LEGISLATIVE GENERAL COUNSEL
₵ Approved for Filing: P. Owen ₵
₵ 01-29-02 12:20 PM ₵

S.B. 122
1st Sub. (Green)

Senator L. Steven Poulton proposes the following substitute bill:

INSURANCE LAW AMENDMENTS

2002 GENERAL SESSION

STATE OF UTAH

Sponsor: L. Steven Poulton

This act modifies the Insurance Code by amending definitions, making technical changes, and making the following changes. The act addresses disclosure of examination reports. The act addresses fees. The act addresses waiver of retaliatory requirements. The act addresses withdrawal from a line of insurance. The act addresses selection and removal of directors and officers of mutual insurers. This act addresses required minimum capital of certain insurers, deposits, and permanent surplus. This act addresses cancellation, termination, nonrenewal, or changes in certain insurance coverage. This act addresses reporting requirements for point of service or point of sales products. The act addresses computation for minimum standards for annuities. This act addresses the scope of the Utah Rate Regulation Act. This act addresses what constitutes an insurable interest. This act addresses when information can be incorporated by reference. The act addresses requirements for certificates of group insurance policies. The act addresses provisions related to the regulation of life and accident and health insurance. This act addresses insurance marketing and licensing, including requirements for title insurance. This act addresses the regulation of third party administrators and insurance adjustors. This act addresses rehabilitation and liquidation of insurers. This act modifies requirements for the account maintained by the Utah Property and Casualty Health Insurance Guaranty Association. This act addresses the Individual and Small Employer Health Insurance Act. This act provides an effective date.

This act affects sections of Utah Code Annotated 1953 as follows:

AMENDS:

31A-1-103, as last amended by Chapter 116, Laws of Utah 2001
31A-1-301, as last amended by Chapter 116, Laws of Utah 2001
31A-2-204, as last amended by Chapter 316, Laws of Utah 1994
31A-2-215, as enacted by Chapter 143, Laws of Utah 1999
31A-2-216, as enacted by Chapter 143, Laws of Utah 1999
31A-3-103, as last amended by Chapter 329, Laws of Utah 1998
31A-3-401, as last amended by Chapter 131, Laws of Utah 1999
31A-4-107, as last amended by Chapter 204, Laws of Utah 1986
31A-4-115, as last amended by Chapter 114, Laws of Utah 2000
31A-4-116, as last amended by Chapter 162, Laws of Utah 2000
31A-5-405, as last amended by Chapter 300, Laws of Utah 2000
31A-5-409, as last amended by Chapter 300, Laws of Utah 2000
31A-5-410, as last amended by Chapter 300, Laws of Utah 2000
31A-8-101, as last amended by Chapter 116, Laws of Utah 2001
31A-8-103, as last amended by Chapter 116, Laws of Utah 2001
31A-8-205, as enacted by Chapter 204, Laws of Utah 1986
31A-8-209, as last amended by Chapter 116, Laws of Utah 2001
31A-8-211, as last amended by Chapter 116, Laws of Utah 2001
31A-8-401, as last amended by Chapter 143, Laws of Utah 1999
31A-8-407, as last amended by Chapter 116, Laws of Utah 2001
31A-8-408, as last amended by Chapter 116, Laws of Utah 2001
31A-17-505, as last amended by Chapter 116, Laws of Utah 2001
31A-17-506, as last amended by Chapter 20, Laws of Utah 1995
31A-19a-101, as last amended by Chapter 116, Laws of Utah 2001
31A-19a-209, as renumbered and amended by Chapter 130, Laws of Utah 1999
31A-21-104, as last amended by Chapter 116, Laws of Utah 2001
31A-21-106, as last amended by Chapter 114, Laws of Utah 2000
31A-21-311, as enacted by Chapter 242, Laws of Utah 1985
31A-22-400, as enacted by Chapter 242, Laws of Utah 1985
31A-22-402, as last amended by Chapter 114, Laws of Utah 2000
31A-22-403, as last amended by Chapter 116, Laws of Utah 2001

31A-22-404, as last amended by Chapter 116, Laws of Utah 2001
31A-22-405, as enacted by Chapter 242, Laws of Utah 1985
31A-22-409, as last amended by Chapter 204, Laws of Utah 1986
31A-22-522, as enacted by Chapter 116, Laws of Utah 2001
31A-22-602, as last amended by Chapter 116, Laws of Utah 2001
31A-22-617, as last amended by Chapter 116, Laws of Utah 2001
31A-22-624, as last amended by Chapter 116, Laws of Utah 2001
31A-22-625, as last amended by Chapter 9, Laws of Utah 2001
31A-22-629, as enacted by Chapter 162, Laws of Utah 2000
31A-22-703, as last amended by Chapter 116, Laws of Utah 2001
31A-22-705, as last amended by Chapter 116, Laws of Utah 2001
31A-22-708, as repealed and reenacted by Chapter 329, Laws of Utah 1998
31A-22-714, as last amended by Chapter 329, Laws of Utah 1998
31A-23-102, as last amended by Chapters 9 and 116, Laws of Utah 2001
31A-23-204, as last amended by Chapter 116, Laws of Utah 2001
31A-23-206, as last amended by Chapter 116, Laws of Utah 2001
31A-23-211, as last amended by Chapter 9, Laws of Utah 1996, Second Special Session
31A-23-216, as last amended by Chapter 116, Laws of Utah 2001
31A-23-302, as last amended by Chapter 116, Laws of Utah 2001
31A-23-307, as last amended by Chapter 116, Laws of Utah 2001
31A-23-308, as enacted by Chapter 242, Laws of Utah 1985
31A-23-503, as last amended by Chapter 116, Laws of Utah 2001
31A-23-601, as last amended by Chapter 116, Laws of Utah 2001
31A-25-205, as last amended by Chapter 116, Laws of Utah 2001
31A-26-202 (Effective 07/01/02), as last amended by Chapter 8, Laws of Utah 2001, First Special Session
31A-26-202 (Superseded 07/01/02), as last amended by Chapter 116, Laws of Utah 2001
31A-26-206, as last amended by Chapter 116, Laws of Utah 2001
31A-26-213, as last amended by Chapter 116, Laws of Utah 2001
31A-26-301.6, as enacted by Chapter 240, Laws of Utah 2001
31A-27-102, as last amended by Chapter 131, Laws of Utah 1999

