6727 (d) paid the applicable fees under Section 31A-3-103.
6728 (2) The license of each third party administrator licensed under former Title 31, Chapter
6729 15a, is continued under this chapter.
6730 (3) (a) This Subsection (3) applies to the following persons:
6731 (i) an applicant for a third party administrator's license; or
6732 (ii) a licensed third party administrator.
6733 (b) A person described in Subsection (3)(a) shall report to the commissioner:
6734 (i) any administrative action taken against the person:
6735 (A) in another jurisdiction; or
6736 (B) by another regulatory agency in this state; and
6737 (ii) any criminal prosecution taken against the person in any jurisdiction.
6738 (c) The report required by Subsection (3)(b) shall:
6739 (i) be filed:
6740 (A) at the time the person applies for a third party administrator's license; or
6741 (B) within 30 days of the initiation of an action or prosecution described in Subsection
6742 (3)(b); and
6743 (ii) include a copy of the complaint or other relevant legal documents related to the action
6744 or prosecution described in Subsection (3)(b).
6745 (4) (a) The department may request concerning a person applying for a third party
6746 administrator's license:
6747 (i) criminal background information maintained pursuant to Title 53, Chapter 10, Part 2,
6748 from the Bureau of Criminal Identification; and
6749 (ii) complete Federal Bureau of Investigation criminal background checks through the
6750 national criminal history system.
6751 (b) Information obtained by the department from the review of criminal history records
6752 received under Subsection (4)(a) shall be used by the department for the purposes of:

6753 (i) determining if a person satisfies the character requirements under Section 31A-25-204
6754 for issuance or renewal of a license;
6755 (ii) determining if a person has failed to maintain the character requirements under Section
6756 31A-25-204; and
6757 (iii) preventing persons who violate the federal Violent Crime Control and Law
6758 Enforcement Act of 1994, 18 U.S.C. Secs. 1033 and 1034, from engaging in the business of
6759 insurance in the state.
6760 (c) If the department requests the criminal background information, the department shall:
6761 (i) pay to the Department of Public Safety the costs incurred by the Department of Public
6762 Safety in providing the department criminal background information under Subsection (4)(a)(i);
6763 (ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau of
6764 Investigation in providing the department criminal background information under Subsection
6765 (4)(a)(ii); and
6766 (iii) charge the person applying for a license or for renewal of a license a fee equal to the
6767 aggregate of Subsections (4)(c)(i) and (ii).
6768 Section 161. Section **31A-25-205** is amended to read:
6769 **31A-25-205. Financial responsibility.**
6770 (1) Every person licensed under this chapter shall, while licensed and for one year after
6771 that date, maintain an insurance policy or surety bond, issued by an authorized insurer, in an
6772 amount specified under Subsection (2), on a policy or contract form which is acceptable under
6773 Subsection (3).
6774 (2) (a) Insurance policies or surety bonds satisfying the requirement of Subsection (1) shall
6775 be in a face amount equal to at least 10% of the total funds handled by the administrator.
6776 However, no policy or bond under this [~~subsection~~] Subsection (2)(a) may be in a face amount of
6777 less than $5,000 nor more than $500,000.
6778 (b) In fixing the policy or bond face amount under Subsection (2)(a), the total funds
6779 handled is:
6780 (i) the greater of:
6781 (A) the premiums received during the previous calendar year; or
6782 (B) claims paid through the administrator during the previous calendar year[~~,~~]; or[~~,~~]
6783 (ii) if no funds were handled during the preceding year, the total funds reasonably

6784 anticipated to be handled by the administrator during the current calendar year.
6785 (c) This section does not prohibit any person dealing with the administrator from requiring,
6786 by contract, insurance coverage in amounts greater than required under this section.
6787 (3) Insurance policies or surety bonds issued to satisfy Subsection (1) shall be on forms
6788 approved by the commissioner. The policies or bonds shall require the insurer to pay, up to the
6789 policy or bond face amount, any judgment obtained by participants in or beneficiaries of plans
6790 administered by the insured licensee which arise from the negligence or culpable acts of the
6791 licensee or any employee or agent of the licensee in connection with the activities described under
6792 Subsection 31A-1-301[~~(90)~~](111). The commissioner may require that policies or bonds issued
6793 to satisfy the requirements of this section require the insurer to give the commissioner 20 day prior
6794 notice of policy cancellation.
6795 (4) The commissioner shall establish annual reporting requirements and forms to monitor
6796 compliance with this section.
6797 (5) This section may not be construed as limiting any cause of action an insured would
6798 otherwise have against the insurer.
6799 Section 162. Section **31A-25-206** is amended to read:
6800 **31A-25-206. Nonresident jurisdictional agreement.**
6801 (1) (a) [~~Nonresident applicants for licenses under this chapter~~] If a nonresident license
6802 applicant has a valid license from the nonresident license applicant's home state and the conditions
6803 of Subsection (1)(b) are met, the commissioner shall:
6804 (i) waive any license requirement for a license under this chapter; and
6805 (ii) issue the nonresident license applicant a nonresident third party administrator license.
6806 (b) Subsection (1)(a) applies if:
6807 (i) the nonresident license applicant:
6808 (A) is licensed as a resident in the nonresident license applicant's home state at the time
6809 the nonresident license applicant applies for a nonresident third party administrator license;
6810 (B) has submitted the proper request for licensure;
6811 (C) has submitted to the commissioner:
6812 (I) the application for licensure that the nonresident license applicant submitted to the
6813 applicant's home state; or
6814 (II) a completed uniform application; and

6815 (D) has paid the applicable fees under Section 31A-3-103;
6816 (ii) the nonresident license applicant's license in the applicant's home state is in good
6817 standing; and
6818 (iii) the nonresident license applicant's home state awards nonresident third party
6819 administrator licenses to residents of this state on the same basis as this state awards licenses to
6820 residents of that home state.
6821 (2) A nonresident applicant shall execute in a form acceptable to the commissioner an
6822 agreement to be subject to the jurisdiction of the Utah commissioner and courts on any matter
6823 related to [his] the applicant's insurance activities in Utah, on the basis of:
6824 (a) service of process under Sections 31A-2-309 and 31A-2-310; or
6825 (b) other service authorized in the Utah Rules of Civil Procedure.
6826 (3) The commissioner may verify the third party administrator's licensing status through
6827 the database maintained by:
6828 (a) the National Association of Insurance Commissioners; or
6829 (b) an affiliate or subsidiary of the National Association of Insurance Commissioners.
6830 (4) The commissioner may not assess a greater fee for an insurance license or related
6831 service to a person not residing in this state based solely on the fact that the person does not reside
6832 in this state.
6833 Section 163. Section **31A-25-207** is amended to read:
6834 **31A-25-207. Form and contents of license.**
6835 (1) Licenses issued under this chapter shall be in the form the commissioner prescribes and
6836 shall set forth:
6837 [(1)] (a) the name, address, and telephone number of the licensee;
6838 [(2)] (b) the date of license issuance; and
6839 [(3)] (c) any other information the commissioner considers advisable.
6840 (2) A third party administrator doing business under any other name than the
6841 administrator's legal name shall notify the commissioner prior to using the assumed name in this
6842 state.
6843 (3) (a) An organization shall be licensed as an agency if the organization acts as a third
6844 party administrator.
6845 (b) An agency license issued under Subsection (3)(a) shall set forth the names of all natural

6846 persons licensed under this chapter who are authorized to act in those capacities for the
6847 organization in this state.
6848 Section 164. Section **31A-25-208** is amended to read:
6849 **31A-25-208. Termination of license.**
6850 (1) A license issued under this chapter remains in force until:
6851 (a) revoked, suspended, or limited under Subsection (2);
6852 (b) lapsed under Subsection (3);
6853 (c) surrendered to and accepted by the commissioner; or
6854 (d) the licensee dies or is adjudicated incompetent as defined under Title 75, Chapter 5,
6855 Part 3 or 4.
6856 (2) After [a hearing] an adjudicative proceeding under Title 63, Chapter 46b,
6857 Administrative Procedures Act, the commissioner may revoke, suspend for a specified period of
6858 [less than] 12 months or less, or limit in whole or in part the license of any administrator, found
6859 to:
6860 (a) be unqualified for a license under Section 31A-25-203;
6861 (b) have violated an insurance statute, valid rule under Subsection 31A-2-201(3), or a valid
6862 order under Subsection 31A-2-201(4);
6863 (c) be insolvent, or the subject of receivership, conservatorship, rehabilitation, or other
6864 delinquency proceedings in any state;
6865 (d) have failed to pay any final judgment rendered against it in this state within 60 days
6866 after the judgment became final;
6867 (e) have failed to meet the same good faith obligations in claims settlement as that required
6868 of admitted insurers;
6869 (f) be affiliated with and under the same general management or interlocking directorate
6870 or ownership as another administrator which transacts business in this state without a license; [or]
6871 (g) have refused to be examined or to produce its accounts, records, and files for
6872 examination, or have officers who have refused to give information with respect to the
6873 administrator's affairs or to perform any other legal obligation as to an examination; [or]
6874 (h) have provided incorrect, misleading, incomplete, or materially untrue information in
6875 the license application;
6876 (i) have violated an insurance law, valid rule, or valid order of another state's insurance

6877 department;
6878 (j) have obtained or attempted to obtain a license through misrepresentation or fraud;
6879 (k) have improperly withheld, misappropriated, or converted any monies or properties
6880 received in the course of doing insurance business;
6881 (l) have intentionally misrepresented the terms of an actual or proposed insurance contract
6882 or application for insurance;
6883 (m) have been convicted of a felony;
6884 (n) have admitted or been found to have committed any insurance unfair trade practice or
6885 fraud;
6886 (o) have used fraudulent, coercive, or dishonest practices in this state or elsewhere;
6887 (p) have demonstrated incompetence, untrustworthiness, or financial irresponsibility in the
6888 conduct of business in this state or elsewhere;
6889 (q) have had an insurance license or its equivalent, denied, suspended, or revoked in any
6890 other state, province, district, or territory;
6891 (r) have forged another's name to:
6892 (i) an application for insurance; or
6893 (ii) a document related to an insurance transaction;
6894 (s) have improperly used notes or any other reference material to complete an examination
6895 for an insurance license;
6896 (t) have knowingly accepted insurance business from an individual who is not licensed;
6897 (u) have failed to comply with an administrative or court order imposing a child support
6898 obligation;
6899 (v) have failed to:
6900 (i) pay state income tax; or
6901 (ii) comply with any administrative or court order directing payment of state income tax;
6902 (w) have violated or permitted others to violate the federal Violent Crime Control and Law
6903 Enforcement Act of 1994, 18 U.S.C. Secs. 1033 and 1034; or
6904 [~~(h)~~] (x) have engaged in methods and practices in the conduct of business [~~which~~] that
6905 endanger the legitimate interests of customers and the public.
6906 (3) (a) Any license issued under this chapter lapses if the licensee fails to:
6907 (i) pay the fee due under Section 31A-3-103[~~,~~]; or [~~if the licensee fails to~~]

6908 (ii) produce, when due, evidence of compliance with the financial responsibility
6909 requirement under Section 31A-25-205. [~~A~~]
6910 (b) Subject to Subsection (3)(c) a license [~~which~~] that has lapsed under this Subsection (3)
6911 may be reinstated if the licensee[~~, within 90 days after license lapse,~~] cures the deficiency or
6912 deficiencies [~~which~~] that brought about the license lapse within 90 days after the date the license
6913 lapsed.
6914 (c) The licensee shall pay twice the applicable license renewal fee if the cause of the
6915 license lapse was failure to pay the usual renewal fee.
6916 (4) Notwithstanding Subsection (3), a licensee whose license lapses due to military service
6917 or some other extenuating circumstance such as a long-term medical disability may request:
6918 (a) reinstatement; and
6919 (b) a waiver of any of the following imposed for failure to comply with renewal
6920 procedures:
6921 (i) an examination requirement;
6922 (ii) a fine; or
6923 (iii) other sanction.
6924 (5) The commissioner shall by rule prescribe the license renewal and reinstatement
6925 procedures, in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act.
6926 [~~(4)~~] (6) A licensee under this chapter whose license is suspended, revoked, or lapsed, but
6927 who continues to act as a licensee, is subject to the penalties for acting as an administrator without
6928 a license.
6929 [~~(5)~~] (7) An order revoking a license under Subsection (2) may specify a time, not to
6930 exceed five years, within which the former licensee may not apply for a new license. If no time
6931 is specified, the former licensee may not apply for five years without the express approval of the
6932 commissioner.
6933 [~~(6)~~] (8) Any person whose license is suspended or revoked under Subsection (2) shall,
6934 when the suspension ends or a new license is issued, pay all the fees that would have been payable
6935 if the license had not been suspended or revoked, unless the commissioner by order waives the
6936 payment of the interim fees. If a new license is issued more than three years after the revocation
6937 of a similar license, this subsection applies only to the fees that would have accrued during the
6938 three years immediately following the revocation.

6939 (9) If ordered by a court, the commissioner shall promptly withhold, suspend, restrict, or
6940 reinstate the use of a license issued under this part.
6941 Section 165. Section **31A-26-101** is amended to read:
6942 **31A-26-101. Purposes.**
6943 The purposes of this chapter are:
6944 (1) to promote the professional competence of those engaged in claims adjusting;
6945 (2) to encourage fair and rapid settlement of claims;
6946 (3) to protect claimants under insurance policies from unfair claims adjustment practices;
6947 [and]
6948 (4) to prevent compensation arrangements for insurance adjusters that endanger the
6949 fairness of claim settlements[.]; and
6950 (5) to govern the qualifications and procedures for the licensing of insurance adjustors.
6951 Section 166. Section **31A-26-202** is amended to read:
6952 **31A-26-202. Application for license.**
6953 (1) (a) The application for a license as an independent adjuster or public adjuster shall be:
6954 (i) made to the commissioner on forms and in a manner [he] the commissioner
6955 prescribes[.]; and
6956 (ii) accompanied by the applicable fee, which is not refunded if the application is denied.
6957 (b) The application shall provide:
6958 (i) information about the identity[,];
6959 (ii) the applicant's:
6960 (A) social security number[,]; or
6961 (B) federal employer identification number;
6962 (iii) the applicant's personal history, experience, education, and business record[, and];
6963 (iv) if the applicant is a natural person, whether the applicant is 18 years of age or older;
6964 (v) whether the applicant has committed an act that is a ground for denial, suspension, or
6965 revocation as set forth in Section 31A-25-208; and
6966 (vi) any other information as the commissioner reasonably requires.
6967 (2) The commissioner may require documents reasonably necessary to verify the
6968 information contained in the application.
6969 [(b)] (3) [An applicant's social security number is a] The following are private [record]

6970 records under Subsection 63-2-302(1)(g)[.]:

6971 [(2) Insurance adjusters' licenses issued under former Title 31 remain in effect until their
6972 expiration date, but they are subject to any requirement or limitation generally imposed under this
6973 title on similar licenses issued after July 1, 1986. Upon timely payment of the license continuation
6974 fee under Section 31A-3-103, the commissioner shall issue to adjusters licensed under the former
6975 title new licenses conforming to the provisions of this title and rules adopted under it.]

6976 (a) the applicant's social security number; and

6977 (b) the applicant's federal employer identification number.

6978 Section 167. Section **31A-26-203** is amended to read:

6979 **31A-26-203. Adjuster's license required.**

6980 (1) The commissioner shall issue a license to act as an independent adjuster or public
6981 adjuster to any person who, as to the license classification applied for under Section 31A-26-204,
6982 has:

6983 [(1)] (a) satisfied the character requirements under Section 31A-26-205;

6984 [(2)] (b) satisfied the applicable continuing education requirements under Section
6985 31A-26-206;

6986 [(3)] (c) satisfied the applicable examination requirements under Section 31A-26-207;

6987 [(4)] (d) if a nonresident, complied with Section 31A-26-208; and

6988 [(5)] (e) paid the applicable fees under Section 31A-3-103.

6989 (2) (a) This Subsection (2) applies to the following persons:

6990 (i) an applicant for:

6991 (A) an independent adjuster's license; or

6992 (B) a public adjuster's license;

6993 (ii) a licensed independent adjuster; or

6994 (iii) a licensed public adjuster.

6995 (b) A person described in Subsection (2)(a) shall report to the commissioner:

6996 (i) any administrative action taken against the person:

6997 (A) in another jurisdiction; or

6998 (B) by another regulatory agency in this state; and

6999 (ii) any criminal prosecution taken against the person in any jurisdiction.

7000 (c) The report required by Subsection (2)(b) shall:

7001 (i) be filed:
7002 (A) at the time the person applies for a third party administrator's license; or
7003 (B) within 30 days of the initiation of an action or prosecution described in Subsection
7004 (2)(b); and
7005 (ii) include a copy of the complaint or other relevant legal documents related to the action
7006 or prosecution described in Subsection (2)(b).
7007 (3) (a) The department may request concerning a person applying for an independent or
7008 public adjuster's license:
7009 (i) criminal background information maintained pursuant to Title 53, Chapter 10, Part 2,
7010 from the Bureau of Criminal Identification; and
7011 (ii) complete Federal Bureau of Investigation criminal background checks through the
7012 national criminal history system.
7013 (b) Information obtained by the department from the review of criminal history records
7014 received under Subsection (3)(a) shall be used by the department for the purposes of:
7015 (i) determining if a person satisfies the character requirements under Section 31A-26-205
7016 for issuance or renewal of a license;
7017 (ii) determining if a person has failed to maintain the character requirements under Section
7018 31A-25-204; and
7019 (iii) preventing persons who violate the federal Violent Crime Control and Law
7020 Enforcement Act of 1994, 18 U.S.C. Secs. 1033 and 1034, from engaging in the business of
7021 insurance in the state.
7022 (c) If the department requests the criminal background information, the department shall:
7023 (i) pay to the Department of Public Safety the costs incurred by the Department of Public
7024 Safety in providing the department criminal background information under Subsection (3)(a)(i);
7025 (ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau of
7026 Investigation in providing the department criminal background information under Subsection
7027 (3)(a)(ii); and
7028 (iii) charge the person applying for a license or for renewal of a license a fee equal to the
7029 aggregate of Subsections (3)(c)(i) and (ii).
7030 Section 168. Section **31A-26-204** is amended to read:
7031 **31A-26-204. License classifications.**

7032 [~~Licenses~~] A resident or nonresident license issued under this chapter shall be issued under
7033 the classifications described under Subsections (1), (2), and (3). These classifications are intended
7034 to describe the matters to be considered under any prerequisite education and examination required
7035 of license applicants under Sections 31A-26-206 and 31A-26-207.
7036 (1) Independent adjuster license classifications include:
7037 (a) [~~disability~~] accident and health insurance, including related service insurance under
7038 Chapter 7 or 8;
7039 (b) property and liability insurance, which includes:
7040 (i) property insurance;
7041 (ii) liability insurance;
7042 (iii) surety bonds; and
7043 (iv) policies containing combinations or variations of these coverages;
7044 (c) service insurance;
7045 (d) title insurance;
7046 (e) credit insurance; and
7047 (f) workers' compensation insurance.
7048 (2) Public adjuster license classifications include:
7049 (a) [~~disability~~] accident and health insurance, including related service insurance under
7050 Chapter 7 or 8;
7051 (b) property and liability insurance, which includes:
7052 (i) property insurance;
7053 (ii) liability insurance;
7054 (iii) surety bonds; and
7055 (iv) policies containing combinations or variations of these coverages;
7056 (c) service insurance;
7057 (d) title insurance;
7058 (e) credit insurance; and
7059 (f) workers' compensation insurance.
7060 (3) The commissioner may by rule recognize other independent adjuster or public adjuster
7061 license classifications as to other kinds of insurance not listed under Subsection (1). The
7062 commissioner may also by rule create license classifications which grant only part of the authority

7063 arising under another license class.