31A-27-103, as enacted by Chapter 242, Laws of Utah 1985
31A-27-305, as last amended by Chapter 204, Laws of Utah 1986
31A-27-311.5, as repealed and reenacted by Chapter 116, Laws of Utah 2001
31A-27-315, as last amended by Chapter 375, Laws of Utah 1997
31A-27-317, as enacted by Chapter 242, Laws of Utah 1985
31A-27-332, as last amended by Chapter 131, Laws of Utah 1999
31A-27-337, as last amended by Chapter 204, Laws of Utah 1986
31A-27-340, as enacted by Chapter 242, Laws of Utah 1985
31A-27-341, as enacted by Chapter 242, Laws of Utah 1985
31A-28-203, as last amended by Chapter 363, Laws of Utah 2001
31A-28-205, as last amended by Chapter 363, Laws of Utah 2001
31A-28-207, as last amended by Chapter 363, Laws of Utah 2001
31A-28-208, as last amended by Chapter 363, Laws of Utah 2001
31A-28-222, as enacted by Chapter 363, Laws of Utah 2001
31A-29-113, as last amended by Chapter 329, Laws of Utah 1998
31A-30-101, as last amended by Chapter 321, Laws of Utah 1995
31A-30-103, as last amended by Chapter 116, Laws of Utah 2001
31A-30-104, as last amended by Chapter 116, Laws of Utah 2001
31A-30-106, as last amended by Chapter 116, Laws of Utah 2001
31A-30-106.7, as enacted by Chapter 265, Laws of Utah 1997
31A-30-107, as last amended by Chapter 116, Laws of Utah 2001
31A-30-108, as last amended by Chapter 329, Laws of Utah 1998
31A-30-110, as last amended by Chapter 53, Laws of Utah 2001
31A-30-111, as enacted by Chapter 321, Laws of Utah 1995
59-9-105, as last amended by Chapter 131, Laws of Utah 1999
63-55-231, as last amended by Chapter 116, Laws of Utah 2001

ENACTS:

31A-3-104, Utah Code Annotated 1953
31A-8-402.3, Utah Code Annotated 1953
31A-8-402.5, Utah Code Annotated 1953
31A-8-402.7, Utah Code Annotated 1953

31A-22-721, Utah Code Annotated 1953

31A-30-107.1, Utah Code Annotated 1953

31A-30-107.3, Utah Code Annotated 1953

31A-30-107.5, Utah Code Annotated 1953

31A-30-114, Utah Code Annotated 1953

REPEALS:

31A-8-402, as last amended by Chapter 116, Laws of Utah 2001

31A-15-206, as enacted by Chapter 258, Laws of Utah 1992

31A-22-720, as last amended by Chapter 116, Laws of Utah 2001

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

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

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

(1) This title does not apply to:

(a) a retainer [~~contracts~~] contract made by [~~attorneys-at-law~~] an attorney-at-law:

(i) with an individual [~~clients with~~] client; and

(ii) under which fees are based on estimates of the nature and amount of services to be provided to the specific client[~~, and similar contracts~~];

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

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

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

[~~(d)~~] (e) legal assistance by employee organizations to their members in matters relating to employment.

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

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

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

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

(b) ocean marine insurance;

(c) death and accident and health benefits provided by an organization [~~where the~~] if the organization:

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

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

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

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

(i) the transaction of [~~such~~] the business in this state does not require regulation for the protection of the interests of the residents of this state; or [~~on a finding that~~]

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

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

[~~(ii) however, the transactions described in Subsection (3)(e)(i) are subject to taxation under Section 31A-3-301;~~]

(f) self-insurance;

(g) reinsurance;

(h) subject to Subsection [~~(4)~~] (5), employee and labor union group or blanket insurance covering risks in this state if:

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

(ii) the policyholder:

(A) is not a resident of this state [~~or~~];

(B) is not a domestic corporation; or

(C) does not have its principal office in this state;

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

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

(v) (A) the insurer agrees to pay premium taxes on the Utah portion of its business, as if

it were authorized to do business in this state[~~;~~]; and [~~if~~]

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

(i) to the extent provided in Subsection [~~(5)~~] (6):

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

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

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

[~~(4)~~] (5) (a) After a hearing, the commissioner may order an insurer of certain group or blanket contracts to transfer the Utah portion of the business otherwise exempted under Subsection (3)(h) to an authorized insurer if the contracts have been written by an unauthorized insurer.

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

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

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

[~~(5)~~] (6) (a) As used in Subsection (3)(i) and this Subsection [~~(5)~~] (6):

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

(A) made available by:

(I) a manufacturer of a product[~~:~~];

(II) a seller of a product; or

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

(B) made available:

(I) on one or more specific [~~product~~] products; or

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

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

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

(A) (I) the manufacturer of a product[~~:~~];

(II) a seller of a product; or

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

[~~(A)~~] (B) (I) on one or more specific [~~product~~] products; or

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

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

(iii) "service contract" is as defined in Section 31A-6a-101.

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

(i) a warranty;

(ii) a guaranty; or

(iii) a term similar to a term described in Subsection [~~(5)~~] (6)(b)(i) or (ii).

(c) This title does not apply to:

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

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

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

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

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

(C) the cost of the product is equal to an amount determined in accordance with Subsection [~~(5)~~] (6)(e); and

(D) the product is not a motor vehicle.

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

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

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

(e) (i) For fiscal year 2001-02, the amount described in Subsection [~~(5)~~] (6)(c)(iii)(C) shall be equal to $3,700 or less.

(ii) For each fiscal year after fiscal year 2001-02, the commissioner shall annually determine whether the amount described in Subsection [~~(5)~~] (6)(c)(iii)(C) should be adjusted in accordance with changes in the Consumer Price Index published by the United States Bureau of Labor Statistics selected by the commissioner by rule, between:

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

(B) the Consumer Price Index for February 2001.

(iii) If under Subsection [~~(5)~~] (6)(e)(ii) the commissioner determines that an adjustment should be made, the commissioner shall make the adjustment by rule.

Section 2. Section **31A-1-301** is amended to read:

31A-1-301. Definitions.

As used in this title, unless otherwise specified:

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

(i) a medical condition including:

(A) medical care expenses; or

(B) the risk of disability;

(ii) accident; or

(iii) sickness.

(b) "Accident and health insurance":

(i) includes a contract with disability contingencies including:

(A) an income replacement contract;

(B) a health care contract;

(C) an expense reimbursement contract;

(D) a credit accident and health contract;

(E) a continuing care contract; and

(F) long-term care contracts; and

(ii) may provide:

(A) hospital coverage;

(B) surgical coverage;

(C) medical coverage; or

(D) loss of income coverage.

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

(2) "Administrator" is defined in Subsection [~~(111)~~] (122).

(3) "Adult" means a natural person who has attained the age of at least 18 years.

(4) "Affiliate" means any person who controls, is controlled by, or is under common control with, another person. A corporation is an affiliate of another corporation, regardless of ownership, if substantially the same group of natural persons manages the corporations.

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

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

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

(8) "Application" means a document:

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

(b) that contains information that is used by the insurer to:

(i) evaluate risk; and

(ii) decide whether to:

(A) insure the risk under:

(I) the coverages as originally offered; or

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

(B) decline to insure the risk.

(9) "Articles" or "articles of incorporation" means the original articles, special laws, charters, amendments, restated articles, articles of merger or consolidation, trust instruments, and other constitutive documents for trusts and other entities that are not corporations, and amendments to any of these.

(10) "Bail bond insurance" means a guarantee that a person will attend court when required, or will obey the orders or judgment of the court, as a condition to the release of that person from confinement.

(11) "Binder" is defined in Section 31A-21-102.

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

(13) "Business of insurance" is defined in Subsection [~~(64)~~] (68).

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

(a) Section 31A-7-201;

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

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

(15) "Bylaws" means the rules adopted for the regulation or management of a corporation's affairs, however designated and includes comparable rules for trusts and other entities that are not corporations.

(16) "Casualty insurance" means liability insurance as defined in Subsection [~~(70)~~] (75).

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

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

(b) a third party.

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

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

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

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

(b) When appropriate, the terms listed in Subsection (21)(a) apply to the equivalent supervisory official of another jurisdiction.

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

(i) provides board and lodging;

(ii) provides one or more of the following services:

(A) personal services;

(B) nursing services;

(C) medical services; or

(D) other health-related services; and

(iii) provides the coverage described in Subsection (22)(a)(i) under an agreement effective:

(A) for the life of the insured; or

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

(b) Insurance is continuing care insurance regardless of whether or not the board and lodging are provided at the same location as the services described in Subsection (22)(a)(ii).

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

(i) by contract;

(ii) by common management;

(iii) through the ownership of voting securities; or

(iv) by a means other than those described in Subsections (23)(a)(i) through (iii).

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

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

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

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

(i) a corporation doing business as an insurance broker, consultant, or adjuster under:

(A) Chapter 23, Insurance Marketing - Licensing Agents, Brokers, Consultants, and Reinsurance Intermediaries; and

(B) Chapter 26, Insurance Adjusters; or

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

(b) "Stock corporation" means stock insurance corporation.

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

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

(26) "Credit insurance" means surety insurance under which mortgagees and other

creditors are indemnified against losses caused by the default of debtors.

(27) "Credit life insurance" means insurance on the life of a debtor in connection with a loan or other credit transaction.