7064 Section 169. Section **31A-26-206** is amended to read:

7065 **31A-26-206. Continuing education requirements.**

7066 (1) The commissioner shall by rule prescribe continuing education requirements for each
7067 class of license under Section 31A-26-204.

7068 (2) (a) The commissioner shall impose continuing education requirements in accordance
7069 with a two-year licensing period in which the licensee meets the requirements of this Subsection
7070 (2).

7071 (b) Except as provided in Subsection (2)(c), for a two-year licensing period described in
7072 Subsection (2)(a) the commissioner shall require that the licensee for each line of authority held
7073 by the licensee:

7074 (i) receive six hours of continuing education; or

7075 (ii) pass a line of authority continuing education examination.

7076 (c) Notwithstanding Subsection (2)(b):

7077 (i) the commissioner may not require continuing education for more than four lines of
7078 authority held by the licensee;

7079 (ii) the commissioner shall require:

7080 (A) a minimum of:

7081 (I) 12 hours of continuing education;

7082 (II) passage of two line of authority continuing education examinations; or

7083 (III) a combination of Subsection (2)(c)(ii)(A)(I) and (II);

7084 (B) that the minimum continuing education requirement of Subsection (2)(c)(ii)(A)
7085 include:

7086 (I) at least six hours or one line of authority continuing education examination for each line
7087 of authority held by the licensee not to exceed four lines of authority held by the licensee; and

7088 (II) three hours of ethics training, which may be taken in place of three hours of the hours
7089 required for a line of authority.

7090 (d) (i) If a licensee completes the licensee's continuing education requirement without
7091 taking a line of authority continuing education examination, the licensee shall complete at least 1/2
7092 of the required hours through classroom hours of insurance-related instruction.

7093 (ii) The hours not completed through classroom hours in accordance with Subsection

7094 (2)(d)(i) may be obtained through:
7095 (A) home study;
7096 (B) video tape;
7097 (C) experience credit; or
7098 (D) other method provided by rule.
7099 (e) (i) A licensee may obtain continuing education hours at any time during the two-year
7100 licensing period.
7101 (ii) The licensee may not take a line of authority continuing education examination more
7102 than 90 calendar days before the date on which the licensee's license is renewed.
7103 (f) The commissioner shall make rules for the content and procedures for line of authority
7104 continuing education examinations.
7105 (g) (i) Beginning May 3, 1999, a licensee is exempt from the continuing education
7106 requirements of this section if:
7107 (A) as of April 1, 1990, the licensee has completed 20 years of licensure in good standing;
7108 (B) the licensee requests an exemption from the department; and
7109 (C) the department approves the exemption.
7110 (ii) If the department approves the exemption under Subsection (2)(g)(i), the licensee is
7111 not required to apply again for the exemption.
7112 (h) A licensee with a variable annuity line of authority is exempt from the requirement for
7113 continuing education for that line of authority so long as:
7114 (i) the National Association of Securities Dealers requires continuing education for
7115 licensees having a securities license; and
7116 (ii) the licensee complies with the National Association of Securities Dealers' continuing
7117 education requirements for securities licensees.
7118 (i) The commissioner shall by rule:
7119 (i) publish a list of insurance professional designations whose continuing education
7120 requirements can be used to meet the requirements for continuing education under Subsection
7121 (2)(c); and
7122 (ii) authorize professional adjuster associations to:
7123 (A) offer qualified programs for all classes of licenses on a geographically accessible basis;
7124 and

7125 (B) collect reasonable fees for funding and administration of the continuing education
7126 programs, subject to the review and approval of the commissioner.
7127 (j) (i) The fees permitted under Subsection (2)(i) that are charged to fund and administer
7128 a program shall reasonably relate to the costs of administering the program.
7129 (ii) Nothing in this section shall prohibit a provider of continuing education programs or
7130 courses from charging fees for attendance at courses offered for continuing education credit.
7131 (iii) The fees permitted under Subsection (2)(i)(ii) that are charged for attendance at an
7132 association program may be less for an association member, based on the member's affiliation
7133 expense, but shall preserve the right of a nonmember to attend without affiliation.
7134 (3) The requirements of this section apply only to licensees who are natural persons.
7135 (4) The requirements of this section do not apply to members of the Utah State Bar.
7136 (5) The commissioner shall designate courses that satisfy the requirements of this section,
7137 including those presented by insurers.
7138 (6) A nonresident adjuster is considered to have satisfied this state's continuing education
7139 requirements if:
7140 (a) the nonresident adjuster satisfies the nonresident producer's home state's continuing
7141 education requirements for a licensed insurance adjuster; and
7142 (b) on the same basis the nonresident adjuster's home state considers satisfaction of Utah's
7143 continuing education requirements for a producer as satisfying the continuing education
7144 requirements of the home state.
7145 Section 170. Section **31A-26-207** is amended to read:
7146 **31A-26-207. Examination requirements.**
7147 (1) The commissioner may require applicants for any particular class of license under
7148 Section 31A-26-204 to pass an examination as a requirement to receiving a license. The
7149 examination shall reasonably relate to the specific license class for which it is prescribed. The
7150 examinations may be administered by the commissioner or as specified by rule.
7151 (2) The commissioner [~~may~~] shall waive the requirement of an examination for a
7152 nonresident applicant who [~~has held a similar license in his home state for the two years~~
7153 ~~immediately preceding application in this state, but only if the applicant's state of residence has~~
7154 ~~imposed upon the applicant examination requirements which are substantially as rigorous as those~~
7155 ~~of this state.~~]:

7156 (a) applies for an insurance adjuster license in this state;
7157 (b) has been licensed for the same line of authority in another state; and
7158 (c) (i) is licensed in the state described in Subsection (2)(b) at the time the applicant
7159 applies for an insurance producer license in this state; or
7160 (ii) if the application is received within 90 days of the cancellation of the applicant's
7161 previous license:
7162 (A) the prior state certifies that at the time of cancellation, the applicant was in good
7163 standing in that state; or
7164 (B) the state's producer database records maintained by the National Association of
7165 Insurance Commissioners or the National Association of Insurance Commissioner's affiliates or
7166 subsidiaries, indicates that the producer is or was licensed in good standing for the line of authority
7167 requested.
7168 (3) (a) To become a resident licensee in accordance with Sections 31A-26-202 and
7169 31A-26-203, a person licensed as an insurance producer in another state who moves to this state
7170 shall make application within 90 days of establishing legal residence in this state.
7171 (b) A person who becomes a resident licensee under Subsection (3)(a) may not be required
7172 to meet prelicensing education or examination requirements to obtain any line of authority
7173 previously held in the prior state unless:
7174 (i) the prior state would require a prior resident of this state to meet the prior state's
7175 prelicensing education or examination requirements to become a resident licensee; or
7176 (ii) the commissioner imposes the requirements by rule.
7177 [~~(3)~~] (4) The requirements of this section only apply to applicants who are natural persons.
7178 [~~(4)~~] (5) The requirements of this section do not apply to members of the Utah State Bar.
7179 Section 171. Section **31A-26-208** is amended to read:
7180 **31A-26-208. Nonresident jurisdictional agreement.**
7181 (1) (a) [~~Nonresident applicants for licenses under this chapter~~] If a nonresident license
7182 applicant has a valid license from the nonresident license applicant's home state and the conditions
7183 of Subsection (1)(b) are met, the commissioner shall:
7184 (i) waive any license requirement for a license under this chapter; and
7185 (ii) issue the nonresident license applicant a nonresident adjuster's license.
7186 (b) Subsection (1)(a) applies if:

7187 (i) the nonresident license applicant:
7188 (A) is licensed as a resident in the nonresident license applicant's home state at the time
7189 the nonresident license applicant applies for a nonresident adjuster license;
7190 (B) has submitted the proper request for licensure;
7191 (C) has submitted to the commissioner:
7192 (I) the application for licensure that the nonresident license applicant submitted to the
7193 applicant's home state; or
7194 (II) a completed uniform application; and
7195 (D) has paid the applicable fees under Section 31A-3-103;
7196 (ii) the nonresident license applicant's license in the applicant's home state is in good
7197 standing; and
7198 (iii) the nonresident license applicant's home state awards nonresident adjuster licenses to
7199 residents of this state on the same basis as this state awards licenses to residents of that home state.
7200 (2) A nonresident applicant shall execute in a form acceptable to the commissioner an
7201 agreement to be subject to the jurisdiction of the commissioner and courts of this state on any
7202 matter related to [his] the adjuster's insurance activities in this state, on the basis of:
7203 (a) service of process under Sections 31A-2-309 and 31A-2-310; or
7204 (b) other service authorized under the Utah Rules of Civil Procedure or Section 78-27-25.
7205 (3) The commissioner may verify the third party administrator's licensing status through
7206 the database maintained by:
7207 (a) the National Association of Insurance Commissioners; or
7208 (b) an affiliate or subsidiary of the National Association of Insurance Commissioners.
7209 (4) The commissioner may not assess a greater fee for an insurance license or related
7210 service to a person not residing in this state based solely on the fact that the person does not reside
7211 in this state.
7212 Section 172. Section **31A-26-209** is amended to read:
7213 **31A-26-209. Form and contents of license.**
7214 (1) Licenses issued under this chapter shall be in the form the commissioner prescribes and
7215 shall set forth:
7216 (a) the name, address, and telephone number of the licensee;
7217 (b) the license classifications under Section 31A-26-204;

7218 (c) the date of license issuance; and
7219 (d) any other information the commissioner considers advisable.
7220 (2) An adjuster doing business under any other name than the adjuster's legal name shall
7221 notify the commissioner prior to using the assumed name in this state.
7222 [(2)] (3) (a) An organization [acting] shall be licensed as an agency if the organization acts
7223 as:
7224 (i) an independent adjuster [shall be licensed under this chapter as an organization.]; or
7225 (ii) a public adjuster.
7226 (b) The [organization] agency license issued under Subsection (3)(a) shall set forth the
7227 names of all natural persons licensed under this chapter who are authorized to act in those
7228 capacities for the organization in this state.
7229 (3) (a) So far as is practicable, the commissioner shall issue a single license to each
7230 licensed adjuster for a single fee.
7231 (b) For fee purposes, the less expensive license is [subsumed] included within the most
7232 expensive license.
7233 Section 173. Section **31A-26-213** is amended to read:
7234 **31A-26-213. Termination of license.**
7235 (1) A license issued under this chapter remains in force until:
7236 (a) revoked, suspended, or limited under Subsection (2);
7237 (b) lapsed under Subsection (3);
7238 (c) surrendered to and accepted by the commissioner; or
7239 (d) the licensee dies or is adjudicated incompetent as defined under Title 75, Chapter 5,
7240 Part 3 or 4.
7241 [(2) After a hearing, the commissioner may revoke, suspend, or limit in whole or in part
7242 the license of any person licensed under this chapter whom the commissioner finds is unqualified
7243 for his license or who has violated an insurance statute, valid rule under Subsection 31A-2-201(3),
7244 or a valid order under Subsection 31A-2-201(4), or if the licensee's methods and practices in the
7245 conduct of business endanger the legitimate interests of customers and the public. Every order
7246 suspending a license issued under this chapter shall specify the period for which the suspension
7247 is to be effective, but in no event may the period exceed 12 months.]
7248 (2) After an adjudicative proceeding under Title 63, Chapter 46b, Administrative

7249 Procedures Act, the commissioner may revoke, suspend for a specified period of 12 months or less,
7250 or limit in whole or in part the license of any adjuster, found to:
7251 (a) be unqualified for a license under Section 31A-26-203;
7252 (b) have violated:
7253 (i) an insurance statute;
7254 (ii) a valid rule under Subsection 31A-2-201(3); or
7255 (iii) a valid order under Subsection 31A-2-201(4);
7256 (c) be insolvent, or the subject of receivership, conservatorship, rehabilitation, or other
7257 delinquency proceedings in any state;
7258 (d) fail to pay any final judgment rendered against it in this state within 60 days after the
7259 judgment became final;
7260 (e) fail to meet the same good faith obligations in claims settlement as that required of
7261 admitted insurers;
7262 (f) be affiliated with and under the same general management or interlocking directorate
7263 or ownership as another adjuster which transacts business in this state without a license;
7264 (g) refuse to be examined or to produce its accounts, records, and files for examination;
7265 (h) have an officer who:
7266 (i) refuses to give information with respect to the administrator's affairs; or
7267 (ii) to perform any other legal obligation as to an examination;
7268 (i) have provided incorrect, misleading, incomplete, or materially untrue information in
7269 the license application;
7270 (j) have violated any insurance law, valid rule, or valid order of another state's insurance
7271 department;
7272 (k) have obtained or attempted to obtain a license through misrepresentation or fraud;
7273 (l) have improperly withheld, misappropriated, or converted any monies or properties
7274 received in the course of doing insurance business;
7275 (m) have intentionally misrepresented the terms of an actual or proposed insurance
7276 contract or application for insurance;
7277 (n) have been convicted of a felony;
7278 (o) have admitted or been found to have committed any insurance unfair trade practice or
7279 fraud;

7280 (p) have used fraudulent, coercive, or dishonest practices in the conduct of business in this
7281 state or elsewhere;
7282 (q) have demonstrated incompetence, untrustworthiness, or financial irresponsibility in the
7283 conduct of business in this state or elsewhere;
7284 (r) have had an insurance license, or its equivalent, denied, suspended, or revoked in any
7285 other state, province, district, or territory;
7286 (s) have forged another's name to:
7287 (i) an application for insurance; or
7288 (ii) any document related to an insurance transaction;
7289 (t) have improperly used notes or any other reference material to complete an examination
7290 for an insurance license;
7291 (u) have knowingly accepted insurance business from an individual who is not licensed;
7292 (v) have failed to comply with an administrative or court order imposing a child support
7293 obligation;
7294 (w) have failed to:
7295 (i) pay state income tax; or
7296 (ii) comply with any administrative or court order directing payment of state income tax;
7297 (x) have violated or permitted others to violate the federal Violent Crime Control and Law
7298 Enforcement Act of 1994, 18 U.S.C. Secs. 1033 and 1034; or
7299 (y) have engaged in methods and practices in the conduct of business which endanger the
7300 legitimate interests of customers and the public.
7301 (3) (a) Any license issued under this chapter lapses if the licensee fails to pay when due
7302 any fee under Section 31A-3-103.
7303 (b) A licensee whose license lapses due to military service or some other extenuating
7304 circumstance such as a long-term medical disability may request:
7305 (i) reinstatement; and
7306 (ii) a waiver of any of the following imposed for failure to comply with renewal
7307 procedures:
7308 (A) an examination requirement;
7309 (B) a fine; or
7310 (C) other sanction.

7311 (c) The commissioner shall by rule prescribe the license renewal and reinstatement
7312 procedures, in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act.
7313 (4) A licensee under this chapter whose license is suspended, revoked, or lapsed, but who
7314 continues to act as a licensee, is subject to the penalties for conducting an insurance business
7315 without a license.
7316 (5) An order revoking a license under Subsection (2) may specify a time not to exceed five
7317 years within which the former licensee may not apply for a new license. If no time is specified,
7318 the former licensee may not apply for a new license for five years without the express approval of
7319 the commissioner.
7320 (6) Any person whose license is suspended or revoked under Subsection (2) shall, when
7321 the suspension ends or a new license is issued, pay all fees that would have been payable if the
7322 license had not been suspended or revoked, unless the commissioner by order waives the payment
7323 of the interim fees. If a new license is issued more than three years after the revocation of a similar
7324 license, this subsection applies only to the fees that would have accrued during the three years
7325 immediately following the revocation.
7326 (7) The division shall promptly withhold, suspend, restrict, or reinstate the use of a license
7327 issued under this part if so ordered by a court.
7328 Section 174. Section **31A-26-215** is enacted to read:
7329 **31A-26-215. Temporary license -- Appointment of trustee for terminated licensee's**
7330 **business.**
7331 (1) (a) The commissioner may issue a temporary insurance adjuster license:
7332 (i) to a person listed in Subsection (1)(b):
7333 (A) if the commissioner considers that the temporary license is necessary:
7334 (I) for the servicing of an insurance business in the public interest; and
7335 (II) to provide continued service to the insureds who are being serviced in a circumstance
7336 described in Subsection (1)(b);
7337 (B) for a period not to exceed 180 days; and
7338 (C) without requiring an examination; or
7339 (ii) in any other circumstance:
7340 (A) if the commissioner considers the public interest will best be served by issuing the
7341 temporary license;

7342 (B) for a period not to exceed 180 days; and
7343 (C) without requiring an examination.
7344 (b) The commissioner may issue a temporary insurance producer license in accordance
7345 with Subsection (1)(a) to:
7346 (i) the surviving spouse or court-appointed personal representative of a licensed insurance
7347 adjuster who dies or becomes mentally or physically disabled to allow adequate time for:
7348 (A) the sale of the insurance business owned by the adjuster;
7349 (B) recovery or return of the adjuster to the business; or
7350 (C) the training and licensing of new personnel to operate the adjuster's business;
7351 (ii) to a member or employee of a business entity licensed as an insurance adjuster upon
7352 the death or disability of an individual designated in:
7353 (A) the business entity application; or
7354 (B) the license; or
7355 (iii) the designee of a licensed insurance adjuster entering active service in the armed
7356 forces of the United States of America.
7357 (2) If a person's license is terminated under Section 31A-26-213, the commissioner may
7358 appoint a trustee to provide in the public interest continuing service to the insureds who procured
7359 insurance through the person whose license is terminated:
7360 (a) at the request of the person whose license is terminated; or
7361 (b) upon the commissioner's own initiative.
7362 (3) This section does not apply if the deceased or disabled adjuster has not owned or does
7363 not own an ownership interest in the accounts and associated expiration lists that were previously
7364 serviced by the adjuster.
7365 (4) (a) A person issued a temporary license under Subsection (1) receives the license and
7366 shall perform the duties under the license subject to the commissioner's authority to:
7367 (i) require a temporary licensee to have a suitable sponsor who:
7368 (A) is a licensed producer; and
7369 (B) assumes responsibility for all acts of the temporary licensee; or
7370 (ii) impose other requirements that are:
7371 (A) designed to protect the insureds and the public; and
7372 (B) similar to the condition described in Subsection (4)(a)(i).

7373 (b) A trustee appointed under Subsection (2) shall receive the trustee's appointment and
7374 perform the trustee's duties subject to the conditions listed in Subsections (4)(b)(i) through (xv).
7375 (i) A trustee appointed under this section shall be licensed under this chapter to perform
7376 the services required by the trustor's clients.
7377 (ii) When possible, the commissioner shall appoint a trustee who is no longer actively
7378 engaged on the trustee's own behalf in business as an adjuster.
7379 (iii) The commissioner shall only select a person to act as trustee who is trustworthy and
7380 competent to perform the necessary services.
7381 (iv) If the deceased, disabled, or unlicenced person for whom the trustee is acting is an
7382 associated adjuster, the insurers through or with which the former adjuster's business was
7383 associated shall cooperate with the trustee in allowing the trustee to service the claims associated
7384 with or through the insurer.
7385 (v) The trustee shall abide by the terms of any agreement between the former adjuster and
7386 the associated insurer, except that terms in those agreements terminating the agreement upon the
7387 death, disability, or license termination of the former agent do not bar the trustee from continuing
7388 to act under the agreement.
7389 (vi) The commissioner shall set the trustee's compensation which:
7390 (A) may be stated in terms of a percentage of commissions;
7391 (B) shall be equitable; and
7392 (C) paid exclusively from:
7393 (I) the commissions generated by the former adjuster's accounts serviced by the trustee;
7394 and
7395 (II) other funds the former adjuster or the former adjuster's successor in interest agree to
7396 pay.
7397 (vii) The trustee has no special priority to commissions over the former adjuster's creditors.
7398 (viii) The following may not be held liable for errors or omissions of the former adjuster
7399 or the trustee:
7400 (A) the commissioner; or
7401 (B) the state.
7402 (ix) The trustee may not be held liable for errors and omissions that were caused in any
7403 material way by the negligence of the former adjuster.