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

(a) matured;

(b) unmatured;

(c) liquidated;

(d) unliquidated;

(e) secured;

(f) unsecured;

(g) absolute;

(h) fixed; or

(i) contingent.

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

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

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

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

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

(a) imposed by:

(i) statute;

(ii) rule; or

(iii) order; and

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

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

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

(33) "Department" means the Insurance Department.

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

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

(a) perform the duties of:

(i) that individual's occupation; or

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

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

(i) eating;

(ii) toileting;

(iii) transferring;

(iv) bathing; or

(v) dressing.

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

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

(a) is incorporated;

(b) is organized; or

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

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

(i) an employee who:

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

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

(ii) a person described in Subsection (38)(b).

(b) "Eligible employee" includes, if the individual is included under a health benefit plan of a small employer:

(i) a sole proprietor;

(ii) a partner in a partnership; or

(iii) an independent contractor.

(c) "Eligible employee" does not include, unless eligible under Subsection (38)(b):

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

(ii) an employer's spouse; or

(iii) a dependent of an employer.

(39) "Employee" means any individual employed by an employer.

[~~(38)~~] (40) "Employee benefits" means one or more benefits or services provided to:

(a) employees; or [~~their~~]

(b) dependents of employees.

[~~(39)~~] (41) (a) "Employee welfare fund" means a fund:

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

(A) one or more employers;

(B) one or more labor organizations; or

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

(ii) that provides employee benefits paid or contracted to be paid, other than income from investments of the fund, by or on behalf of an employer doing business in this state or for the benefit of any person employed in this state.

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

[~~(40)~~] (42) "Endorsement" means a written agreement attached to a policy or certificate to modify one or more of the provisions of the policy or certificate.

[~~(41)~~] (43) "Excludes" is not exhaustive and does not mean that other things are not also excluded. The items listed are representative examples for use in interpretation of this title.

[~~(42)~~] (44) "Expense reimbursement insurance" means insurance:

(a) written to provide payments for expenses relating to hospital confinements resulting from illness or injury; and

(b) written:

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

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

[~~(43)~~] (45) "Fidelity insurance" means insurance guaranteeing the fidelity of persons holding positions of public or private trust.

[~~(44)~~] (46) (a) "Filed" means that a filing is:

(i) submitted to the department in accordance with any applicable statute, rule, or filing order;

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

(iii) accompanied with the applicable one or more filing fees required by:

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

(B) rule.

(b) "Filed" does not include a filing that is rejected by the department because it is not submitted in accordance with Subsection [~~(44)~~] (46)(a).

[~~(45)~~] (47) "Filing," when used as a noun, means an item required to be filed with the department including:

(a) a policy;

(b) a rate;

(c) a form;

(d) a document;

(e) a plan;

(f) a manual;

(g) an application;

(h) a report;

(i) a certificate;

(j) an endorsement;

(k) an actuarial certification;

(l) a licensee annual statement;

(m) a licensee renewal application; or

(n) an advertisement.

[~~(46)~~] (48) "First party insurance" means an insurance policy or contract in which the insurer agrees to pay claims submitted to it by the insured for the insured's losses.

[~~(47)~~] (49) "Foreign insurer" means an insurer domiciled outside of this state, including an alien insurer.

[~~(48)~~] (50) (a) "Form" means [~~a policy, certificate, or application~~] one of the following prepared for general use[~~.~~]:

(i) a policy;

(ii) a certificate;

(iii) an application; or

(iv) an outline of coverage.

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

[~~(49)~~] (51) "Franchise insurance" means individual insurance policies provided through a mass marketing arrangement involving a defined class of persons related in some way other than through the purchase of insurance.

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

(a) (i) to employees; or

(ii) to a dependent of an employee; and

(b) (i) directly;

(ii) through insurance reimbursement; or

(iii) through any other method.

(53) "Health benefit plan" means a policy or certificate for health care insurance, except that health benefit plan does not include coverage:

(a) solely for:

(i) accident;

(ii) dental;

(iii) vision;

(iv) Medicare supplement;

(v) long-term care; or

(vi) income replacement; or

(b) that is:

(i) offered and marketed as supplemental health insurance;

(ii) not offered or marketed as a substitute for:

(A) hospital or medical expense insurance; or

(B) major medical expense insurance; and

(iii) solely for:

(A) a specified disease;

(B) hospital confinement indemnity; or

(C) limited benefit plan.

[~~(50)~~] (54) "Health care" means any of the following intended for use in the diagnosis, treatment, mitigation, or prevention of a human ailment or impairment:

(a) professional services;

(b) personal services;

(c) facilities;

(d) equipment;

(e) devices;

(f) supplies; or

(g) medicine.

[~~(51)~~] (55) (a) "Health care insurance" or "health insurance" means insurance providing:

(i) health care benefits; or

(ii) payment of incurred health care expenses.

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

(i) replacement of income;

(ii) short-term accident;

(iii) fixed indemnity;

(iv) credit accident and health;

(v) supplements to liability;

(vi) workers' compensation;

(vii) automobile medical payment;

(viii) no-fault automobile;

(ix) equivalent self-insurance; or

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

[~~(52)~~] (56) "Income replacement insurance" or "disability income insurance" means insurance written to provide payments to replace income lost from accident or sickness.

[~~(53)~~] (57) "Indemnity" means the payment of an amount to offset all or part of an insured loss.