7404 (x) The trustee may be held liable for errors and omissions that arise solely from the
7405 trustee's negligence.
7406 (xi) The trustee's compensation level shall be sufficient to allow the trustee to purchase
7407 errors and omissions coverage, if that coverage is not provided to the trustee by:
7408 (A) the former adjuster; or
7409 (B) the former adjuster's successor in interest.
7410 (xii) It is a breach of the trustee's fiduciary duty to capture the accounts of trustor's clients,
7411 either directly or indirectly.
7412 (xiii) The trustee may not purchase the accounts or expiration lists of the former adjuster,
7413 unless the commissioner expressly ratifies the terms of the sale.
7414 (xiv) The commissioner may adopt rules that:
7415 (A) further define the trustee's fiduciary duties; and
7416 (B) explain how the trustee is to carry out the trustee's responsibilities.
7417 (xv) The trust may be terminated by:
7418 (A) the commissioner; or
7419 (B) the person that requested the trust be established.
7420 (c) A person described in Subsection (4)(b)(vi)(B) shall terminate the trust by sending
7421 written notice to:
7422 (i) the trustee; and
7423 (ii) the commissioner.
7424 (5) (a) The commissioner may by order limit the authority of any temporary licensee or
7425 trustee in any way considered necessary to protect:
7426 (i) persons being serviced; and
7427 (ii) the public.
7428 (b) The commissioner may by order revoke a temporary license or trustee's appointment
7429 if the interest of persons being serviced or the public are endangered.
7430 (c) A temporary license or trustee's appointment may not continue after the owner or
7431 personal representative disposes of the business.
7432 Section 175. Section **31A-26-302** is amended to read:
7433 **31A-26-302. Settlement of claims in credit life and accident and health insurance.**
7434 (1) The creditor shall promptly report all claims to the insurer or its designated claim

7435 representative. The insurer shall maintain adequate claims files. All claims shall be settled as
7436 soon as possible in accordance with the terms of the insurance contract.
7437 (2) The insurer shall pay all claims either by draft drawn upon the insurer or by check of
7438 the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy
7439 provisions, or upon direction of that claimant to another.
7440 (3) [No] A person other than the insurer or its designated claim representative may not
7441 settle or adjust claims. The creditor may not be designated as a claims representative.
7442 Section 176. Section **31A-27-311.5** is repealed and reenacted to read:
7443 **31A-27-311.5. Continuance of coverage -- Health maintenance organizations.**
7444 (1) As used in this section:
7445 (a) "basic health care services" is as defined in Section 31A-8-101;
7446 (b) "enrollee" is as defined in Section 31A-8-101;
7447 (c) "health care" is as defined in Section 31A-1-301;
7448 (d) "health maintenance organization" is as defined in Section 31A-8-101;
7449 (e) "limited health plan" is as defined in Section 31A-8-101;
7450 (f) (i) "managed care organization" means any entity licensed by, or holding a certificate
7451 of authority from, the department to furnish health care services or health insurance;
7452 (ii) "managed care organization" includes:
7453 (A) a limited health plan;
7454 (B) a health maintenance organization;
7455 (C) a preferred provider organization;
7456 (D) a fraternal benefit society; or
7457 (E) any entity similar to an entity described in Subsections (1)(f)(ii)(A) through (D);
7458 (iii) "managed care organization" does not include:
7459 (A) an insurer or other person that is eligible for membership in a guaranty association
7460 under Chapter 28;
7461 (B) a mandatory state pooling plan;
7462 (C) a mutual assessment company or any entity that operates on an assessment basis; or
7463 (D) any entity similar to an entity described in Subsections (1)(f)(iii)(A) through (C);
7464 (g) "participating provider" means a provider who, under a contract with a managed care
7465 organization authorized under Section 31A-8-407, has agreed to provide health care services to

7466 enrollees with an expectation of receiving payment, directly or indirectly, from the managed care
7467 organization, other than copayment;
7468 (h) "participating provider contract" means the agreement between a participating provider
7469 and a managed care organization authorized under Section 31A-8-407;
7470 (i) "preferred provider" means a provider who agrees to provide health care services under
7471 an agreement authorized under Subsection 31A-22-617(1);
7472 (j) "preferred provider contract" means the written agreement between a preferred provider
7473 and a managed care organization authorized under Subsection 31A-22-617(1);
7474 (k) "preferred provider organization" means any person, other than an insurer licensed
7475 under Chapter 7 or an individual who contracts to render professional or personal services that the
7476 individual performs himself, that:
7477 (i) furnishes at a minimum, through preferred providers, basic health care services to an
7478 enrollee in return for prepaid periodic payments in an amount agreed to prior to the time during
7479 which the health care may be furnished;
7480 (ii) is obligated to the enrollee to arrange for the services described in Subsection (1)(k)(i);
7481 and
7482 (iii) permits the enrollee to obtain health care services from providers who are not
7483 preferred providers;
7484 (l) "provider" is as defined in Section 31A-8-101; and
7485 (m) "uncovered expenditure" means the costs of health care services that are covered by
7486 an organization for which an enrollee is liable in the event of the managed care organization's
7487 insolvency.
7488 (2) The rehabilitator or liquidator may take one or more of the actions described in
7489 Subsections (2)(a) through (f) to assure continuation of health care coverage for enrollees of an
7490 insolvent managed care organization.
7491 (a) (i) Subject to Subsection (2)(a)(ii), a rehabilitator or liquidator may require a
7492 participating provider and preferred provider of health care services to continue to provide the
7493 health care services the provider is required to provide under the respective participating provider
7494 contract or preferred provider contract until the later of:
7495 (A) 90 days from the date of the filing of a petition for rehabilitation or the petition for
7496 liquidation; or

7497 (B) the date the term of the contract ends.
7498 (ii) A requirement by the rehabilitator or liquidator under Subsection (2)(a)(i) that a
7499 participating provider or preferred provider continue to provide health care services under a
7500 provider's participating provider contract or preferred providers contract expires when health care
7501 coverage for all enrollees of the insolvent managed care organization is obtained from another
7502 managed care organization or insurer.
7503 (b) (i) Subject to Subsection (2)(b)(ii), a rehabilitator or liquidator may reduce the fees a
7504 participating provider or preferred provider is otherwise entitled to receive from the managed care
7505 organization under its participating provider contract or preferred provider contract during the time
7506 period in Subsection (2)(a)(i).
7507 (ii) Notwithstanding Subsection (2)(b)(i):
7508 (A) a rehabilitator or liquidator may not reduce a fee to less than 75% of the regular fee
7509 set forth in the respective participating provider contract or preferred provider contract; and
7510 (B) the enrollee shall continue to pay the same copayments, deductibles, and other
7511 payments for services received from the participating provider or preferred provider that the
7512 enrollee was required to pay before the date of filing of:
7513 (I) the petition for rehabilitation; or
7514 (II) the petition for liquidation.
7515 (c) (i) If the conditions of Subsection (2)(b) are met, a participating provider or preferred
7516 provider shall:
7517 (A) accept the reduced payment as payment in full; and
7518 (B) relinquish the right to collect additional amounts from the insolvent managed care
7519 organization's enrollee.
7520 (ii) Subsection (2)(b) and Subsections (2)(c)(i)(A) and (B) shall apply to the fees paid to
7521 a provider who agrees to provide health care services to an enrollee but is not a preferred or
7522 participating provider.
7523 (d) If the managed care organization is a health maintenance organization, Subsections
7524 (2)(d)(i) through (v) apply.
7525 (i) Subject to Subsections (2)(d)(ii) and (iv), upon notification from and subject to the
7526 direction of the rehabilitator or liquidator of a health maintenance organization licensed under
7527 Chapter 8, a solvent health maintenance organization licensed under Chapter 8 and operating

7528 within a portion of the insolvent health maintenance organization's service area shall extend to the
7529 enrollees all rights, privileges, and obligations of being an enrollee in the accepting health
7530 maintenance organization, except that the accepting health maintenance organization shall give
7531 credit to an enrollee for any waiting period already satisfied under the provisions of the enrollee's
7532 contract with the insolvent health maintenance organization.
7533 (ii) A health maintenance organization accepting an enrollee of an insolvent health
7534 maintenance organization under Subsection (2)(d)(i) shall charge the enrollee the premiums
7535 applicable to the existing business of the accepting health maintenance organization.
7536 (iii) A health maintenance organization's obligation to accept an enrollee under Subsection
7537 (2)(d)(i) is limited in number to its pro rata share of all health maintenance organization enrollees
7538 in this state, as determined after excluding the enrollees of the insolvent insurer.
7539 (iv) The rehabilitator or liquidator of an insolvent health maintenance organization shall
7540 take those measures that are possible to ensure that no health maintenance organization is required
7541 to accept more than its pro rata share of the adverse risk represented by the enrollees of the
7542 insolvent health maintenance organization. As long as the methodology used by the rehabilitator
7543 or liquidator to assign an enrollee is one which can be expected to produce a reasonably equitable
7544 distribution of adverse risk, that methodology and its results are acceptable under this Subsection
7545 (2)(d)(iv).
7546 (v) (A) Notwithstanding Section 31A-27-311, the rehabilitator or liquidator may require
7547 all solvent health maintenance organizations to pay for the covered claims incurred by the enrollees
7548 of the insolvent health maintenance organization.
7549 (B) As determined by the rehabilitator or liquidator, payments required under this
7550 Subsection (2)(d)(v) may:
7551 (I) begin as of the filing of the petition for reorganization or the petition for liquidation;
7552 and
7553 (II) continue for a maximum period through the time all enrollees are assigned pursuant
7554 to this section.
7555 (C) If the rehabilitator or liquidator makes an assessment under this Subsection (2)(d)(v),
7556 the rehabilitator or liquidator shall assess each solvent health maintenance organization its pro rata
7557 share of the total assessment based upon its premiums from the previous calendar year.
7558 (e) A rehabilitator or liquidator may transfer, through sale, or otherwise, the group and

7559 individual health care obligations of the insolvent managed care organization to other managed
7560 care organizations or other insurers, if those other managed care organizations and other insurers
7561 are licensed or have a certificate of authority to provide the same health care services in this state
7562 that the insolvent managed care organization has.
7563 (i) The rehabilitator or liquidator may combine group and individual health care
7564 obligations of the insolvent managed care organization in any manner the rehabilitator or liquidator
7565 considers best to provide for continuous health care coverage for the maximum number of
7566 enrollees of the insolvent managed care organization.
7567 (ii) If the terms of a proposed transfer of the same combination of group and individual
7568 policy obligations to more than one other managed care organization or insurer are otherwise
7569 equal, the rehabilitator or liquidator shall give preference to the transfer of the group and individual
7570 policy obligations of an insolvent managed care organization as follows:
7571 (A) from one category of managed care organization to another managed care organization
7572 of the same category, as follows:
7573 (I) from a limited health plan to a limited health plan;
7574 (II) from a health maintenance organization to a health maintenance organization;
7575 (III) from a preferred provider organization to a preferred provider organization;
7576 (IV) from a fraternal benefit society to a fraternal benefit society; and
7577 (V) from any entity similar to any of the above to a category that is similar;
7578 (B) from one category of managed care organization to another managed care organization,
7579 regardless of the category of the transferee managed care organization; and
7580 (C) from a managed care organization to a nonmanaged care provider of health care
7581 coverage, including insurers.
7582 (f) A rehabilitator or liquidator may use the insolvent managed care organization's required
7583 capital or permanent surplus, and compulsory surplus, to continue to provide coverage for the
7584 insolvent managed care organization's enrollees, including paying uncovered expenditures.
7585 Section 177. Section **31A-28-102** is amended to read:
7586 **31A-28-102. Purpose.**
7587 (1) The purpose of this part is to protect, subject to certain limitations, the persons
7588 specified in Subsection 31A-28-103(1) against failure in the performance of contractual
7589 obligations, under the life and [~~disability~~] accident and health insurance policies and annuity

7590 contracts specified in Subsection 31A-28-103(2), because of the impairment or insolvency of the
7591 member insurer that issued the policies or contracts.
7592 (2) To provide the protection described in Subsection (1), the Utah Life and Disability
7593 Insurance Guaranty Association, which currently exists, is continued in order to pay benefits and
7594 to continue coverages as limited in this part, and members of the association are subject to
7595 assessment to provide funds to carry out the purpose of this part.
7596 Section 178. Section **31A-28-103** is amended to read:
7597 **31A-28-103. Coverage and limitations.**
7598 (1) This part provides coverage for the policies and contracts specified in Subsection (2)
7599 to persons who are:
7600 (a) beneficiaries, assignees, or payees of the persons covered under Subsection (1)(b),
7601 regardless of where they reside, except for nonresident certificate holders under group policies or
7602 contracts;
7603 (b) owners of or certificate holders under such policies or contracts; or, in the case of
7604 unallocated annuity contracts, to the persons who are the contract holders, and who are:
7605 (i) residents of Utah; or
7606 (ii) not residents of Utah, but only under the following conditions:
7607 (A) the insurers which issued the policies or contracts are domiciled in this state;
7608 (B) the insurers never held a license or certificate of authority in the states in which the
7609 persons reside;
7610 (C) the states have associations similar to the association created by this chapter; and
7611 (D) the persons are not eligible for coverage by the associations described in Subsection
7612 (1)(b)(ii)(C).
7613 (2) (a) Except as otherwise limited by this part, this part provides coverage to the persons
7614 specified in Subsection (1) for direct, nongroup life, [~~disability~~] accident and health, annuity and
7615 supplemental policies or contracts, for certificates under direct group policies and contracts, and
7616 for unallocated annuity contracts issued by member insurers. Annuity contracts and certificates
7617 under group annuity contracts include guaranteed investment contracts, deposit administration
7618 contracts, unallocated funding agreements, structured settlement agreements, lottery contracts, and
7619 any immediate or deferred annuity contracts.
7620 (b) This part does not provide coverage for:

7621 (i) any portion of a policy or contract not guaranteed by the insurer, or under which the risk
7622 is borne by the policy or contract holder;
7623 (ii) any policy or contract of reinsurance, unless assumption certificates have been issued;
7624 (iii) any portion of a policy or contract to the extent that the rate of interest on which it is
7625 based:
7626 (A) averaged over the period of four years prior to the date on which the association
7627 becomes obligated with respect to the policy or contract, exceeds a rate of interest determined by
7628 subtracting two percentage points from Moody's Corporate Bond Yield Average averaged for that
7629 same four-year period or for the corresponding lesser period if the policy or contract was issued
7630 less than four years before the association became obligated; and
7631 (B) on or after the date on which the association becomes obligated with respect to the
7632 policy or contract, exceeds the rate of interest determined by subtracting three percentage points
7633 from Moody's Corporate Bond Yield Average as most recently available;
7634 (iv) any plan or program of an employer, association, or similar entity to provide life,
7635 [~~disability~~] accident and health, or annuity benefits to its employees or members to the extent that
7636 the plan or program is self-funded or uninsured, including benefits payable by an employer,
7637 association, or similar entity under:
7638 (A) a multiple employer welfare arrangement as defined in Section 514 of the Employee
7639 Retirement Income Security Act of 1974, as amended;
7640 (B) a minimum premium group insurance plan;
7641 (C) a stop-loss group insurance plan; or
7642 (D) an administrative services only contract;
7643 (v) any portion of a policy or contract to the extent that it provides dividends or experience
7644 rating credits, or provides that any fees or allowances be paid to any person, including the policy
7645 or contract holder, in connection with the service to or administration of the policy or contract;
7646 (vi) any policy or contract issued in this state by a member insurer at a time when it was
7647 not licensed or did not have a certificate of authority to issue the policy or contract in this state;
7648 (vii) any unallocated annuity contract issued to an employee benefit plan protected under
7649 the federal Pension Benefit Guaranty Corporation; and
7650 (viii) any portion of any unallocated annuity contract which is not issued to or in
7651 connection with a specific employee, union, or association of natural persons benefit plan or a

7652 government lottery.
7653 (c) The benefits for which the association may become liable shall in no event exceed the
7654 lesser of:
7655 (i) the contractual obligations for which the insurer is liable or would have been liable if
7656 it were not an impaired or insolvent insurer; or
7657 (ii) (A) with respect to any one life, regardless of the number of policies or contracts:
7658 (I) $300,000 in life insurance death benefits, but not more than $100,000 in net cash
7659 surrender and net cash withdrawal values for life insurance;
7660 (II) $100,000 in [~~disability~~] accident and health insurance benefits, including any net cash
7661 surrender and net cash withdrawal values;
7662 (III) $100,000 in the present value of annuity benefits, including net cash surrender and
7663 net cash withdrawal values;
7664 (B) with respect to each individual participating in a governmental retirement plan
7665 established under Section 401(k), 403(b), or 457 of the Internal Revenue Code covered by an
7666 unallocated annuity contract or the beneficiaries of each such individual if deceased, in the
7667 aggregate, $100,000 in present value of annuity benefits, including net cash surrender and net cash
7668 withdrawal values;
7669 (C) however, in no event shall the association be liable to expend more than $300,000 in
7670 the aggregate with respect to any one individual under Subsections (2)(c)(ii)(A) and (ii)(B);
7671 (iii) with respect to any one contract holder covered by any unallocated annuity contract
7672 not included in Subsection (2)(c)(ii)(B), $5,000,000 in benefits, irrespective of the number of
7673 contracts held by that contract holder.
7674 Section 179. Section **31A-28-106** is amended to read:
7675 **31A-28-106. Continuation of the association.**
7676 (1) There is continued under this chapter the nonprofit legal entity known as the Utah Life
7677 and Disability Insurance Guaranty Association created under former provisions of this title. All
7678 member insurers shall be and remain members of the association as a condition of their authority
7679 to transact business in this state. The association shall perform its functions under the plan of
7680 operation established and approved under Section 31A-28-110 and shall exercise its powers
7681 through a board of directors under the provisions of Section 31A-28-107. For purposes of
7682 administration and assessment the association shall maintain two accounts:

7683 (a) the life and annuity account, which includes the following subaccounts:
7684 (i) Life Insurance Account;
7685 (ii) Annuity Account; and
7686 (iii) Unallocated Annuity Account, which includes contracts qualified under Sections
7687 401(k), 403(b), or 457 of the Internal Revenue Code; and
7688 (b) the [~~disability~~] accident and health insurance account.
7689 (2) The association shall come under the immediate supervision of the commissioner and
7690 shall be subject to the applicable provisions of the insurance laws of this state. Meetings or records
7691 of the association may be opened to the public upon majority vote of the board of directors of the
7692 association.
7693 Section 180. Section **31A-28-108** is amended to read:
7694 **31A-28-108. Powers and duties of the association.**
7695 (1) If a member insurer is an impaired domestic insurer, the association in its discretion
7696 and subject to any conditions imposed by the association that do not impair the contractual
7697 obligations of the impaired insurer that are approved by the commissioner, and also by the
7698 impaired insurer, except in cases of court-ordered conservation or rehabilitation, may:
7699 (a) guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, any
7700 or all of the policies or contracts of the impaired insurer;
7701 (b) provide the necessary monies, pledges, notes, guarantees or other means to effectuate
7702 Subsection (1)(a) and assure payment of the contractual obligations of the impaired insurer
7703 pending action under Subsection (1)(a); or
7704 (c) loan money to the impaired insurer.
7705 (2) (a) If a member insurer is an impaired insurer, whether domestic, foreign, or alien, and
7706 the insurer is not paying claims timely, the association shall in its discretion and subject to the
7707 preconditions specified in Subsection (2)(b), either:
7708 (i) take any of the actions specified in Subsection (1), subject to the conditions specified
7709 in Subsection (1); or
7710 (ii) provide substitute benefits in lieu of the contractual obligations of the impaired insurer
7711 solely for [~~disability~~] accident and health claims, periodic annuity benefit payments, death benefits,
7712 supplemental benefits, and cash withdrawals for policy or contract owners who petition for such
7713 benefits under claims of emergency or hardship in accordance with the standards proposed by the

7714 association and approved by the commissioner.
7715 (b) The association is subject to the requirements of Subsection (2)(a) only if:
7716 (i) the laws of the impaired insurer's state of domicile provide that until all payments of,
7717 or an account of, the impaired insurer's contractual obligations by all guaranty associations, along
7718 with all expenses of the obligation and interest on all such payments and expenses, have been
7719 repaid to the guaranty associations or a plan of repayment by the impaired insurer has been
7720 approved by the guaranty associations:
7721 (A) the delinquency proceeding shall not be dismissed;
7722 (B) neither the impaired insurer nor its assets shall be returned to the control of its
7723 shareholders or private management;
7724 (C) it shall not be permitted to solicit or accept new business or have any suspended or
7725 revoked license restored; and
7726 (ii) (A) if the impaired insurer is a domestic insurer, it has been placed under an order of
7727 rehabilitation by a court of competent jurisdiction in this state; or
7728 (B) if the impaired insurer is a foreign or alien insurer:
7729 (I) it has been prohibited from soliciting or accepting new business in this state;
7730 (II) its certificate of authority has been suspended or revoked in this state; and
7731 (III) a petition for rehabilitation or liquidation has been filed in a court of competent
7732 jurisdiction in its state of domicile by the commissioner of the state.
7733 (3) If a member insurer is an insolvent insurer, the association in its discretion shall either:
7734 (a) (i) guaranty, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the
7735 policies or contracts of the insolvent insurer; or
7736 (ii) assure payment of the contractual obligations of the insolvent insurer; and
7737 (iii) provide such monies, pledges, guarantees, or other means as are reasonably necessary
7738 to discharge such duties; or
7739 (b) with respect only to [~~disability~~] <u>accident and health</u> insurance policies, provide benefits
7740 and coverages in accordance with Subsection (4).
7741 (4) When proceeding under Subsections (2)(a)(ii) or (3)(b), with respect only to [~~disability~~]
7742 <u>accident and health</u> insurance policies, the association shall:
7743 (a) assure payment of benefits for premiums identical to the premiums and benefits, except
7744 for terms of conversion and renewability, that would have been payable under the policies of the

7745 insolvent insurer, for claims incurred:
7746 (i) with respect to group policies, not later than the earlier of the next renewal date under
7747 the policies or contracts or 45 days, but in no event less than 30 days, after the date on which the
7748 association becomes obligated with respect to the policies;
7749 (ii) with respect to individual policies, not later than the earlier of the next renewal date,
7750 if any, under the policies or one year, but in no event less than 30 days, from the date on which the
7751 association becomes obligated with respect to the policies;
7752 (b) make diligent efforts to provide 30 days' notice of the termination of the benefits
7753 provided to all known insureds, or group policyholders with respect to group policies;
7754 (c) make available substitute coverage on an individual basis, in accordance with the
7755 provisions of Subsection (4)(d), to each known insured or owner under an individual policy, and
7756 to each individual formerly insured under a group policy who is not eligible for replacement group
7757 coverage, if the insured had a right under law or the terminated policy to convert coverage to
7758 individual coverage or to continue an individual policy in force until a specified age or for a
7759 specified time during which the insurer had no right unilaterally to make changes in any provision
7760 of the policy or had a right only to make changes in premium by class.
7761 (d) (i) In providing the substitute coverage required under Subsection (4)(c), the
7762 association may offer either to reissue the terminated coverage or to issue an alternative policy.
7763 (ii) Alternate or reissued policies shall be offered without requiring evidence of
7764 insurability, and shall not provide for any waiting period or exclusion that would not have applied
7765 under the terminated policy.
7766 (iii) The association may reinsure any alternative or reissued policy.
7767 (e) (i) Alternative policies adopted by the association shall be subject to the approval of
7768 the commissioner. The association may adopt alternative policies of various types for future
7769 issuance without regard to any particular impairment or insolvency.
7770 (ii) Alternative policies shall contain at least the minimum statutory provisions required
7771 in this state and provide benefits that are not unreasonable in relation to the premium charged. The
7772 association shall set the premium in accordance with its table of adopted rates. The premium shall
7773 reflect the amount of insurance to be provided and the age and class of risk of each insured. For
7774 alternative policies issued to insureds under individual policies of the impaired or insolvent
7775 insurer, age shall be determined in accordance with the original policy provisions and class of risk

7776 shall be the class of risk under the original policy. For alternative policies issued to individuals
7777 insured under a group policy, age and class of risk shall be determined by the association in
7778 accordance with the alternative policy provisions and risk classification standards approved by the
7779 commissioner. However, the premium may not reflect any changes in the health of the insured
7780 after the original policy was last underwritten.
7781 (iii) Any alternative policy issued by the association shall provide coverage of a type
7782 similar to that of the policy issued by the impaired or insolvent insurer, as determined by the
7783 association.
7784 (f) If the association elects to reissue terminated coverage at a premium rate different from
7785 that charged under the terminated policy, the premium shall be set by the association in accordance
7786 with the amount of insurance provided and the age and class of risk, subject to the approval of the
7787 commissioner or by a court of competent jurisdiction.
7788 (g) The association's obligations with respect to coverage under any policy of the impaired
7789 or insolvent insurer or under any reissued or alternative policy shall cease on the date the coverage
7790 or policy is replaced by another similar policy by the policyholder, the insured, or the association.
7791 (h) With respect to claims unpaid as of the date of insolvency and claims incurred during
7792 the period defined in Subsection (4)(a), a provider of health care services, by accepting a payment
7793 from the association upon a claim of the provider against an insured whose health care insurer is
7794 an insolvent member insurer, agrees to forgive the insured of 20% of the debt which otherwise
7795 would be paid by the insurer had it not been insolvent, subject to a maximum of $4,000 being
7796 required to be forgiven by any one provider as to each claimant. The obligations of solvent
7797 insurers to pay all or part of the covered claim are not diminished by the forgiveness provided for
7798 in this section.
7799 (5) When proceeding under Subsection (2)(a)(ii) or (3) with respect to any policy or
7800 contract carrying guaranteed minimum interest rates, the association shall assure the payment or
7801 crediting of a rate of interest consistent with Subsection 31A-28-103(2)(b)(iii).
7802 (6) Nonpayment of premiums within 31 days after the date required under the terms of any
7803 guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage shall
7804 terminate the association's obligations under the policy or coverage under this chapter with respect
7805 to the policy or coverage, except with respect to any claims incurred or any net cash surrender
7806 value which may be due in accordance with the provisions of this chapter.

7807 (7) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer
7808 shall belong to and be payable at the direction of the association, and the association shall be liable
7809 for unearned premiums due to policy or contract owners of the insurer after the entry of the order.
7810 (8) The protection provided by this chapter does not apply if any guaranty protection is
7811 provided to residents of this state by laws of the domiciliary state or jurisdiction of the impaired
7812 or insolvent insurer other than this state.
7813 (9) In carrying out its duties under this subsection and Subsections (2) and (3), and subject
7814 to approval by the court, the association may:
7815 (a) impose permanent policy or contract liens in connection with any guarantee,
7816 assumption, or reinsurance agreement, if the association finds that the amounts which can be
7817 assessed under this chapter are less than the amounts needed to assure full and prompt performance
7818 of the association's duties under this chapter, or that the economic or financial conditions as they
7819 affect member insurers are sufficiently adverse to render the imposition of the permanent policy
7820 or contract liens to be in the public interest;
7821 (b) impose temporary moratoriums or liens on payments of cash values and policy loans,
7822 or any other right to withdraw funds held in conjunction with policies or contracts, in addition to
7823 any contractual provisions for deferral of cash or policy loan value.
7824 (10) If the association fails to act within a reasonable period of time as provided in
7825 Subsections (2)(a)(ii), (3), and (4), the commissioner shall have the powers and duties of the
7826 association under this chapter with respect to impaired or insolvent insurers.
7827 (11) The association may render assistance and advice to the commissioner, upon his
7828 request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance
7829 of other contractual obligations of any impaired or insolvent insurer.
7830 (12) The association has standing to appear before any court in this state with jurisdiction
7831 over an impaired or insolvent insurer concerning which the association is or may become obligated
7832 under this chapter. Standing extends to all matters germane to the powers and duties of the
7833 association, including proposals for reinsuring, modifying, or guaranteeing the policies or contracts
7834 of the impaired or insolvent insurer and the determination of the policies or contracts and
7835 contractual obligations. The association also has the right to appear or intervene before a court in
7836 another state with jurisdiction over an impaired or insolvent insurer for which the association is
7837 or may become obligated or with jurisdiction over a third party against whom the association may

7838 have rights through subrogation of the insurer's policyholders.
7839 (13) (a) Any person receiving benefits under this chapter shall be considered to have
7840 assigned the rights under, and any causes of action relating to the covered policy or contract to the
7841 association to the extent of the benefits received because of this chapter, whether the benefits are
7842 payments of, or on account of, contractual obligations, continuation of coverage, or provision of
7843 substitute or alternative coverages. The association may require an assignment to it of these rights
7844 and causes of action by any payee, policy or contract owner, beneficiary, insured, or annuitant as
7845 a condition precedent to the receipt of any right or benefits conferred by this chapter upon that
7846 person.
7847 (b) The subrogation rights obtained by the association under this subsection become third
7848 class claims under Section 31A-27-335.
7849 (c) In addition to Subsections (13)(a) and (b), the association has all common law rights
7850 of subrogation and any other equitable or legal remedy which would have been available to the
7851 impaired or insolvent insurer or holder of a policy or contract with respect to the policy or contract.
7852 (14) The association may:
7853 (a) enter into contracts which are necessary or proper to carry out the provisions and
7854 purposes of this chapter;
7855 (b) sue or be sued, including taking any legal actions necessary or proper to recover any
7856 unpaid assessments under Section 31A-28-109 and to settle claims or potential claims against it;
7857 (c) borrow money to effect the purposes of this chapter, and any notes or other evidence
7858 or indebtedness of the association not in default shall be legal investments for domestic insurers
7859 and may be carried as admitted assets;
7860 (d) employ or retain necessary staff members to handle the financial transactions of the
7861 association, and to perform other functions as become necessary or proper under this chapter;
7862 (e) take necessary legal action to avoid payment of improper claims;
7863 (f) exercise, for the purposes of this chapter and to the extent approved by the
7864 commissioner, the powers of a domestic life or health insurer, but in no case may the association
7865 issue insurance policies or annuity contracts other than those issued to perform its obligation under
7866 this chapter; or
7867 (g) act as a special deputy liquidator if appointed by the commissioner.
7868 (15) The association may join an organization of one or more other state associations of

7869 similar purposes to further the purposes and administer the powers and duties of the association.
7870 Section 181. Section **31A-28-109** is amended to read:
7871 **31A-28-109. Assessments.**
7872 (1) For the purpose of providing the funds necessary to carry out the powers and duties of
7873 the association, the board of directors shall assess the member insurers, separately for each
7874 account, at the time and for the amounts that the board finds necessary. Assessments are due not
7875 less than 30 days after prior written notice to the member insurers. Class B assessments, described
7876 in Subsection (2)(b), shall accrue interest at 10% per annum on and after the due date.
7877 (2) There are two classes of assessment:
7878 (a) Class A assessments shall be made for the purpose of meeting administrative and legal
7879 costs and other expenses and examinations conducted under the authority of Subsection
7880 31A-28-112(5). Class A assessments may be made whether or not related to a particular impaired
7881 or insolvent insurer.
7882 (b) Class B assessments shall be made to the extent necessary to carry out the powers and
7883 duties of the association under Section 31A-28-108 with regard to an impaired or an insolvent
7884 insurer.
7885 (3) (a) The amount of any Class A assessment shall be determined by the board and may
7886 be made on a pro rata or non-pro rata basis. If the assessment is pro rata, the board may credit the
7887 assessment against future Class B assessments. A non-pro rata assessment may not exceed $150
7888 per member insurer in any one calendar year.
7889 (b) The amount of any Class B assessment shall be allocated for assessment purposes
7890 among the accounts pursuant to an allocation formula which may be based on the premiums or
7891 reserves of the impaired or insolvent insurer or based on any other standard determined by the
7892 board in its sole discretion to be fair and reasonable under the circumstances.
7893 (c) (i) Class B assessments against member insurers for each account and subaccount shall
7894 be in the proportion that the premiums received on business in this state by each assessed member
7895 insurer bears to the premiums received on business in this state for the same calendar years by all
7896 assessed member insurers.
7897 (ii) "Premiums received" is based on policies or contracts covered by each account for the
7898 three most recent calendar years for which information is available, which precede the year in
7899 which the insurer became impaired or insolvent.

7900 (d) Assessments for funds to meet the requirements of the association with respect to an
7901 impaired or insolvent insurer may not be made until necessary to implement the purposes of this
7902 chapter. Classification of assessments under Subsection (3)(b) and computation of assessments
7903 under this Subsection (3) shall be made with a reasonable degree of accuracy, recognizing that
7904 exact determinations may not always be possible.
7905 (4) The association may abate or defer, in whole or in part, the assessment of a member
7906 insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the
7907 member insurer to fulfill its contractual obligations. In the event an assessment against a member
7908 insurer is abated or deferred in whole or in part, the amount by which the assessment is abated or
7909 deferred may be assessed against the other member insurers in a manner consistent with the basis
7910 for assessments set forth in this section.
7911 (5) (a) The total of all assessments upon a member insurer for the life and annuity account,
7912 and for each subaccount, may not in any one calendar year exceed 2% and the [~~disability~~] accident
7913 and health account may not in any one calendar year exceed 2% of the insurer's yearly average
7914 premiums received in this state on the policies and contracts covered by the account during the
7915 three calendar years preceding the year in which the insurer became an impaired or insolvent
7916 insurer. If the maximum assessment, together with the other assets of the association in any
7917 account, does not provide in any one year in either account an amount sufficient to carry out the
7918 responsibilities of the association, the necessary additional funds shall be assessed as soon as
7919 permitted by this chapter.
7920 (b) The board may provide in the plan of operation a method of allocating funds among
7921 claims, whether relating to one or more impaired or insolvent insurers, when the maximum
7922 assessment will be insufficient to cover anticipated claims.
7923 (c) If a 1% assessment for any subaccount of the life and annuity account in any one year
7924 does not provide an amount sufficient to carry out the responsibilities of the association, the board
7925 shall assess all subaccounts of the life and annuity account for the necessary additional amount
7926 pursuant to Subsection (3)(b), subject to the maximum stated in Subsection (5)(a).
7927 (6) The board may, by an equitable method established in the plan of operation, refund to
7928 member insurers in proportion to the contribution of each insurer to that account the amount by
7929 which the assets of the account exceed the amount the board finds is necessary to carry out during
7930 the coming year the obligations of the association with regard to that account, including assets

7931 accruing from assignment, subrogation, net realized gains, and income from investments. A
7932 reasonable amount may be retained in any account to provide funds for the continuing expenses
7933 of the association and for future losses.
7934 (7) It shall be proper for any member insurer, in determining its premium rates and
7935 policyowner dividends as to any kind of insurance within the scope of this chapter, to consider the
7936 amount reasonably necessary to meet its assessment obligations under this chapter.
7937 (8) The association shall issue to each insurer paying an assessment under this chapter,
7938 other than a Class A assessment, a certificate of contribution, in a form approved by the
7939 commissioner, for the amount of the assessment so paid. All outstanding certificates shall be of
7940 equal dignity and priority without reference to amounts or dates of issue. A certificate of
7941 contribution may be shown by the insurer in its financial statement as an asset in such form and
7942 for such amount, if any, and period of time as the commissioner may approve.
7943 Section 182. Section **31A-28-202** is amended to read:
7944 **31A-28-202. Scope.**
7945 This part applies to protect resident policyowners and insureds under all types of direct
7946 insurance, except:
7947 (1) life[,];
7948 (2) title[,];
7949 (3) surety[~~, disability,~~];
7950 (4) accident and health;
7951 (5) credit, [(]including mortgage guarantee[~~),~~];
7952 (6) ocean marine insurance[,];
7953 (7) insurance of warranties or service contracts[,];
7954 (8) financial guarantee[,]; and
7955 (9) all insurance coverages guaranteed by the United States Government.
7956 Section 183. Section **31A-29-103** is amended to read:
7957 **31A-29-103. Definitions.**
7958 As used in this chapter:
7959 (1) "Board" means the board of directors of the pool created in Section 31A-29-104.
7960 (2) "Health care facility" means any entity providing health care services which is licensed
7961 under Title 26, Chapter 21.

7962 (3) "Health care provider" has the same meaning as provided in Section 78-14-3.
7963 (4) "Health care services" means any service or product used in furnishing to any
7964 individual medical care or hospitalization, or incidental to furnishing medical care or
7965 hospitalization, and any other service or product furnished for the purpose of preventing,
7966 alleviating, curing, or healing human illness or injury.
7967 (5) (a) "Health insurance" means any:
7968 (i) hospital and medical expense-incurred policy;
7969 (ii) nonprofit health care service plan contract; and
7970 (iii) health maintenance organization subscriber contract.
7971 (b) "Health insurance" does not include any insurance arising out of the Workers'
7972 Compensation Act or similar law, automobile medical payment insurance, or insurance under
7973 which benefits are payable with or without regard to fault and which is required by law to be
7974 contained in any liability insurance policy[~~;~~]<u>.</u>
7975 (6) "Health maintenance organization" has the same meaning as provided in Section
7976 31A-8-101.
7977 (7) "Health plan" means any arrangement by which a person, including a dependent or
7978 spouse, covered or making application to be covered under the pool has access to hospital and
7979 medical benefits or reimbursement including group or individual insurance or subscriber contract;
7980 coverage through a health maintenance organization, preferred provider prepayment, group
7981 practice, or individual practice plan; coverage under an uninsured arrangement of group or
7982 group-type contracts including employer self-insured, cost-plus, or other benefits methodologies
7983 not involving insurance; coverage under a group type contract which is not available to the general
7984 public and can be obtained only because of connection with a particular organization or group; and
7985 coverage by medicare or other governmental benefit. The term includes coverage through health
7986 insurance.
7987 (8) "Insured" means an individual resident of this state who is eligible to receive benefits
7988 from any insurer, health maintenance organization, or other health plan.
7989 (9) "Insurer" means an insurance company authorized to transact [~~disability~~] <u>accident and</u>
7990 <u>health</u> insurance business in this state, health maintenance organization, and a self-insurer not
7991 subject to federal preemption.
7992 (10) "Medicaid" means coverage under Title XIX of the Social Security Act, 42 U.S.C.