[~~(54)~~] (58) "Independent adjuster" means an insurance adjuster required to be licensed under Section 31A-26-201 who engages in insurance adjusting as a representative of insurers.

[~~(55)~~] (59) "Independently procured insurance" means insurance procured under Section 31A-15-104.

[~~(56)~~] (60) "Individual" means a natural person.

[~~(57)~~] (61) "Inland marine insurance" includes insurance covering:

(a) property in transit on or over land;

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

(c) bailee liability;

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

(e) personal and commercial property floaters.

[~~(58)~~] (62) "Insolvency" means that:

(a) an insurer is unable to pay its debts or meet its obligations as they mature;

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

(c) an insurer is determined to be hazardous under this title.

[~~(59)~~] (63) (a) "Insurance" means:

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

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

(b) "Insurance" includes:

(i) risk distributing arrangements providing for compensation or replacement for damages or loss through the provision of services or benefits in kind;

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

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

[~~(60)~~] (64) "Insurance adjuster" means a person who directs the investigation, negotiation, or settlement of a claim under an insurance policy other than life insurance or an annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.

[~~(61)~~] (65) "Interinsurance exchange" is defined in Subsection [~~(100)~~] (110).

[~~(62)~~] (66) Except as provided in Subsection 31A-23-201.5(1), "insurance agent" or "agent" means a person who represents insurers in soliciting, negotiating, or placing insurance.

[~~(63)~~] (67) Except as provided in Subsection 31A-23-201.5(1), "insurance broker" or "broker" means a person who:

(a) acts in procuring insurance on behalf of an applicant for insurance or an insured; and

(b) does not act on behalf of the insurer except by collecting premiums or performing other ministerial acts.

[~~(64)~~] (68) "Insurance business" or "business of insurance" includes:

(a) providing health care insurance, as defined in Subsection [~~(51)~~] (55), by organizations that are or should be licensed under this title;

(b) providing benefits to employees in the event of contingencies not within the control of the employees, in which the employees are entitled to the benefits as a right, which benefits may be provided either:

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

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

(c) providing annuities, including those issued in return for gifts, except those provided by persons specified in Subsections 31A-22-1305(2) and (3);

(d) providing the characteristic services of motor clubs as outlined in Subsection [~~(77)~~] (82);

(e) providing other persons with insurance as defined in Subsection [~~(59)~~] (63);

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

(g) transacting or proposing to transact any phase of title insurance, including solicitation, negotiation preliminary to execution, execution of a contract of title insurance, insuring, and transacting matters subsequent to the execution of the contract and arising out of it, including reinsurance; and

(h) doing, or proposing to do, any business in substance equivalent to Subsections [~~(64)~~] (68)(a) through (g) in a manner designed to evade the provisions of this title.

[~~(65)~~] (69) Except as provided in Subsection 31A-23-201.5(1), "insurance consultant" or "consultant" means a person who:

(a) advises other persons about insurance needs and coverages;

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

(c) is not compensated directly or indirectly by an insurer, agent, or broker for advice given.

[~~(66)~~] (70) "Insurance holding company system" means a group of two or more affiliated persons, at least one of whom is an insurer.

[~~(67)~~] (71) (a) "Insured" means a person to whom or for whose benefit an insurer makes a promise in an insurance policy and includes:

(i) policyholders;

(ii) subscribers;

(iii) members; and

(iv) beneficiaries.

(b) The definition in Subsection [~~(67)~~] (71)(a):

(i) applies only to this title; and

(ii) does not define the meaning of this word as used in insurance policies or certificates.

[~~(68)~~] (72) (a) (i) "Insurer" means any person doing an insurance business as a principal including:

(A) fraternal benefit societies;

(B) issuers of gift annuities other than those specified in Subsections 31A-22-1305(2) and (3);

(C) motor clubs;

(D) employee welfare plans; and

(E) any person purporting or intending to do an insurance business as a principal on that person's own account.

(ii) "Insurer" does not include a governmental entity, as defined in Section 63-30-2, to the extent it is engaged in the activities described in Section 31A-12-107.

(b) "Admitted insurer" is defined in Subsection [~~(115)~~] (126)(b).

(c) "Alien insurer" is defined in Subsection (5).

(d) "Authorized insurer" is defined in Subsection [~~(115)~~] (126)(b).

(e) "Domestic insurer" is defined in Subsection (36).

(f) "Foreign insurer" is defined in Subsection [~~(47)~~] (49).

(g) "Nonadmitted insurer" is defined in Subsection [~~(115)~~] (126)(a).

(h) "Unauthorized insurer" is defined in Subsection [~~(115)~~] (126)(a).

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

(a) employed an average of at least 51 eligible employees on each business day during the preceding calendar year; and

(b) employs at least two employees on the first day of the plan year.

[~~(69)~~] (74) (a) Except [~~as provided~~] for a retainer contract or legal assistance described in Section 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for specified legal expenses.

(b) "Legal expense insurance" includes arrangements that create reasonable expectations of enforceable rights[~~, but it~~].