7993 Sec. 1396 et seq., as amended.
7994 (11) "Medicare" means coverage under both Part A and B of Title XVIII of the Social
7995 Security Act, 42 U.S.C. 1395 et seq., as amended.
7996 (12) "Plan of operation" means the plan developed by the board in accordance with Section
7997 31A-29-105 and includes the articles, bylaws, and operating rules adopted by the board under
7998 Section 31A-29-106.
7999 (13) "Pool" means the Utah Comprehensive Health Insurance Pool created in Section
8000 31A-29-104.
8001 (14) "Pool Fund" means the Comprehensive Health Insurance Pool Enterprise Fund
8002 created in Section 31A-29-120.
8003 (15) "Pool policy" means an insurance policy issued under this chapter.
8004 (16) "Third-party administrator" has the same meaning as provided in Section 31A-1-301.
8005 Section 184. Section **31A-29-117** is amended to read:
8006 **31A-29-117. Premium rates.**
8007 (1) (a) Premium charges for coverage under the pool may not be unreasonable in relation
8008 to:
8009 (i) the benefits provided;
8010 (ii) the risk experience; and
8011 (iii) the reasonable expenses provided in the coverage.
8012 (b) Separate schedules of premium rates based on age and other appropriate demographic
8013 characteristics may apply for individual risks.
8014 (2) A small employer carrier shall annually inform the commissioner by April 1 of the
8015 carrier's:
8016 (a) small employer index premium rates as of March 1 of the current and preceding year[.];
8017 and
8018 (b) average percentage change in the index premium rate as of March 1, of the current and
8019 preceding year.
8020 (3) (a) Premium rates in effect as of January 1, 1997, shall be adjusted on July 1, 1997, and
8021 each following July 1 may be adjusted by the board.
8022 (b) In adjusting premium rates, the board shall:
8023 (i) consider the average increase in small employer index rates for the five largest small

8024 employer carriers submitted under Subsection (2); and
8025 (ii) be subject to Subsection (1).
8026 (4) The board may establish a premium scale based on income. The highest rate may not
8027 exceed the expected claims and expenses for the individual.
8028 (5) If a person is an eligible individual as defined in the Health Insurance Portability and
8029 Accountability Act, P.L. 104-191, 110 Stat. 1979, Sec. 2741(b), the maximum premium rate for
8030 that person may not exceed the amount permitted under P.L. 104-191, 110 Stat. 1986, Sec.
8031 2744(c)(2)(B).
8032 (6) All rates and rate schedules shall be submitted by the board to the commissioner for
8033 approval.
8034 Section 185. Section **31A-30-103** is amended to read:
8035 **31A-30-103. Definitions.**
8036 As used in this part:
8037 (1) "Actuarial certification" means a written statement by a member of the American
8038 Academy of Actuaries or other individual approved by the commissioner that a covered carrier is
8039 in compliance with the provisions of Section 31A-30-106, based upon the examination of the
8040 covered carrier, including review of the appropriate records and of the actuarial assumptions and
8041 methods utilized by the covered carrier in establishing premium rates for applicable health benefit
8042 plans.
8043 (2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through
8044 one or more intermediaries, controls or is controlled by, or is under common control with, a
8045 specified entity or person.
8046 (3) "Base premium rate" means, for each class of business as to a rating period, the lowest
8047 premium rate charged or that could have been charged under a rating system for that class of
8048 business by the covered carrier to covered insureds with similar case characteristics for health
8049 benefit plans with the same or similar coverage.
8050 (4) "Basic coverage" means the coverage provided in the Basic Health Care Plan
8051 established by the Health Benefit Plan Committee under Subsection 31A-22-613.5[(8)] (6).
8052 (5) "Carrier" means any person or entity that provides health insurance in this state
8053 including an insurance company, a prepaid hospital or medical care plan, a health maintenance
8054 organization, a multiple employer welfare arrangement, and any other person or entity providing

8055 a health insurance plan under this title.

8056 (6) "Case characteristics" means demographic or other objective characteristics of a
8057 covered insured that are considered by the carrier in determining premium rates for the covered
8058 insured. However, duration of coverage since the policy was issued, claim experience, and health
8059 status, are not case characteristics for the purposes of this chapter.

8060 (7) "Class of business" means all or a separate grouping of covered insureds established
8061 under Section 31A-30-105.

8062 (8) "Conversion policy" means a policy providing coverage under the conversion
8063 provisions required in Title 31A, Chapter 22, Part VII, Group [~~Disability~~] Accident and Health
8064 Insurance.

8065 (9) "Covered carrier" means any individual carrier or small employer carrier subject to this
8066 act.

8067 (10) "Covered individual" means any individual who is covered under a health benefit plan
8068 subject to this act.

8069 (11) "Covered insureds" means small employers and individuals who are issued a health
8070 benefit plan that is subject to this act.

8071 (12) "Dependent" means individuals to the extent they are defined to be a dependent by:

8072 (a) the health benefit plan covering the covered individual; and

8073 (b) the provisions of Chapter 22, Part VI, Disability Insurance.

8074 (13) (a) "Eligible employee" means:

8075 (i) an employee who works on a full-time basis and has a normal work week of 30 or more
8076 hours, and includes a sole proprietor, and a partner of a partnership, if the sole proprietor or partner
8077 is included as an employee under a health benefit plan of a small employer; or

8078 (ii) an independent contractor if the independent contractor is included under a health
8079 benefit plan of a small employer.

8080 (b) "Eligible employee" does not include:

8081 (i) an employee who works on a part-time, temporary, or substitute basis; or

8082 (ii) the spouse or dependents of the employer.

8083 (14) "Established geographic service area" means a geographical area approved by the
8084 commissioner within which the carrier is authorized to provide coverage.

8085 (15) "Health benefit plan" means any certificate under a group health insurance policy, or

8086 any health insurance policy, except that health benefit plan does not include coverage only for:
8087 (a) accident;
8088 (b) dental;
8089 (c) vision;
8090 (d) Medicare supplement;
8091 (e) long-term care; or
8092 (f) the following when offered and marketed as supplemental health insurance and not as
8093 a substitute for hospital or medical expense insurance or major medical expense insurance:
8094 (i) specified disease;
8095 (ii) hospital confinement indemnity; or
8096 (iii) limited benefit plan.
8097 (16) "Index rate" means, for each class of business as to a rating period for covered
8098 insureds with similar case characteristics, the arithmetic average of the applicable base premium
8099 rate and the corresponding highest premium rate.
8100 (17) "Individual carrier" means a carrier that offers health benefit plans covering insureds
8101 in this state under individual policies.
8102 (18) "Individual conversion policy" means a conversion policy issued by a health benefit
8103 plan as defined in Subsection (15) to:
8104 (a) an individual; or
8105 (b) an individual with a family.
8106 [~~(18)~~] (19) "Individual coverage count" means the number of natural persons covered
8107 under a carrier's health benefit plans that are individual policies.
8108 [~~(19)~~] (20) "Individual enrollment cap" means the percentage set by the commissioner in
8109 accordance with Section 31A-30-110.
8110 [~~(20)~~] (21) "New business premium rate" means, for each class of business as to a rating
8111 period, the lowest premium rate charged or offered, or that could have been charged or offered, by
8112 the carrier to covered insureds with similar case characteristics for newly issued health benefit
8113 plans with the same or similar coverage.
8114 [~~(21)~~] (22) "Premium" means all monies paid by covered insureds and covered individuals
8115 as a condition of receiving coverage from a covered carrier, including any fees or other
8116 contributions associated with the health benefit plan.

8117 [(22)] (23) "Rating period" means the calendar period for which premium rates established
8118 by a covered carrier are assumed to be in effect, as determined by the carrier. However, a covered
8119 carrier may not have more than one rating period in any calendar month, and no more than 12
8120 rating periods in any calendar year.
8121 [(23)] (24) "Resident" means an individual who has resided in this state for at least 12
8122 consecutive months immediately preceding the date of application.
8123 [(24)] (25) "Small employer" means any person, firm, corporation, partnership, or
8124 association actively engaged in business that, on at least 50% of its working days during the
8125 preceding calendar quarter, employed at least two and no more than 50 eligible employees, the
8126 majority of whom were employed within this state. In determining the number of eligible
8127 employees, companies that are affiliated or that are eligible to file a combined tax return for
8128 purposes of state taxation are considered one employer.
8129 [(25)] (26) "Small employer carrier" means a carrier that offers health benefit plans
8130 covering eligible employees of one or more small employers in this state.
8131 [(26)] (27) "Uninsurable" means an individual who:
8132 (a) is eligible for the Comprehensive Health Insurance Pool coverage under the
8133 underwriting criteria established in Subsection 31A-29-111(4); or
8134 (b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and
8135 (ii) has a condition of health that does not meet consistently applied underwriting criteria
8136 as established by the commissioner in accordance with Subsections 31A-30-106(1)(k) and (l) for
8137 which coverage the applicant is applying.
8138 [(27)] (28) "Uninsurable percentage" for a given calendar year equals UC/CI where, for
8139 purposes of this formula:
8140 (a) "UC" means the number of uninsurable individuals who were issued an individual
8141 policy on or after July 1, 1997; and
8142 (b) "CI" means the carrier's individual coverage count as of December 31 of the preceding
8143 year.
8144 Section 186. Section **31A-30-104** is amended to read:
8145 **31A-30-104. Applicability and scope.**
8146 (1) This chapter applies to any:
8147 (a) health benefit plan that provides coverage to:

8148 (i) individuals;
8149 (ii) small employer groups; or
8150 (iii) both Subsections (1)(a)(i) and (ii); or
8151 (b) individual conversion policy for purposes of [Section] Sections 31A-30-106.5 and
8152 31A-30-107.
8153 (2) (a) Except as provided in Subsection (2)(b), for the purposes of this chapter, carriers
8154 that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as
8155 one carrier and any restrictions or limitations imposed by this chapter shall apply as if all health
8156 benefit plans delivered or issued for delivery to covered insureds in this state by the affiliated
8157 carriers were issued by one carrier.
8158 (b) An affiliated carrier that is a health maintenance organization having a certificate of
8159 authority under this title may be considered to be a separate carrier for the purposes of this chapter.
8160 (c) Unless otherwise authorized by the commissioner, a covered carrier may not enter into
8161 one or more ceding arrangements with respect to health benefit plans delivered or issued for
8162 delivery to covered insureds in this state if such arrangements would result in less than 50% of the
8163 insurance obligation or risk for such health benefit plans being retained by the ceding carrier.
8164 (d) The provisions of Section 31A-22-1201 apply if a covered carrier cedes or assumes all
8165 of the insurance obligation or risk with respect to one or more health benefit plans delivered or
8166 issued for delivery to covered insureds in this state.
8167 (3) (a) A Taft Hartley trust created in accordance with Section 302(c)(5) of the Federal
8168 Labor Management Relations Act, or a carrier with the written authorization of such a trust, may
8169 make a written request to the commissioner for a waiver from the application of any of the
8170 provisions of Subsection 31A-30-106(1) with respect to a health benefit plan provided to the trust.
8171 (b) The commissioner may grant such a waiver if the commissioner finds that application
8172 with respect to the trust would:
8173 (i) have a substantial adverse effect on the participants and beneficiaries of the trust; and
8174 (ii) require significant modifications to one or more collective bargaining arrangements
8175 under which the trust is established or maintained.
8176 (c) A waiver granted under this Subsection (3) may not apply to an individual if the person
8177 participates in such a trust as an associate member of any employee organization.
8178 (4) A carrier who offers individual and small employer health benefit plans may use the

8179 small employer index rates to establish the rate limitations for individual policies, even if some
8180 individual policies are rated below the small employer base rate.
8181 (5) Sections 31A-30-106, 31A-30-106.5, 31A-30-106.7, 31A-30-107, 31A-30-108, and
8182 31A-30-111 apply to:
8183 (a) any insurer engaging in the business of insurance related to the risk of a small employer
8184 for medical, surgical, hospital, or ancillary health care expenses of its employees provided as an
8185 employee benefit; and
8186 (b) any contract of an insurer, other than a workers' compensation policy, related to the risk
8187 of a small employer for medical, surgical, hospital, or ancillary health care expenses of its
8188 employees provided as an employee benefit.
8189 (6) The commissioner may make rules requiring that the marketing practices be consistent
8190 with this chapter for:
8191 (a) an insurer and its agent;
8192 (b) an insurance broker; and
8193 (c) an insurance consultant.
8194 Section 187. Section **31A-30-106** is amended to read:
8195 **31A-30-106. Premiums -- Rating restrictions -- Disclosure.**
8196 (1) Premium rates for health benefit plans under this chapter are subject to the following
8197 provisions:
8198 (a) The index rate for a rating period for any class of business shall not exceed the index
8199 rate for any other class of business by more than 20%.
8200 (b) For a class of business, the premium rates charged during a rating period to covered
8201 insureds with similar case characteristics for the same or similar coverage, or the rates that could
8202 be charged to such employers under the rating system for that class of business, may not vary from
8203 the index rate by more than 30% of the index rate, except as provided in Section 31A-22-625.
8204 (c) The percentage increase in the premium rate charged to a covered insured for a new
8205 rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of the
8206 following:
8207 (i) the percentage change in the new business premium rate measured from the first day
8208 of the prior rating period to the first day of the new rating period. In the case of a health benefit
8209 plan into which the covered carrier is no longer enrolling new covered insureds, the covered carrier

8210 shall use the percentage change in the base premium rate, provided that such change does not
8211 exceed, on a percentage basis, the change in the new business premium rate for the most similar
8212 health benefit plan into which the covered carrier is actively enrolling new covered insureds;
8213 (ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods
8214 of less than one year, due to the claim experience, health status, or duration of coverage of the
8215 covered individuals as determined from the covered carrier's rate manual for the class of business,
8216 except as provided in Section 31A-22-625; and
8217 (iii) any adjustment due to change in coverage or change in the case characteristics of the
8218 covered insured as determined from the covered carrier's rate manual for the class of business.
8219 (d) Adjustments in rates for claims experience, health status, and duration from issue may
8220 not be charged to individual employees or dependents. Any such adjustment shall be applied
8221 uniformly to the rates charged for all employees and dependents of the small employer.
8222 (e) A covered carrier may utilize industry as a case characteristic in establishing premium
8223 rates, provided that the highest rate factor associated with any industry classification does not
8224 exceed the lowest rate factor associated with any industry classification by more than 15%.
8225 (f) In the case of health benefit plans issued prior to July 1, 1994, a premium rate for a
8226 rating period, adjusted pro rata for rating period of less than a year, may exceed the ranges under
8227 Subsections (1)(a) and (b) until July 1, 1996. In that case, the percentage increase in the premium
8228 rate charged to a covered insured for a new rating period may not exceed the sum of the following:
8229 (i) the percentage change in the new business premium rate measured from the first day
8230 of the prior rating period to the first day of the new rating period. In the case where a covered
8231 carrier is not issuing any new policies the covered carrier shall use the percentage change in the
8232 base premium rate, provided that such change does not exceed, on a percentage basis, the change
8233 in the new business premium rate for the most similar health benefit plan into which the covered
8234 carrier is actively enrolling new covered insureds; and
8235 (ii) any adjustment due to change in coverage or change in the case characteristics of the
8236 covered insured as determined from the carrier's rate manual for the class of business.
8237 (g) The commissioner may grant a one-year extension of the July 1, 1996, deadline
8238 specified in Subsection <u>(1)</u>(f) if the commissioner determines that an extension is needed to avoid
8239 significant disruption of the health insurance market subject to this chapter or to insure the
8240 financial stability of carriers in the market.

8241 (h) (i) Covered carriers shall apply rating factors, including case characteristics,
8242 consistently with respect to all covered insureds in a class of business. Rating factors shall produce
8243 premiums for identical groups which differ only by the amounts attributable to plan design and do
8244 not reflect differences due to the nature of the groups assumed to select particular health benefit
8245 plans.
8246 (ii) A covered carrier shall treat all health benefit plans issued or renewed in the same
8247 calendar month as having the same rating period.
8248 (i) For the purposes of this subsection, a health benefit plan that utilizes a restricted
8249 network provision shall not be considered similar coverage to a health benefit plan that does not
8250 utilize such a network, provided that utilization of the restricted network provision results in
8251 substantial difference in claims costs.
8252 (j) The covered carrier shall not, without prior approval of the commissioner, use case
8253 characteristics other than age, gender, industry, geographic area, family composition, and group
8254 size.
8255 (k) The commissioner may establish regulations in accordance with Title 63, Chapter 46a,
8256 Utah Administrative Rulemaking Act, to implement the provisions of this chapter and to assure
8257 that rating practices used by covered carriers are consistent with the purposes of this chapter,
8258 including regulations that:
8259 (i) assure that differences in rates charged for health benefit plans by covered carriers are
8260 reasonable and reflect objective differences in plan design (not including differences due to the
8261 nature of the groups assumed to select particular health benefit plans);
8262 (ii) prescribe the manner in which case characteristics may be used by covered carriers;
8263 (iii) require insurers, as a condition of transacting business with regard to health care
8264 insurance [~~disability~~] policies after January 1, 1995, to reissue a health care insurance [~~disability~~]
8265 policy to any policyholder whose health care insurance [~~disability~~] policy has, after January 1,
8266 1994, been terminated by the insurer for reasons other than those listed in Subsections
8267 31A-30-107(1)(a) through (1)(e) or not renewed by the insurer after January 1, 1994. The
8268 commissioner may prescribe terms for the reissue of coverage that the commissioner determines
8269 are reasonable and necessary to provide continuity of coverage to insured individuals;
8270 (iv) implement the individual enrollment cap under Section 31A-30-110, including
8271 specifying the contents for certification, auditing standards, underwriting criteria for uninsurable

8272 classification, and limitations on high risk enrollees under Section 31A-30-111; and
8273 (v) establish the individual enrollment cap under Subsection 31A-30-110(1).
8274 (l) Before implementing regulations for underwriting criteria for uninsurable classification,
8275 the commissioner shall contract with an independent consulting organization to develop
8276 industry-wide underwriting criteria for uninsurability based on an individual's expected claims
8277 under open enrollment coverage exceeding 200% of that expected for a standard insurable
8278 individual with the same case characteristics.
8279 (m) The commissioner shall revise rules issued for Sections 31A-22-602 and 31A-22-605
8280 regarding individual [~~disability~~] accident and health policy rates to allow rating in accordance with
8281 this section.
8282 (2) A covered carrier shall not transfer a covered insured involuntarily into or out of a class
8283 of business. A covered carrier shall not offer to transfer a covered insured into or out of a class
8284 of business unless such offer is made to transfer all covered insureds in the class of business
8285 without regard to case characteristics, claim experience, health status, or duration of coverage since
8286 issue.
8287 (3) Upon offering for sale any health benefit plan to a small employer, or individual, the
8288 covered carrier shall, as part of its solicitation and sales materials, disclose or make available all
8289 of the following:
8290 (a) the extent to which premium rates for a specified covered insured are established or
8291 adjusted in part based on the actual or expected variation in claims costs or actual or expected
8292 variation in health status of covered individuals;
8293 (b) provisions concerning the covered carrier's right to change premium rates and the
8294 factors other than claim experience which affect changes in premium rates;
8295 (c) provisions relating to renewability of policies and contracts; and
8296 (d) provisions relating to any preexisting condition provision.
8297 (4) (a) Each covered carrier shall maintain at its principal place of business a complete and
8298 detailed description of its rating practices and renewal underwriting practices, including
8299 information and documentation that demonstrate that its rating methods and practices are based
8300 upon commonly accepted actuarial assumptions and are in accordance with sound actuarial
8301 principles.
8302 (b) Each covered carrier shall file with the commissioner, on or before March 15 of each

8303 year, in a form, manner, and containing such information as prescribed by the commissioner, an
8304 actuarial certification certifying that the covered carrier is in compliance with this chapter and that
8305 the rating methods of the covered carrier are actuarially sound. A copy of that certification shall
8306 be retained by the covered carrier at its principal place of business.
8307 (c) A covered carrier shall make the information and documentation described in this
8308 subsection available to the commissioner upon request.
8309 (d) Records submitted to the commissioner under the provisions of this section shall be
8310 maintained by the commissioner as protected records under Title 63, Chapter 2, Government
8311 Records Access and Management Act.
8312 Section 188. Section **31A-30-106.5** is amended to read:
8313 **31A-30-106.5. Conversion policy -- Premiums -- Rating restrictions.**
8314 (1) All provisions of Section 31A-30-106, except Subsection 31A-30-106(1)(b), apply to
8315 conversion policies.
8316 (2) Conversion policy premium rates may not exceed by more than 35% the index rate for
8317 individuals with similar case characteristics for any class of business in which the policy form has
8318 been approved.
8319 <u>(3) An insurer may not consider pregnancy of a covered insured in determining its</u>
8320 <u>conversion policy premium rates.</u>
8321 Section 189. Section **31A-30-107** is amended to read:
8322 **31A-30-107. Renewal -- Limitations -- Exclusions.**
8323 (1) A health benefit plan subject to this chapter is renewable with respect to all covered
8324 individuals at the option of the covered insured except in any of the following cases:
8325 (a) nonpayment of the required premiums;
8326 (b) fraud or misrepresentation of:
8327 (i) the employer; or
8328 (ii) with respect to coverage of individual insureds, the insureds or their representatives;
8329 (c) noncompliance with the covered carrier's minimum participation requirements;
8330 (d) noncompliance with the covered carrier's employer contribution requirements;
8331 (e) repeated misuse of a provider network provision; or
8332 (f) an election by the covered carrier to nonrenew all of its health benefit plans issued to
8333 covered insureds in this state, in which case the covered carrier shall:

8334 (i) provide advanced notice of its decision under this Subsection (1) to the commissioner
8335 in each state in which it is licensed; [~~and~~]
8336 (ii) provide notice of the decision not to renew coverage to all affected covered insureds
8337 and to the commissioner in each state in which an affected insured individual is known to reside[~~.~~];
8338 and
8339 (iii) provide a plan of orderly withdrawal as required by Section 31A-4-115.
8340 (2) Notice under Subsection (1) shall be provided:
8341 (a) to affected covered insureds at least 180 days prior to nonrenewal of any health benefit
8342 plans by the covered carrier; and
8343 (b) to the commissioner at least three working days prior to the notice to the affected
8344 covered insureds.
8345 (3) A covered carrier that elects not to renew a health benefit plan under Subsection (1)(f)
8346 is prohibited from writing new business subject to this chapter in this state for a period of five
8347 years from the date of notice to the commissioner.
8348 (4) When a covered carrier is doing business subject to this chapter in one service area of
8349 this state, Subsections (1) through (3) apply only to the covered carrier's operations in that service
8350 area.
8351 (5) Health benefit plans covering covered insureds shall comply with Subsections (5)(a)
8352 and (b).
8353 (a) (i) A health benefit plan may not deny, exclude, or limit benefits for a covered
8354 individual for losses incurred more than 12 months, or 18 months in the case of a late enrollee, as
8355 defined in P.L. 104-191, 110 Stat. 1940, Sec. 101, following the effective date of the individual's
8356 coverage due to a preexisting condition.
8357 (ii) A health benefit plan may not define a preexisting condition more restrictively than:
8358 (A) a condition for which medical advice, diagnosis, care, or treatment was recommended
8359 or received during the six months immediately preceding the earlier of:
8360 (I) the enrollment date; or
8361 (II) the effective date of coverage; or
8362 (B) for an individual insurance policy, a pregnancy existing on the effective date of
8363 coverage.
8364 (iii) An individual insurer shall offer a health benefit plan in compliance with Subsections

8365 (5)(a)(i) and (ii), and may, when the insurer and the insured mutually agree in writing to a
8366 condition-specific exclusion rider, offer to issue an individual policy that excludes a specific
8367 physical condition consistent with Subsections (5)(a)(iv) and (v).
8368 (iv) The commissioner shall establish, in rule, a list of nonlife threatening [~~and~~
8369 ~~nondegenerative~~] physical conditions that may be the subject of a condition-specific exclusion
8370 rider.
8371 (v) A condition-specific exclusion rider shall be limited to the excluded condition and may
8372 not extend to any secondary medical condition that may or may not be directly related to the
8373 excluded condition.
8374 (b) (i) A covered carrier shall waive any time period applicable to a preexisting condition
8375 exclusion or limitation period with respect to particular services in a health benefit plan for the
8376 period of time the individual was previously covered by public or private health insurance or by
8377 any other health benefit arrangement that provided benefits with respect to such services, provided
8378 that:
8379 (A) the previous coverage was continuous to a date not more than 63 full days prior to the
8380 effective date of the new coverage; and
8381 (B) the insured provides notification of previous coverage to the covered carrier within 36
8382 months of the coverage effective date if the insurer has previously requested such notification.
8383 (ii) The period of continuous coverage under Subsection (5)(b)(i)(A) may not include any
8384 waiting period for the effective date of the new coverage applied by the employer or the carrier.
8385 This Subsection (5)(b)(ii) does not preclude application of any waiting period applicable to all new
8386 enrollees under the plan.
8387 (iii) Credit for previous coverage as provided under Subsection (5)(b)(i)(A) need not be
8388 given for any condition which was previously excluded under a condition-specific exclusion rider.
8389 A new preexisting waiting period may be applied to any condition that was excluded by a rider
8390 under the terms of previous individual coverage.
8391 Section 190. Section **31A-32a-102** is amended to read:
8392 **31A-32a-102. Definitions.**
8393 As used in this chapter:
8394 (1) "Account administrator" means any of the following:
8395 (a) a depository institution as defined in Section 7-1-103;

8396 (b) a trust company as defined in Section 7-1-103;
8397 (c) an insurance company authorized to do business in this state under this title;
8398 (d) a third party administrator licensed under Section 31A-25-203; and
8399 (e) an employer if the employer has a self-insured health plan under ERISA.
8400 (2) "Account holder" means the resident individual who establishes a medical care savings
8401 account or for whose benefit a medical care savings account is established.
8402 (3) "Deductible" means the total deductible for an employee and all the dependents of that
8403 employee for a calendar year.
8404 (4) "Dependent" means the same as "dependent" under Section 31A-30-103.
8405 (5) "Eligible medical expense" means an expense paid by the taxpayer for:
8406 (a) medical care described in Section 213(d), Internal Revenue Code;
8407 (b) the purchase of a health coverage policy, certificate, or contract, including a qualified
8408 higher deductible health plan; or
8409 (c) premiums on long-term care insurance policies as defined in Section [~~31A-22-1402~~]
8410 <u>31A-1-301</u>.
8411 (6) "Employee" means the individual for whose benefit or for the benefit of whose
8412 dependents a medical care savings account is established. Employee includes a self-employed
8413 individual.
8414 (7) "ERISA" means the Employee Retirement Income Security Act of 1974, Public Law
8415 93-406, 88 Stat. 829.
8416 (8) "Higher deductible" means a deductible of not less than $1,000.
8417 (9) "Medical care savings account" or "account" means a trust account established at a
8418 depository institution in this state pursuant to a medical care savings account program to pay the
8419 eligible medical expenses of:
8420 (a) an employee or account holder; and
8421 (b) the dependents of the employee or account holder.
8422 (10) "Medical care savings account program" or "program" means one of the following
8423 programs:
8424 (a) a program established by an employer in which the employer:
8425 (i) purchases a qualified higher deductible health plan for the benefit of an employee and
8426 the employee's dependents; and

8427 (ii) contributes on behalf of an employee into a medical care savings account; or
8428 (b) a program established by an account holder in which the account holder:
8429 (i) purchases a qualified higher deductible health plan for the benefit of the account holder
8430 and the account holder's dependents; and
8431 (ii) contributes an amount to the medical care savings account.
8432 (11) "Qualified higher deductible health plan" means a health coverage policy, certificate,
8433 or contract that:
8434 (a) provides for payments for covered benefits that exceed the higher deductible; and
8435 (b) is purchased by:
8436 (i) an employer for the benefit of an employee for whom the employer makes deposits into
8437 a medical care savings account; or
8438 (ii) an account holder.
8439 Section 191. Section **31A-33-103.5** is amended to read:
8440 **31A-33-103.5. Powers of Fund -- Limitations.**
8441 (1) The fund may form or acquire subsidiaries or enter into a joint enterprise:
8442 (a) in accordance with Section 31A-33-107; and
8443 (b) except as limited by this section and applicable insurance rules and statutes.
8444 (2) Subject to applicable insurance rules and statutes, the fund may only offer:
8445 (a) workers' compensation insurance in Utah;
8446 (b) workers' compensation insurance in a state other than Utah to the extent necessary to:
8447 (i) accomplish its purpose under Subsection 31A-33-102(1)(b); and
8448 (ii) provide workers' compensation or occupational disease insurance coverage to Utah
8449 employers and their employees engaged in interstate commerce; and
8450 (c) workers' compensation products and services in Utah or other states.
8451 (3) Subject to applicable insurance rules and statutes, a subsidiary of the fund may:
8452 (a) offer workers' compensation insurance coverage only:
8453 (i) in a state other than Utah; and
8454 (ii) (A) to insure the following against liability for compensation based on job-related
8455 accidental injuries and occupational diseases[;]:
8456 (I) an employer, as defined in Section 34A-2-103, that has a majority of its employees, as
8457 defined in Section 34A-2-104, hired or regularly employed in Utah;

8458 (II) an employer, as defined in Section 34A-2-103, whose principal administrative office
8459 is located in Utah; or
8460 (III) a subsidiary or affiliate of an employer described in Subsection (3)(a)(ii)(A)(I) or (II);
8461 or
8462 (B) for a state fund organization that is not an admitted insurer in the other state:
8463 (I) on a fee for service basis; and
8464 (II) without bearing any insurance risk; and
8465 (b) offer workers' compensation products and services in Utah and other states.
8466 (4) The fund shall write workers' compensation insurance in accordance with Section
8467 31A-22-1001.
8468 (5) (a) The fund may enter into a joint enterprise that offers workers' compensation
8469 insurance and other coverage only in the state, provided:
8470 (i) the joint enterprise offers only property or liability insurance in addition to workers'
8471 compensation insurance;
8472 (ii) the fund may not bear any insurance risk associated with the insurance coverage other
8473 than risk associated with workers' compensation insurance; and
8474 (iii) the offer of other insurance shall be part of an insurance program that includes
8475 workers' compensation insurance coverage that is provided by the fund.
8476 (b) The fund or a subsidiary of the fund may not offer, or enter into a joint enterprise that
8477 offers, or otherwise participate in the offering of accident and health [or disability] insurance.
8478 Section 192. Section **31A-33-113** is amended to read:
8479 **31A-33-113. Cancellation of policies.**
8480 The Workers' Compensation Fund may cancel a policy [prior to the conclusion of the
8481 policy period only:] as provided in Section 31A-22-1002.
8482 [(1) (a) by agreeing to the cancellation with the policyholder; and]
8483 [(b) sending notice of the cancellation to the Labor Commission;]
8484 [(2) for nonpayment of premium, after 30 days' notice to:]
8485 [(a) the Labor Commission; and]
8486 [(b) the policyholder; or]
8487 [(3) for failure on the part of the policyholder to comply with the contractual provisions
8488 of the policy, after 30 days' notice to:]

8489 [~~(a) the Labor Commission; and~~]

8490 [~~(b) the policyholder.~~]

8491 Section 193. Section **34A-2-103** is amended to read:

8492 **34A-2-103. Employers enumerated and defined -- Regularly employed -- Statutory**
8493 **employers.**

8494 (1) (a) The state, and each county, city, town, and school district in the state are considered
8495 employers under this chapter and Chapter 3, Utah Occupational Disease Act.

8496 (b) For the purposes of the exclusive remedy in this chapter and Chapter 3, Utah
8497 Occupational Disease Act prescribed in Sections 34A-2-105 and 34A-3-102, the state is considered
8498 to be a single employer and includes any office, department, agency, authority, commission, board,
8499 institution, hospital, college, university, or other instrumentality of the state.

8500 (2) Except as provided in Subsection (4), each person, including each public utility and
8501 each independent contractor, who regularly employs one or more workers or operatives in the same
8502 business, or in or about the same establishment, under any contract of hire, express or implied, oral
8503 or written, is considered an employer under this chapter and Chapter 3, Utah Occupational Disease
8504 Act. As used in this Subsection (2):

8505 (a) "Independent contractor" means any person engaged in the performance of any work
8506 for another who, while so engaged, is:

8507 (i) independent of the employer in all that pertains to the execution of the work;

8508 (ii) not subject to the routine rule or control of the employer;

8509 (iii) engaged only in the performance of a definite job or piece of work; and

8510 (iv) subordinate to the employer only in effecting a result in accordance with the
8511 employer's design.

8512 (b) "Regularly" includes all employments in the usual course of the trade, business,
8513 profession, or occupation of the employer, whether continuous throughout the year or for only a
8514 portion of the year.

8515 (3) (a) The client company in an employee leasing arrangement under Title 58, Chapter
8516 59, Professional Employer Organization Licensing Act, is considered the employer of leased
8517 employees and shall secure workers' compensation benefits for them by complying with
8518 Subsection 34A-2-201(1) or (2) and commission rules.

8519 (b) Insurance carriers may underwrite workers' compensation secured in accordance with

8520 Subsection (3)(a) showing the leasing company as the named insured and each client company as
8521 an additional insured by means of individual endorsements.
8522 (c) Endorsements shall be filed with the division as directed by commission rule.
8523 (d) The division shall promptly inform the Division of Occupation and Professional
8524 Licensing within the Department of Commerce if the division has reason to believe that an
8525 employee leasing company is not in compliance with Subsection 34A-2-201(1) or (2) and
8526 commission rules.
8527 (4) A domestic employer who does not employ one employee or more than one employee
8528 at least 40 hours per week is not considered an employer under this chapter and Chapter 3, Utah
8529 Occupational Disease Act.
8530 (5) (a) As used in this Subsection (5):
8531 (i) (A) "agricultural employer" means a person who employs agricultural labor as defined
8532 in Subsections 35A-4-206(1) and (2) and does not include employment as provided in Subsection
8533 35A-4-206(3); and
8534 (B) notwithstanding Subsection (5)(a)(i)(A), only for purposes of determining who is a
8535 member of the employer's immediate family under Subsection (5)(a)(ii), if the agricultural
8536 employer is a corporation, partnership, or other business entity, "agricultural employer" means an
8537 officer, director, or partner of the business entity;
8538 (ii) "employer's immediate family" means:
8539 (A) an agricultural employer's:
8540 (I) spouse;
8541 (II) grandparent;
8542 (III) parent;
8543 (IV) sibling;
8544 (V) child;
8545 (VI) grandchild;
8546 (VII) nephew; or
8547 (VIII) niece;
8548 (B) a spouse of any person provided in Subsection [~~(4)~~] (5)(a)(ii)(A)(II) through (VIII);
8549 or
8550 (C) an individual who is similar to those listed in Subsections [~~(4)~~] (5)(a)(ii)(A) or (B) as

8551 defined by rules of the commission; and

8552 (iii) "non-immediate family" means a person who is not a member of the employer's

8553 immediate family.

8554 (b) For purposes of this chapter and Chapter 3, Utah Occupational Disease Act, an

8555 agricultural employer is not considered an employer of a member of the employer's immediate

8556 family.

8557 (c) For purposes of this chapter and Chapter 3, Utah Occupational Disease Act, an

8558 agricultural employer is not considered an employer of a non-immediate family employee if:

8559 (i) for the previous calendar year the agricultural employer's total annual payroll for all

8560 non-immediate family employees was less than $8,000; or

8561 (ii) (A) for the previous calendar year the agricultural employer's total annual payroll for

8562 all non-immediate family employees was equal to or greater than $8,000 but less than $50,000; and

8563 (B) the agricultural employer maintains insurance that covers job-related injuries of the

8564 employer's non-immediate family employees in at least the following amounts:

8565 (I) $300,000 liability insurance, as defined in Section 31A-1-301; and

8566 (II) $5,000 for [~~medical, hospital, and surgical~~] health care benefits similar to benefits

8567 under health care insurance as [~~described~~] defined in [~~Subsection~~] Section 31A-1-301[~~(50)(a)(ii)~~].

8568 (d) For purposes of this chapter and Chapter 3, Utah Occupational Disease Act, an

8569 agricultural employer is considered an employer of a non-immediate family employee if:

8570 (i) for the previous calendar year the agricultural employer's total annual payroll for all

8571 non-immediate family employees is equal to or greater than $50,000; or

8572 (ii) (A) for the previous year the agricultural employer's total payroll for non-immediate

8573 family employees was equal to or exceeds $8,000 but is less than $50,000; and

8574 (B) the agricultural employer fails to maintain the insurance required under Subsection

8575 (5)(c)(ii).

8576 (6) An employer of agricultural laborers or domestic servants who is not considered an

8577 employer under this chapter and Chapter 3, Utah Occupational Disease Act, may come under this

8578 chapter and Chapter 3, Utah Occupational Disease Act, by complying with:

8579 (a) this chapter and Chapter 3, Utah Occupational Disease Act; and

8580 (b) the rules of the commission.