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

[~~(70)~~] (75) (a) "Liability insurance" means insurance against liability:

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

(A) Subsection [~~(74)~~] (79) for medical malpractice insurance;

(B) Subsection [~~(92)~~] (102) for professional liability insurance; and

(C) Subsection [~~(118)~~] (129) for workers' compensation insurance;

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

(A) Subsection [~~(74)~~] (79) for medical malpractice insurance;

(B) Subsection [~~(92)~~] (102) for professional liability insurance; and

(C) Subsection [~~(118)~~] (129) for workers' compensation insurance;

(iii) for loss or damage to property resulting from accidents to or explosions of boilers, pipes, pressure containers, machinery, or apparatus;

(iv) for loss or damage to any property caused by the breakage or leakage of sprinklers, water pipes and containers, or by water entering through leaks or openings in buildings; or

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

(b) "Liability insurance" includes:

(i) vehicle liability insurance as defined in Subsection [~~(116)~~] (127);

(ii) residential dwelling liability insurance as defined in Subsection [~~(102)~~] (112); and

(iii) making inspection of, and issuing certificates of inspection upon, elevators, boilers, machinery, and apparatus of any kind when done in connection with insurance on them.

[~~(71)~~] (76) (a) "License" means the authorization issued by the insurance commissioner under this title to engage in some activity that is part of or related to the insurance business. [~~It~~]

(b) "License" includes certificates of authority issued to insurers.

[~~(72)~~] (77) (a) "Life insurance" means insurance on human lives and insurances pertaining to or connected with human life.

(b) The business of life insurance includes:

(i) granting death benefits;

(ii) granting annuity benefits;

(iii) granting endowment benefits;

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

(v) granting additional benefits to safeguard the policy against lapse in the event of disability; and

(vi) providing optional methods of settlement of proceeds.

[~~(73)~~] (78) (a) "Long-term care insurance" means an insurance policy or rider advertised, marketed, offered, or designated to provide coverage:

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

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

(A) expenses incurred;

(B) indemnity;

(C) prepayment; or

(D) another method;

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

(A) diagnostic;

(B) preventative;

(C) therapeutic;

(D) rehabilitative;

(E) maintenance; or

(F) personal care; and

(iv) that may be issued by:

(A) an insurer;

(B) a fraternal benefit society;

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

(II) a medical service corporation;

(D) a prepaid health plan;

(E) a health maintenance organization; or

(F) an entity similar to the entities described in Subsections [~~(73)~~] (78)(a)(iv)(A) through (E) to the extent that the entity is otherwise authorized to issue life or health care insurance.

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

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

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

(B) a life insurance policy or rider;

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

(A) cognitive impairment; or

(B) functional capacity; or

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

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

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

(ii) basic hospital expense coverage;

(iii) basic medical/surgical expense coverage;

(iv) hospital confinement indemnity coverage;

(v) major medical expense coverage;

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

(vii) accident only coverage;

(viii) coverage for a specified:

(A) disease; or

(B) accident;

(ix) limited benefit health coverage; or

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

(A) if [~~neither the benefits nor eligibility is~~] the following are not conditioned on the receipt of long-term care:

(I) benefits; or

(II) eligibility; and

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

(I) terminal illness;

(II) medical conditions requiring extraordinary medical intervention; or

(III) permanent institutional confinement.

[~~(74)~~] (79) "Medical malpractice insurance" means insurance against legal liability incident to the practice and provision of medical services other than the practice and provision of dental services.

[~~(75)~~] (80) "Member" means a person having membership rights in an insurance corporation.

[~~(76)~~] (81) "Minimum capital" or "minimum required capital" means the capital that must be constantly maintained by a stock insurance corporation as required by statute.

[~~(77)~~] (82) "Motor club" means a person:

(a) licensed under:

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

(ii) Chapter 11, Motor Clubs; or

(iii) Chapter 14, Foreign Insurers; and

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

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

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

(iii) trip reimbursement, towing services, emergency road services, stolen automobile services, a combination of these services, or any other services given in Subsections 31A-11-102(1)(b) through (f).

[~~(78)~~] (83) "Mutual" means mutual insurance corporation.

(84) "Network plan" means health care insurance that:

(a) is issued by an insurer; and

(b) under which the financing and delivery of medical care is provided, in whole or in part, through a defined set of providers under contract with the insurer, including the financing and delivery of items paid for as **§ [~~medial~~] MEDICAL §** care.

[~~(79)~~] (85) "Nonparticipating" means a plan of insurance under which the insured is not entitled to receive dividends representing shares of the surplus of the insurer.

[~~(80)~~] (86) "Ocean marine insurance" means insurance against loss of or damage to:

(a) ships or hulls of ships;

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

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

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

[~~(81)~~] (87) "Order" means an order of the commissioner.

[~~(82)~~] (88) "Outline of coverage" means a summary that explains an accident and health insurance policy.

[~~(83)~~] (89) "Participating" means a plan of insurance under which the insured is entitled to receive dividends representing shares of the surplus of the insurer.

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

[~~(84)~~] (91) "Person" includes an individual, partnership, corporation, incorporated or unincorporated association, joint stock company, trust, reciprocal, syndicate, or any similar entity or combination of entities acting in concert.

(92) "Plan sponsor" is as defined in 29 U.S.C. Sec. 1002(16)(B).

(93) "Plan year" means:

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

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

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

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

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

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

(iii) the employer's taxable year if:

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

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

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

(c) in a case not described in Subsection (93)(a) or (b), the calendar year.