8581 (7) (a) If any person who is an employer procures any work to be done wholly or in part

8582 for the employer by a contractor over whose work the employer retains supervision or control, and
8583 this work is a part or process in the trade or business of the employer, the contractor, all persons
8584 employed by the contractor, all subcontractors under the contractor, and all persons employed by
8585 any of these subcontractors, are considered employees of the original employer for the purposes
8586 of this chapter and Chapter 3, Utah Occupational Disease Act.
8587 (b) Any person who is engaged in constructing, improving, repairing, or remodelling a
8588 residence that the person owns or is in the process of acquiring as the person's personal residence
8589 may not be considered an employee or employer solely by operation of Subsection (7)(a).
8590 (c) A partner in a partnership or an owner of a sole proprietorship may not be considered
8591 an employee under Subsection (7)(a) if the employer who procures work to be done by the
8592 partnership or sole proprietorship obtains and relies on either:
8593 (i) a valid certification of the partnership's or sole proprietorship's compliance with Section
8594 34A-2-201 indicating that the partnership or sole proprietorship secured the payment of workers'
8595 compensation benefits pursuant to Section 34A-2-201; or
8596 (ii) if a partnership or sole proprietorship with no employees other than a partner of the
8597 partnership or owner of the sole proprietorship, a workers' compensation policy issued by an
8598 insurer pursuant to Subsection 31A-21-104(8) stating that:
8599 (A) the partnership or sole proprietorship is customarily engaged in an independently
8600 established trade, occupation, profession, or business; and
8601 (B) the partner or owner personally waives the partner's or owner's entitlement to the
8602 benefits of this chapter and Chapter 3, Utah Occupational Disease Act, in the operation of the
8603 partnership or sole proprietorship.
8604 (d) A director or officer of a corporation may not be considered an employee under
8605 Subsection (7)(a) if the director or officer is excluded from coverage under Subsection
8606 34A-2-104(4).
8607 (e) A contractor or subcontractor is not an employee of the employer under Subsection
8608 (7)(a), if the employer who procures work to be done by the contractor or subcontractor obtains
8609 and relies on either:
8610 (i) a valid certification of the contractor's or subcontractor's compliance with Section
8611 34A-2-201; or
8612 (ii) if a partnership, corporation, or sole proprietorship with no employees other than a

8613 partner of the partnership, officer of the corporation, or owner of the sole proprietorship, a workers'
8614 compensation policy issued by an insurer pursuant to Subsection 31A-21-104(8) stating that:
8615 (A) the partnership, corporation, or sole proprietorship is customarily engaged in an
8616 independently established trade, occupation, profession, or business; and
8617 (B) the partner, corporate officer, or owner personally waives the partner's, corporate
8618 officer's, or owner's entitlement to the benefits of this chapter and Chapter 3, Utah Occupational
8619 Disease Act, in the operation of the partnership's, corporation's, or sole proprietorship's enterprise
8620 under a contract of hire for services.
8621 Section 194. Section **58-67-501** is amended to read:
8622 **58-67-501. Unlawful conduct.**
8623 (1) "Unlawful conduct" includes, in addition to the definition in Section 58-1-501:
8624 (a) buying, selling, or fraudulently obtaining, any medical diploma, license, certificate, or
8625 registration;
8626 (b) aiding or abetting the buying, selling, or fraudulently obtaining of any medical diploma,
8627 license, certificate, or registration;
8628 (c) substantially interfering with a licensee's lawful and competent practice of medicine
8629 in accordance with this chapter by:
8630 (i) any person or entity that manages, owns, operates, or conducts a business having a
8631 direct or indirect financial interest in the licensee's professional practice; or
8632 (ii) anyone other than another physician licensed under this title, who is engaged in direct
8633 clinical care or consultation with the licensee in accordance with the standards and ethics of the
8634 profession of medicine; or
8635 (d) entering into a contract that limits a licensee's ability to advise the licensee's patients
8636 fully about treatment options or other issues that affect the health care of the licensee's patients.
8637 (2) "Unlawful conduct" does not include:
8638 (a) establishing, administering, or enforcing the provisions of a policy of [~~disability~~]
8639 accident and health insurance by an insurer doing business in this state in accordance with Title
8640 31A, Insurance Code;
8641 (b) adopting, implementing, or enforcing utilization management standards related to
8642 payment for a licensee's services, provided that:
8643 (i) utilization management standards adopted, implemented, and enforced by the payer

8644 have been approved by a physician or by a committee that contains one or more physicians; and
8645 (ii) the utilization management standards does not preclude a licensee from exercising
8646 independent professional judgment on behalf of the licensee's patients in a manner that is
8647 independent of payment considerations;
8648 (c) developing and implementing clinical practice standards that are intended to reduce
8649 morbidity and mortality or developing and implementing other medical or surgical practice
8650 standards related to the standardization of effective health care practices, provided that:
8651 (i) the practice standards and recommendations have been approved by a physician or by
8652 a committee that contains one or more physicians; and
8653 (ii) the practice standards do not preclude a licensee from exercising independent
8654 professional judgment on behalf of the licensee's patients in a manner that is independent of
8655 payment considerations;
8656 (d) requesting or recommending that a patient obtain a second opinion from a licensee;
8657 (e) conducting peer review, quality evaluation, quality improvement, risk management,
8658 or similar activities designed to identify and address practice deficiencies with health care
8659 providers, health care facilities, or the delivery of health care;
8660 (f) providing employment supervision or adopting employment requirements that do not
8661 interfere with the licensee's ability to exercise independent professional judgment on behalf of the
8662 licensee's patients, provided that employment requirements that may not be considered to interfere
8663 with an employed licensee's exercise of independent professional judgment include:
8664 (i) an employment requirement that restricts the licensee's access to patients with whom
8665 the licensee's employer does not have a contractual relationship, either directly or through contracts
8666 with one or more third-party payers; or
8667 (ii) providing compensation incentives that are not related to the treatment of any
8668 particular patient;
8669 (g) providing benefit coverage information, giving advice, or expressing opinions to a
8670 patient or to a family member of a patient to assist the patient or family member in making a
8671 decision about health care that has been recommended by a licensee; or
8672 (h) any otherwise lawful conduct that does not substantially interfere with the licensee's
8673 ability to exercise independent professional judgment on behalf of the licensee's patients and that
8674 does not constitute the practice of medicine as defined in this chapter.

8675 Section 195. Section **58-68-501** is amended to read:

8676 **58-68-501. Unlawful conduct.**

8677 (1) "Unlawful conduct" includes, in addition to the definition in Section 58-1-501:

8678 (a) buying, selling, or fraudulently obtaining any osteopathic medical diploma, license,

8679 certificate, or registration; and

8680 (b) aiding or abetting the buying, selling, or fraudulently obtaining of any osteopathic

8681 medical diploma, license, certificate, or registration;

8682 (c) substantially interfering with a licensee's lawful and competent practice of medicine

8683 in accordance with this chapter by:

8684 (i) any person or entity that manages, owns, operates, or conducts a business having a

8685 direct or indirect financial interest in the licensee's professional practice; or

8686 (ii) anyone other than another physician licensed under this title, who is engaged in direct

8687 clinical care or consultation with the licensee in accordance with the standards and ethics of the

8688 profession of medicine; or

8689 (d) entering into a contract that limits a licensee's ability to advise the licensee's patients

8690 fully about treatment options or other issues that affect the health care of the licensee's patients.

8691 (2) "Unlawful conduct" does not include:

8692 (a) establishing, administering, or enforcing the provisions of a policy of [~~disability~~]

8693 accident and health insurance by an insurer doing business in this state in accordance with Title

8694 31A, Insurance Code;

8695 (b) adopting, implementing, or enforcing utilization management standards related to

8696 payment for a licensee's services, provided that:

8697 (i) utilization management standards adopted, implemented, and enforced by the payer

8698 have been approved by a physician or by a committee that contains one or more physicians; and

8699 (ii) the utilization management standards does not preclude a licensee from exercising

8700 independent professional judgment on behalf of the licensee's patients in a manner that is

8701 independent of payment considerations;

8702 (c) developing and implementing clinical practice standards that are intended to reduce

8703 morbidity and mortality or developing and implementing other medical or surgical practice

8704 standards related to the standardization of effective health care practices, provided that:

8705 (i) the practice standards and recommendations have been approved by a physician or by

8706 a committee that contains one or more physicians; and
8707 (ii) the practice standards do not preclude a licensee from exercising independent
8708 professional judgment on behalf of the licensee's patients in a manner that is independent of
8709 payment considerations;
8710 (d) requesting or recommending that a patient obtain a second opinion from a licensee;
8711 (e) conducting peer review, quality evaluation, quality improvement, risk management,
8712 or similar activities designed to identify and address practice deficiencies with health care
8713 providers, health care facilities, or the delivery of health care;
8714 (f) providing employment supervision or adopting employment requirements that do not
8715 interfere with the licensee's ability to exercise independent professional judgment on behalf of the
8716 licensee's patients, provided that employment requirements that may not be considered to interfere
8717 with an employed licensee's exercise of independent professional judgment include:
8718 (i) an employment requirement that restricts the licensee's access to patients with whom
8719 the licensee's employer does not have a contractual relationship, either directly or through contracts
8720 with one or more third-party payers; or
8721 (ii) providing compensation incentives that are not related to the treatment of any
8722 particular patient;
8723 (g) providing benefit coverage information, giving advice, or expressing opinions to a
8724 patient or to a family member of a patient to assist the patient or family member in making a
8725 decision about health care that has been recommended by a licensee; or
8726 (h) any otherwise lawful conduct that does not substantially interfere with the licensee's
8727 ability to exercise independent professional judgment on behalf of the licensee's patients and that
8728 does not constitute the practice of medicine as defined in this chapter.
8729 Section 196. Section **59-10-114** is amended to read:
8730 **59-10-114. Additions to and subtractions from federal taxable income of an**
8731 **individual.**
8732 (1) There shall be added to federal taxable income of a resident or nonresident individual:
8733 (a) the amount of any income tax imposed by this or any predecessor Utah individual
8734 income tax law and the amount of any income tax imposed by the laws of another state, the District
8735 of Columbia, or a possession of the United States, to the extent deducted from federal adjusted
8736 gross income, as defined by Section 62, Internal Revenue Code, in determining federal taxable

8737 income;
8738 (b) a lump sum distribution allowable as a deduction under Section 402(d)(3), Internal
8739 Revenue Code, to the extent deductible under Section 62(a)(8), Internal Revenue Code, in
8740 determining federal adjusted gross income;
8741 (c) 25% of the personal exemptions, as defined and calculated in the Internal Revenue
8742 Code;
8743 (d) a withdrawal from a medical care savings account and any penalty imposed in the
8744 taxable year if:
8745 (i) the taxpayer did not deduct or include the amounts on his federal tax return pursuant
8746 to Section 220, Internal Revenue Code; and
8747 (ii) the withdrawal is subject to Subsections 31A-32a-105(1) and (2); and
8748 (e) the amount refunded to a participant under Title 53B, Chapter 8a, Higher Education
8749 Savings Incentive Program, in the year in which the amount is refunded.
8750 (2) There shall be subtracted from federal taxable income of a resident or nonresident
8751 individual:
8752 (a) the interest or dividends on obligations or securities of the United States and its
8753 possessions or of any authority, commission, or instrumentality of the United States, to the extent
8754 includable in gross income for federal income tax purposes but exempt from state income taxes
8755 under the laws of the United States, but the amount subtracted under this subsection shall be
8756 reduced by any interest on indebtedness incurred or continued to purchase or carry the obligations
8757 or securities described in this subsection, and by any expenses incurred in the production of
8758 interest or dividend income described in this subsection to the extent that such expenses, including
8759 amortizable bond premiums, are deductible in determining federal taxable income;
8760 (b) 1/2 of the net amount of any income tax paid or payable to the United States after all
8761 allowable credits, as reported on the United States individual income tax return of the taxpayer for
8762 the same taxable year;
8763 (c) the amount of adoption expenses which, for purposes of this subsection, means any
8764 actual medical and hospital expenses of the mother of the adopted child which are incident to the
8765 child's birth and any welfare agency, child placement service, legal, and other fees or costs relating
8766 to the adoption;
8767 (d) amounts received by taxpayers under age 65 as retirement income which, for purposes

8768 of this section, means pensions and annuities, paid from an annuity contract purchased by an
8769 employer under a plan which meets the requirements of Section 404(a)(2), Internal Revenue Code,
8770 or purchased by an employee under a plan which meets the requirements of Section 408, Internal
8771 Revenue Code, or paid by the United States, a state, or political subdivision thereof, or the District
8772 of Columbia, to the employee involved or the surviving spouse;
8773 (e) for each taxpayer age 65 or over before the close of the taxable year, a $7,500 personal
8774 retirement exemption;
8775 (f) 75% of the amount of the personal exemption, as defined and calculated in the Internal
8776 Revenue Code, for each dependent child with a disability and adult with a disability who is
8777 claimed as a dependent on a taxpayer's return;
8778 (g) any amount included in federal taxable income that was received pursuant to any
8779 federal law enacted in 1988 to provide reparation payments, as damages for human suffering, to
8780 United States citizens and resident aliens of Japanese ancestry who were interned during World
8781 War II;
8782 (h) subject to the limitations of Subsection (3)(e), amounts a taxpayer pays during the
8783 taxable year for health care insurance, as defined in Title 31A, Chapter 1, General Provisions:
8784 (i) for:
8785 (A) the taxpayer;
8786 (B) the taxpayer's spouse; and
8787 (C) the taxpayer's dependents; and
8788 (ii) to the extent the taxpayer does not deduct the amounts under Section 125, 162, or 213,
8789 Internal Revenue Code, in determining federal taxable income for the taxable year;
8790 (i) except as otherwise provided in this subsection, the amount of a contribution made in
8791 the tax year on behalf of the taxpayer to a medical care savings account and interest earned on a
8792 contribution to a medical care savings account established pursuant to Title 31A, Chapter 32a,
8793 Medical Care Savings Account Act, to the extent the contribution is accepted by the account
8794 administrator as provided in the Medical Care Savings Account Act, and if the taxpayer did not
8795 deduct or include amounts on his federal tax return pursuant to Section 220, Internal Revenue
8796 Code. A contribution deductible under this subsection may not exceed either of the following:
8797 (i) the maximum contribution allowed under the Medical Care Savings Account Act for
8798 the tax year multiplied by two for taxpayers who file a joint return, if neither spouse is covered by

8799 health care insurance as defined in Section 31A-1-301 or self-funded plan that covers the other
8800 spouse, and each spouse has a medical care savings account; or
8801 (ii) the maximum contribution allowed under the Medical Care Savings Account Act for
8802 the tax year for taxpayers:
8803 (A) who do not file a joint return; or
8804 (B) who file a joint return, but do not qualify under Subsection (2)(i)(i); and
8805 (j) the amount included in federal taxable income that was derived from money paid by
8806 the taxpayer to the program fund under Title 53B, Chapter 8a, Higher Education Savings Incentive
8807 Program, not to exceed amounts determined under Subsection 53B-8a-106(1)(d) and investment
8808 income earned on participation agreements under Subsection 53B-8a-106(1) when used for higher
8809 education costs of the beneficiary;
8810 (k) for tax years beginning on or after January 1, 2000, any amounts paid for premiums
8811 on long-term care insurance policies as defined in Section [~~31A-22-1402~~] 31A-1-301 to the extent
8812 the amounts paid for long-term care insurance were not deducted under Section 213, Internal
8813 Revenue Code, in determining federal taxable income; and
8814 (l) for taxable years beginning on or after January 1, 2000, if the conditions of Subsection
8815 (4)(a) are met, the amount of income derived by a Ute tribal member:
8816 (i) during a time period that the Ute tribal member resides on homesteaded land
8817 diminished from the Uintah and Ouray Reservation; and
8818 (ii) from a source within the Uintah and Ouray Reservation.
8819 (3) (a) For purposes of Subsection (2)(d), the amount of retirement income subtracted for
8820 taxpayers under 65 shall be the lesser of the amount included in federal taxable income, or $4,800,
8821 except that:
8822 (i) for married taxpayers filing joint returns, for each $1 of adjusted gross income earned
8823 over $32,000, the amount of the retirement income exemption that may be subtracted shall be
8824 reduced by 50 cents;
8825 (ii) for married taxpayers filing separate returns, for each $1 of adjusted gross income
8826 earned over $16,000, the amount of the retirement income exemption that may be subtracted shall
8827 be reduced by 50 cents; and
8828 (iii) for individual taxpayers, for each $1 of adjusted gross income earned over $25,000,
8829 the amount of the retirement income exemption that may be subtracted shall be reduced by 50

8830 cents.

8831 (b) For purposes of Subsection (2)(e), the amount of the personal retirement exemption
8832 shall be further reduced according to the following schedule:

8833 (i) for married taxpayers filing joint returns, for each $1 of adjusted gross income earned
8834 over $32,000, the amount of the personal retirement exemption shall be reduced by 50 cents;

8835 (ii) for married taxpayers filing separate returns, for each $1 of adjusted gross income
8836 earned over $16,000, the amount of the personal retirement exemption shall be reduced by 50
8837 cents; and

8838 (iii) for individual taxpayers, for each $1 of adjusted gross income earned over $25,000,
8839 the amount of the personal retirement exemption shall be reduced by 50 cents.

8840 (c) For purposes of Subsections (3)(a) and (b), adjusted gross income shall be calculated
8841 by adding to federal adjusted gross income any interest income not otherwise included in federal
8842 adjusted gross income.

8843 (d) For purposes of determining ownership of items of retirement income common law
8844 doctrine will be applied in all cases even though some items may have originated from service or
8845 investments in a community property state. Amounts received by the spouse of a living retiree
8846 because of the retiree's having been employed in a community property state are not deductible as
8847 retirement income of such spouse.

8848 (e) For purposes of Subsection (2)(h), a subtraction for an amount paid for health care
8849 insurance as defined in Title 31A, Chapter 1, General Provisions, is not allowed:

8850 (i) for an amount that is reimbursed or funded in whole or in part by the federal
8851 government, the state, or an agency or instrumentality of the federal government or the state; and

8852 (ii) for a taxpayer who is eligible to participate in a health plan maintained and funded in
8853 whole or in part by the taxpayer's employer or the taxpayer's spouse's employer.

8854 (4) (a) A subtraction for an amount described in Subsection (2)(l) is allowed only if:

8855 (i) the taxpayer is a Ute tribal member; and

8856 (ii) the governor and the Ute tribe execute and maintain an agreement meeting the
8857 requirements of this Subsection (4).

8858 (b) The agreement described in Subsection (4)(a):

8859 (i) may not:

8860 (A) authorize the state to impose a tax in addition to a tax imposed under this chapter;

8861 (B) provide a subtraction under this section greater than or different from the subtraction
8862 described in Subsection (2)(l); or
8863 (C) affect the power of the state to establish rates of taxation; and
8864 (ii) shall:
8865 (A) provide for the implementation of the subtraction described in Subsection (2)(l);
8866 (B) be in writing;
8867 (C) be signed by:
8868 (I) the governor; and
8869 (II) the chair of the Business Committee of the Ute tribe;
8870 (D) be conditioned on obtaining any approval required by federal law; and
8871 (E) state the effective date of the agreement.
8872 (c) (i) The governor shall report to the commission by no later than February 1 of each year
8873 regarding whether or not an agreement meeting the requirements of this Subsection (4) is in effect.
8874 (ii) If an agreement meeting the requirements of this Subsection (4) is terminated, the
8875 subtraction permitted under Subsection (2)(l) is not allowed for taxable years beginning on or after
8876 the January 1 following the termination of the agreement.
8877 (d) For purposes of Subsection (2)(l) and in accordance with Title 63, Chapter 46a, Utah
8878 Administrative Rulemaking Act, the commission may make rules:
8879 (i) for determining whether income is derived from a source within the Uintah and Ouray
8880 Reservation; and
8881 (ii) that are substantially similar to how federal adjusted gross income derived from Utah
8882 sources is determined under Section 59-10-117.
8883 Section 197. Section **62A-11-326.1** is amended to read:
8884 **62A-11-326.1. Enrollment of child in accident and health insurance plan -- Order**
8885 **-- Notice.**
8886 (1) The office may issue a notice to existing and future employers or unions to enroll a
8887 dependent child in [~~a disability~~] an accident and health insurance plan that is available through
8888 [~~his~~] the dependent child's parent or legal guardian's employer or union, when the following
8889 conditions are satisfied:
8890 (a) the parent or legal guardian is already required to obtain insurance coverage for the
8891 child by a prior court or administrative order; and

8892 (b) the parent or legal guardian has failed to provide written proof to the office that:
8893 (i) the child has been enrolled in [~~a disability~~] an accident and health insurance plan in
8894 accordance with the court or administrative order; or
8895 (ii) the coverage required by the order was not available at group rates through the
8896 employer or union 30 or more days prior to the date of the mailing of the notice to enroll.
8897 (2) The office shall provide concurrent notice to the parent or legal guardian in accordance
8898 with Section 62A-11-304.4 of:
8899 (a) the notice to enroll sent to the employer or union; and
8900 (b) the opportunity to contest the enrollment due to a mistake of fact by filing a written
8901 request for an adjudicative proceeding with the office within 15 days of the notice being sent.
8902 (3) A notice to enroll shall result in the enrollment of the child in the parent's [~~disability~~]
8903 accident and health insurance plan, unless the parent successfully contests the notice based on a
8904 mistake of fact.
8905 (4) A notice to enroll issued under this section may be considered a "qualified medical
8906 support order" for the purposes of enrolling a dependent child in a group [~~disability~~] accident and
8907 health insurance plan as defined in Section 609(a), Federal Employee Retirement Income Security
8908 Act of 1974.
8909 Section 198. Section **62A-11-326.2** is amended to read:
8910 **62A-11-326.2. Compliance with order -- Enrollment of dependent child for**
8911 **insurance.**
8912 (1) An employer or union shall comply with a notice to enroll issued by the office under
8913 Section 62A-11-326.1 by enrolling the dependent child that is the subject of the notice in the:
8914 (a) [~~disability~~] accident and health insurance plan in which the parent or legal guardian is
8915 enrolled, if the plan satisfies the prior court or administrative order; or
8916 (b) least expensive plan, assuming equivalent benefits, offered by the employer or union
8917 that complies with the prior court or administrative order which provides coverage [~~which~~] that
8918 is reasonably accessible to the dependent child.
8919 (2) The employer, union, or insurer may not refuse to enroll a dependent child pursuant
8920 to a notice to enroll because a parent or legal guardian has not signed an enrollment application.
8921 (3) Upon enrollment of the dependent child, the employer shall deduct the appropriate
8922 premiums from the parent or legal guardian's wages and remit them directly to the insurer.

8923 (4) The insurer shall provide proof of insurance to the office upon request.
8924 (5) The signature of the custodial parent of the insured dependent is a valid authorization
8925 to the insurer for purposes of processing any insurance reimbursement claim.
8926 Section 199. Section **63-25a-413** is amended to read:
8927 **63-25a-413. Collateral sources.**
8928 (1) Collateral source shall include any source of benefits or advantages for economic loss
8929 otherwise reparable under this chapter which the victim or claimant has received, or which is
8930 readily available to the victim from:
8931 (a) the offender;
8932 (b) the insurance of the offender;
8933 (c) the United States government or any of its agencies, a state or any of its political
8934 subdivisions, or an instrumentality of two or more states, except in the case on nonobligatory
8935 state-funded programs;
8936 (d) social security, Medicare, and Medicaid;
8937 (e) state-required temporary nonoccupational income replacement insurance or disability
8938 income insurance;
8939 (f) workers' compensation;
8940 (g) wage continuation programs of any employer;
8941 (h) proceeds of a contract of insurance payable to the victim for the loss he sustained
8942 because of the criminally injurious conduct;
8943 (i) a contract providing prepaid hospital and other health care services or benefits for
8944 disability; or
8945 (j) veteran's benefits, including veteran's hospitalization benefits.
8946 (2) (a) An order of restitution shall not be considered readily available as a collateral
8947 source.
8948 (b) Receipt of an award of reparations under this chapter shall be considered an assignment
8949 of the victim's rights to restitution from the offender.
8950 (3) The victim shall not discharge a claim against a person or entity without the state's
8951 written permission and shall fully cooperate with the state in pursuing its right of reimbursement,
8952 including providing the state with any evidence in his possession.
8953 (4) The state's right of reimbursement applies regardless of whether the victim has been

8954 fully compensated for his losses.

8955 (5) Notwithstanding the collateral source provisions in [~~Subsections~~] Subsection (1) and
8956 Subsection 63-25a-412(1)(a) [~~and 63-25a-413(1)~~], a victim of a sexual offense who requests
8957 testing of himself may be reimbursed for the costs of the HIV test only as provided in Subsection
8958 76-5-503(4).

8959 Section 200. Section **63-55-231** is amended to read:

8960 **63-55-231. Repeal dates, Title 31A.**

8961 (1) Section 31A-2-208.5, Comparison tables, is repealed July 1, 2005.

8962 (2) Section 31A-2-217, Coordination with other states, is repealed July 1, 2003.

8963 [~~(2)~~] (3) Section 31A-22-315, Motor Vehicle Insurance Reporting, is repealed July 1,
8964 2010.

8965 [~~(3)~~] (4) Section 31A-22-625, Catastrophic Coverage of Mental Health Conditions, is
8966 repealed July 1, 2011.

8967 [~~(4)~~] (5) Title 31A, Chapter 31, Insurance Fraud Act, is repealed July 1, 2007.

8968 Section 201. Section **67-22-1** is amended to read:

8969 **67-22-1. Compensation -- Constitutional offices.**

8970 (1) The Legislature fixes salaries for the constitutional offices as follows:

8971 (a) Governor $96,700

8972 (b) Lieutenant Governor $75,200

8973 (c) Attorney General $81,300

8974 (d) State Auditor $77,600

8975 (e) State Treasurer $75,200

8976 (2) The Legislature fixes benefits for the constitutional offices as follows:

8977 (a) Governor:

8978 (i) a vehicle for official and personal use;

8979 (ii) housing;

8980 (iii) household and security staff;

8981 (iv) household expenses;

8982 (v) retirement benefits as provided in Title 49;

8983 (vi) health insurance;

8984 (vii) dental insurance;

8985 (viii) basic life insurance;
8986 (ix) workers' compensation;
8987 (x) required employer contribution to Social Security;
8988 (xi) long-term disability <u>income</u> insurance; and
8989 (xii) the same additional state paid life insurance available to other noncareer service
8990 employees.
8991 (b) Lieutenant governor, attorney general, state auditor, and state treasurer:
8992 (i) a vehicle for official and personal use;
8993 (ii) the option of participating in a state retirement system established by Title 49, Chapter
8994 2, Public Employees' Retirement Act, or Chapter 3, Public Employees' Noncontributory
8995 Retirement Act, or in a deferred compensation plan administered by the State Retirement Office,
8996 in accordance with the Internal Revenue Code and its accompanying rules and regulations;
8997 (iii) health insurance;
8998 (iv) dental insurance;
8999 (v) basic life insurance;
9000 (vi) workers' compensation;
9001 (vii) required employer contribution to social security;
9002 (viii) long-term disability <u>income</u> insurance; and
9003 (ix) the same additional state paid life insurance available to other noncareer service
9004 employees.
9005 (c) Each constitutional office shall pay the cost of the additional state-paid life insurance
9006 for its constitutional officer from its existing budget.
9007 Section 202. Section **67-22-2** is amended to read:
9008 **67-22-2. Compensation -- Other state officers.**
9009 (1) The governor shall establish salaries for the following state officers within the
9010 following salary ranges fixed by the Legislature:

	State Officer	Salary Range
9011		
9012	Director, Health Policy Commission	$57,900 - $78,400
9013	Commissioner of Agriculture and Food	$62,100 - $84,100
9014	Commissioner of Insurance	$62,100 - $84,100
9015	Commissioner of the Labor Commission	$62,100 - $84,100

9016 Director, Alcoholic Beverage Control
9017 Commission $62,100 - $84,100
9018 Commissioner, Department of
9019 Financial Institutions $62,100 - $84,100
9020 Members, Board of Pardons and Parole $62,100 - $84,100
9021 Executive Director, Department
9022 of Commerce $62,100 - $84,100
9023 Executive Director, Commission on
9024 Criminal and Juvenile Justice $62,100 - $84,100
9025 Adjutant General $62,100 - $84,100
9026 Chair, Tax Commission $67,200 - $90,700
9027 Commissioners, Tax Commission $67,200 - $90,700
9028 Executive Director, Department of
9029 Community and Economic
9030 Development $67,200 - $90,700
9031 Executive Director, Tax Commission $67,200 - $90,700
9032 Chair, Public Service Commission $67,200 - $90,700
9033 Commissioner, Public Service Commission $67,200 - $90,700
9034 Executive Director, Department
9035 of Corrections $73,100 - $98,700
9036 Commissioner, Department of Public Safety $73,100 - $98,700
9037 Executive Director, Department of
9038 Natural Resources $73,100 - $98,700
9039 Director, Office of Planning
9040 and Budget $73,100 - $98,700
9041 Executive Director, Department of
9042 Administrative Services $73,100 - $98,700
9043 Executive Director, Department of
9044 Human Resource Management $73,100 - $98,700
9045 Executive Director, Department of
9046 Environmental Quality $73,100 - $98,700

9047 State Olympic Officer $79,600 - $107,500
9048 Executive Director, Department of $79,600 - $107,500
9049 Workforce Services
9050 Executive Director, Department of
9051 Health $79,600 - $107,500
9052 Executive Director, Department
9053 of Human Services $79,600 - $107,500
9054 Executive Director, Department
9055 of Transportation $79,600 - $107,500
9056 Chief Information Officer $79,600 - $107,500
9057 (2) (a) The Legislature fixes benefits for the state offices outlined in Subsection (1) as
9058 follows:
9059 (i) the option of participating in a state retirement system established by Title 49, Utah
9060 State Retirement Act, or in a deferred compensation plan administered by the State Retirement
9061 Office in accordance with the Internal Revenue Code and its accompanying rules and regulations;
9062 (ii) health insurance;
9063 (iii) dental insurance;
9064 (iv) basic life insurance;
9065 (v) unemployment compensation;
9066 (vi) workers' compensation;
9067 (vii) required employer contribution to Social Security;
9068 (viii) long-term disability income insurance;
9069 (ix) the same additional state-paid life insurance available to other noncareer service
9070 employees;
9071 (x) the same severance pay available to other noncareer service employees;
9072 (xi) the same sick leave, converted sick leave, educational allowances, and holidays
9073 granted to Schedule B state employees, and the same annual leave granted to Schedule B state
9074 employees with more than ten years of state service;
9075 (xii) the option to convert accumulated sick leave to cash or insurance benefits as provided
9076 by law or rule upon resignation or retirement according to the same criteria and procedures applied
9077 to Schedule B state employees;

9078 (xiii) the option to purchase additional life insurance at group insurance rates according
9079 to the same criteria and procedures applied to Schedule B state employees; and
9080 (xiv) professional memberships if being a member of the professional organization is a
9081 requirement of the position.
9082 (b) Each department shall pay the cost of additional state-paid life insurance for its
9083 executive director from its existing budget.
9084 (3) The Legislature fixes the following additional benefits:
9085 (a) for the executive director of the State Tax Commission a vehicle for official and
9086 personal use;
9087 (b) for the executive director of the Department of Transportation a vehicle for official and
9088 personal use;
9089 (c) for the executive director of the Department of Natural Resources a vehicle for
9090 commute and official use;
9091 (d) for the Commissioner of Public Safety:
9092 (i) an accidental death insurance policy if POST certified; and
9093 (ii) a public safety vehicle for official and personal use;
9094 (e) for the executive director of the Department of Corrections:
9095 (i) an accidental death insurance policy if POST certified; and
9096 (ii) a public safety vehicle for official and personal use;
9097 (f) for the Adjutant General a vehicle for official and personal use; and
9098 (g) for each member of the Board of Pardons and Parole a vehicle for commute and official
9099 use.
9100 (4) (a) The governor has the discretion to establish a specific salary for each office listed
9101 in Subsection (1), and, within that discretion, may provide salary increases within the range fixed
9102 by the Legislature.
9103 (b) The governor shall apply the same overtime regulations applicable to other FLSA
9104 exempt positions.
9105 (c) The governor may develop standards and criteria for reviewing the performance of the
9106 state officers listed in Subsection (1).
9107 (5) Salaries for other Schedule A employees, as defined in Section 67-19-15, which are
9108 not provided for in this chapter, or in Title 67, Chapter 8, Utah Executive and Judicial Salary Act,

9109 shall be established as provided in Section 67-19-15.

9110 Section 203. Section **78-14-4.5** is amended to read:

9111 **78-14-4.5. Amount of award reduced by amounts of collateral sources available to**
9112 **plaintiff -- No reduction where subrogation right exists -- Collateral sources defined --**
9113 **Procedure to preserve subrogation rights -- Evidence admissible -- Exceptions.**

9114 (1) In all malpractice actions against health care providers as defined in Section 78-14-3
9115 in which damages are awarded to compensate the plaintiff for losses sustained, the court shall
9116 reduce the amount of such award by the total of all amounts paid to the plaintiff from all collateral
9117 sources which are available to him; however, there shall be no reduction for collateral sources for
9118 which a subrogation right exists as provided in this section nor shall there be a reduction for any
9119 collateral payment not included in the award of damages. Upon a finding of liability and an
9120 awarding of damages by the trier of fact, the court shall receive evidence concerning the total
9121 amounts of collateral sources which have been paid to or for the benefit of the plaintiff or are
9122 otherwise available to him. The court shall also take testimony of any amount which has been
9123 paid, contributed, or forfeited by, or on behalf of the plaintiff or members of his immediate family
9124 to secure his right to any collateral source benefit which he is receiving as a result of his injury,
9125 and shall offset any reduction in the award by such amounts. No evidence shall be received and
9126 no reduction made with respect to future collateral source benefits except as specified in
9127 Subsection (4).

9128 (2) For purposes of this section "collateral source" means payments made to or for the
9129 benefit of the plaintiff for:

9130 (a) medical expenses and disability payments payable under the United States Social
9131 Security Act, any federal, state, or local income disability act, or any other public program, except
9132 the federal programs which are required by law to seek subrogation;

9133 (b) any health, sickness, or income [disability] replacement insurance, automobile accident
9134 insurance that provides health benefits or income [disability] replacement coverage, and any other
9135 similar insurance benefits, except life insurance benefits available to the plaintiff, whether
9136 purchased by the plaintiff or provided by others;

9137 (c) any contract or agreement of any person, group, organization, partnership, or
9138 corporation to provide, pay for, or reimburse the costs of hospital, medical, dental, or other health
9139 care services, except benefits received as gifts, contributions, or assistance made gratuitously; and

9140 (d) any contractual or voluntary wage continuation plan provided by employers or any
9141 other system intended to provide wages during a period of disability.
9142 (3) To preserve subrogation rights for amounts paid or received prior to settlement or
9143 judgment, a provider of collateral sources shall serve at least 30 days before settlement or trial of
9144 the action a written notice upon each health care provider against whom the malpractice action has
9145 been asserted. The written notice shall state the name and address of the provider of collateral
9146 sources, the amount of collateral sources paid, the names and addresses of all persons who received
9147 payment, and the items and purposes for which payment has been made.
9148 (4) Evidence is admissible of government programs that provide payments or benefits
9149 available in the future to or for the benefit of the plaintiff to the extent available irrespective of the
9150 recipient's ability to pay. Evidence of the likelihood or unlikelihood that such programs, payments,
9151 or benefits will be available in the future is also admissible. The trier of fact may consider such
9152 evidence in determining the amount of damages awarded to a plaintiff for future expenses.
9153 (5) [~~No~~] A provider of collateral sources is not entitled to recover the amounts of such
9154 benefits from a health care provider, the plaintiff, or any other person or entity as reimbursement
9155 for collateral source payments made prior to settlement or judgment, including any payments made
9156 under Title 26, Chapter 19, Medical Benefits Recovery Act, except to the extent that subrogation
9157 rights to amounts paid prior to settlement or judgment are preserved as provided in this section.
9158 All policies of insurance providing benefits affected by this section are construed in accordance
9159 with this section.
9160 Section 204. Section **78-45-7.5** is amended to read:
9161 **78-45-7.5. Determination of gross income -- Imputed income.**
9162 (1) As used in the guidelines, "gross income" includes:
9163 (a) prospective income from any source, including nonearned sources, except under
9164 Subsection (3); and
9165 (b) income from salaries, wages, commissions, royalties, bonuses, rents, gifts from anyone,
9166 prizes, dividends, severance pay, pensions, interest, trust income, alimony from previous
9167 marriages, annuities, capital gains, social security benefits, workers' compensation benefits,
9168 unemployment compensation, income replacement disability insurance benefits, and payments
9169 from "nonmeans-tested" government programs.
9170 (2) Income from earned income sources is limited to the equivalent of one full-time

9171 40-hour job. However, if and only if during the time prior to the original support order, the parent
9172 normally and consistently worked more than 40 hours at his job, the court may consider this extra
9173 time as a pattern in calculating the parent's ability to provide child support.
9174 (3) Specifically excluded from gross income are:
9175 (a) cash assistance provided under Title 35A, Chapter 3, Part 3, Family Employment
9176 Program;
9177 (b) benefits received under a housing subsidy program, the Job Training Partnership Act,
9178 Supplemental Security Income, Social Security Disability Insurance, Medicaid, Food Stamps, or
9179 General Assistance; and
9180 (c) other similar means-tested welfare benefits received by a parent.
9181 (4) (a) Gross income from self-employment or operation of a business shall be calculated
9182 by subtracting necessary expenses required for self-employment or business operation from gross
9183 receipts. The income and expenses from self-employment or operation of a business shall be
9184 reviewed to determine an appropriate level of gross income available to the parent to satisfy a child
9185 support award. Only those expenses necessary to allow the business to operate at a reasonable
9186 level may be deducted from gross receipts.
9187 (b) Gross income determined under this subsection may differ from the amount of business
9188 income determined for tax purposes.
9189 (5) (a) When possible, gross income should first be computed on an annual basis and then
9190 recalculated to determine the average gross monthly income.
9191 (b) Each parent shall provide verification of current income. Each parent shall provide
9192 year-to-date pay stubs or employer statements and complete copies of tax returns from at least the
9193 most recent year unless the court finds the verification is not reasonably available. Verification
9194 of income from records maintained by the Department of Workforce Services may be substituted
9195 for pay stubs, employer statements, and income tax returns.
9196 (c) Historical and current earnings shall be used to determine whether an
9197 underemployment or overemployment situation exists.
9198 (6) Gross income includes income imputed to the parent under Subsection (7).
9199 (7) (a) Income may not be imputed to a parent unless the parent stipulates to the amount
9200 imputed, the party defaults, or, in contested cases, a hearing is held and a finding made that the
9201 parent is voluntarily unemployed or underemployed.

9202 (b) If income is imputed to a parent, the income shall be based upon employment potential
9203 and probable earnings as derived from work history, occupation qualifications, and prevailing
9204 earnings for persons of similar backgrounds in the community, or the median earning for persons
9205 in the same occupation in the same geographical area as found in the statistics maintained by the
9206 Bureau of Labor Statistics.
9207 (c) If a parent has no recent work history or their occupation is unknown, income shall be
9208 imputed at least at the federal minimum wage for a 40-hour work week. To impute a greater
9209 income, the judge in a judicial proceeding or the presiding officer in an administrative proceeding
9210 shall enter specific findings of fact as to the evidentiary basis for the imputation.
9211 (d) Income may not be imputed if any of the following conditions exist:
9212 (i) the reasonable costs of child care for the parents' minor children approach or equal the
9213 amount of income the custodial parent can earn;
9214 (ii) a parent is physically or mentally disabled to the extent he cannot earn minimum wage;
9215 (iii) a parent is engaged in career or occupational training to establish basic job skills; or
9216 (iv) unusual emotional or physical needs of a child require the custodial parent's presence
9217 in the home.
9218 (8) (a) Gross income may not include the earnings of a minor child who is the subject of
9219 a child support award nor benefits to a minor child in the child's own right such as Supplemental
9220 Security Income.
9221 (b) Social Security benefits received by a child due to the earnings of a parent shall be
9222 credited as child support to the parent upon whose earning record it is based, by crediting the
9223 amount against the potential obligation of that parent. Other unearned income of a child may be
9224 considered as income to a parent depending upon the circumstances of each case.
9225 Section 205. **Repealer.**
9226 This act repeals:
9227 Section **31A-8-210, Solvency standards.**
9228 Section **31A-8-212, Solvency standards transition.**