[~~(85)~~] (94) (a) (i) "Policy" means any document, including attached endorsements and riders, purporting to be an enforceable contract, which memorializes in writing some or all of the terms of an insurance contract.

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

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

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

(C) a corporation licensed under:

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

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

(iii) "Policy" does not include:

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

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

(b) (i) "Group insurance policy" means a policy covering a group of persons that is issued to a policyholder on behalf of the group, for the benefit of group members who are selected under procedures defined in the policy or in agreements which are collateral to the policy. [~~This type of~~]

(ii) A group insurance policy may include members of the policyholder's family or dependents.

(c) "Blanket insurance policy" means a group policy covering classes of persons without

individual underwriting, where the persons insured are determined by definition of the class with or without designating the persons covered.

[~~(86)~~] (95) "Policyholder" means the person who controls a policy, binder, or oral contract by ownership, premium payment, or otherwise.

[~~(87)~~] (96) "Policy illustration" means a presentation or depiction that includes nonguaranteed elements of a policy of life insurance over a period of years.

[~~(88)~~] (97) "Policy summary" means a synopsis describing the elements of a life insurance policy.

(98) "Preexisting condition," in connection with a health benefit plan, means:

(a) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the earlier of:

(i) the enrollment date; or

(ii) the effective date of coverage; or

(b) for an individual insurance policy, a pregnancy existing on the effective date of coverage.

[~~(89)~~] (99) (a) "Premium" means the monetary consideration for an insurance policy, and includes assessments, membership fees, required contributions, or monetary consideration, however designated.

(b) Consideration paid to third party administrators for their services is not "premium," though amounts paid by third party administrators to insurers for insurance on the risks administered by the third party administrators are "premium."

[~~(90)~~] (100) "Principal officers" of a corporation means the officers designated under Subsection 31A-5-203(3).

[~~(91)~~] (101) "Proceedings" includes actions and special statutory proceedings.

[~~(92)~~] (102) "Professional liability insurance" means insurance against legal liability incident to the practice of a profession and provision of any professional services.

[~~(93)~~] (103) "Property insurance" means insurance against loss or damage to real or personal property of every kind and any interest in that property, from all hazards or causes, and against loss consequential upon the loss or damage including vehicle comprehensive and vehicle physical damage coverages, but excluding inland marine insurance and ocean marine insurance as defined under Subsections [~~(57)~~] (61) and [~~(80)~~] (86).

[~~(94)~~] (104) (a) "Public agency insurance mutual" means any entity formed by joint venture or interlocal cooperation agreement by two or more political subdivisions or public agencies of the state for the purpose of providing insurance coverage for the political subdivisions or public agencies.

(b) Any public agency insurance mutual created under this title and Title 11, Chapter 13, Interlocal Cooperation Act, is considered to be a governmental entity and political subdivision of the state with all of the rights, privileges, and immunities of a governmental entity or political subdivision of the state.

[~~(95)~~] (105) "Qualified long-term care insurance contract" or "federally tax qualified long-term care insurance contract" means:

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

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

(i) (A) by rider; or

(B) as a part of the contract; and

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

[~~(96)~~] (106) (a) "Rate" means:

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

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

(A) a single number; or

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

(I) expenses;

(II) profit; and

(III) individual insurer variation in loss experience.

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

[~~(97)~~] (107) (a) Except as provided in Subsection [~~(97)~~] (107)(b), "rate service organization" means any person who assists insurers in rate making or filing by:

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

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

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

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

(i) an employee of an insurer;

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

(iii) a joint underwriting group; or

(iv) a natural person serving as an actuarial or legal consultant.

[~~(98)~~] (108) "Rating manual" means any of the following used to determine initial and renewal policy premiums:

(a) a manual of rates;

(b) classifications;

(c) rate-related underwriting rules; and

(d) rating formulas that describe steps, policies, and procedures for determining initial and renewal policy premiums.

[~~(99)~~] (109) "Received by the department" means:

(a) except as provided in Subsection [~~(99)~~] (109)(b), the date delivered to and stamped received by the department, whether delivered:

(i) in person;

(ii) by a delivery service; or

(iii) electronically; and

(b) if an item with a department imposed deadline is delivered to the department by a delivery service, the delivery service's postmark date or pick-up date unless otherwise stated in:

(i) statute;

(ii) rule; or

(iii) a specific filing order.

[~~(100)~~] (110) "Reciprocal" or "interinsurance exchange" means any unincorporated association of persons:

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

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

[~~(101)~~] (111) "Reinsurance" means an insurance transaction where an insurer, for consideration, transfers any portion of the risk it has assumed to another insurer. In referring to

reinsurance transactions, this title sometimes refers to:

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

(b) the insurer assuming the risk as the:

(i) "assuming insurer"; or

(ii) "assuming reinsurer."

[~~(102)~~] (112) "Residential dwelling liability insurance" means insurance against liability resulting from or incident to the ownership, maintenance, or use of a residential dwelling that is a detached single family residence or multifamily residence up to four units.

[~~(103)~~] (113) "Retrocession" means reinsurance with another insurer of a liability assumed under a reinsurance contract. A reinsurer "retrocedes" when it reinsures with another insurer part of a liability assumed under a reinsurance contract.

[~~(104)~~] (114) "Rider" means an endorsement to:

(a) an insurance policy; or

(b) an insurance certificate.

[~~(105)~~] (115) (a) "Security" means any:

(i) note;

(ii) stock;

(iii) bond;

(iv) debenture;

(v) evidence of indebtedness;

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

(vii) collateral-trust certificate;

(viii) preorganization certificate or subscription;

(ix) transferable share;

(x) investment contract;

(xi) voting trust certificate;

(xii) certificate of deposit for a security;

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

(xiv) commodity contract or commodity option;

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

receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed in Subsections [~~(105)~~] (115)(a)(i) through (xiv); or

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

(b) "Security" does not include:

(i) any insurance or endowment policy or annuity contract under which an insurance company promises to pay money in a specific lump sum or periodically for life or some other specified period; or

(ii) a burial certificate or burial contract.

[~~(106)~~] (116) "Self-insurance" means any arrangement under which a person provides for spreading its own risks by a systematic plan.

(a) Except as provided in this Subsection [~~(106)~~] (116), self-insurance does not include an arrangement under which a number of persons spread their risks among themselves.

(b) Self-insurance does include an arrangement by which a governmental entity, as defined in Section 63-30-2, undertakes to indemnify its employees for liability arising out of the employees' employment.

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

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

[~~(107)~~] (117) "Short-term care insurance" means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage that is similar to long-term care insurance but that provides coverage for less than 12 consecutive months for each covered person.

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

(a) employed an average of at least two employees but not more than 50 eligible employees on each business day during the preceding calendar year; and

(b) employs at least two employees on the first day of the plan year.

[~~(108)~~] (119) (a) "Subsidiary" of a person means an affiliate controlled by that person either directly or indirectly through one or more affiliates or intermediaries.

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

are owned by that person either alone or with its affiliates, except for the minimum number of shares the law of the subsidiary's domicile requires to be owned by directors or others.

[~~(109)~~] (120) Subject to Subsection [~~(59)~~] (63)(b), "surety insurance" includes:

(a) a guarantee against loss or damage resulting from failure of principals to pay or perform their obligations to a creditor or other obligee;

(b) bail bond insurance; and

(c) fidelity insurance.

[~~(110)~~] (121) (a) "Surplus" means the excess of assets over the sum of paid-in capital and liabilities.

(b) (i) "Permanent surplus" means the surplus of a mutual insurer that has been designated by the insurer as permanent.

(ii) Sections 31A-5-211, 31A-7-201, 31A-8-209, 31A-9-209, and 31A-14-209 require that mutuals doing business in this state maintain specified minimum levels of permanent surplus.

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

(c) "Excess surplus" means:

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

(A) that amount of an insurer's or health organization's total adjusted capital, as defined in Subsection [~~(113)~~] (124), that exceeds the product of:

(I) 2.5; and

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

(B) that amount of an insurer's or health organization's total adjusted capital, as defined in Subsection [~~(113)~~] (124), that exceeds the product of:

(I) 3.0; and

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

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

(A) 1.5; and

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

[~~(111)~~] (122) "Third party administrator" or "administrator" means any person who collects charges or premiums from, or who, for consideration, adjusts or settles claims of residents of the state in connection with insurance coverage, annuities, or service insurance coverage, except:

(a) a union on behalf of its members;

(b) a person administering any:

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

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

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

(c) an employer on behalf of the employer's employees or the employees of one or more of the subsidiary or affiliated corporations of the employer;

(d) an insurer licensed under Chapter 5, 7, 8, 9, or 14, but only for a line of insurance for which the insurer holds a license in this state; or

(e) a person licensed or exempt from licensing under Chapter 23 or 26 whose activities are limited to those authorized under the license the person holds or for which the person is exempt.

[~~(112)~~] (123) "Title insurance" means the insuring, guaranteeing, or indemnifying of owners of real or personal property or the holders of liens or encumbrances on that property, or others interested in the property against loss or damage suffered by reason of liens or encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity or unenforceability of any liens or encumbrances on the property.

[~~(113)~~] (124) "Total adjusted capital" means the sum of an insurer's or health organization's statutory capital and surplus as determined in accordance with:

(a) the statutory accounting applicable to the annual financial statements required to be filed under Section 31A-4-113; and

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

[~~(114)~~] (125) (a) "Trustee" means "director" when referring to the board of directors of a corporation.

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

management of an employee welfare fund.

[~~(115)~~] (126) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted insurer" means an insurer:

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

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

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

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

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

[~~(116)~~] (127) "Vehicle liability insurance" means insurance against liability resulting from or incident to ownership, maintenance, or use of any land vehicle or aircraft, exclusive of vehicle comprehensive and vehicle physical damage coverages under Subsection [~~(93)~~] (103).

[~~(117)~~] (128) "Voting security" means a security with voting rights, and includes any security convertible into a security with a voting right associated with it.

[~~(118)~~] (129) "Workers' compensation insurance" means:

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

(i) compensable accidental injuries; and

(ii) occupational disease disability;

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

(c) insurance assuring to the persons entitled to [~~workers~~] workers' compensation benefits the compensation provided by law.

Section 3. Section **31A-2-204** is amended to read:

31A-2-204. Conducting examinations.

(1) (a) For each examination under Section 31A-2-203, the commissioner shall issue an order:

(i) stating the scope of the examination; and

(ii) designating the examiner in charge.

(b) The commissioner need not give advance notice of an examination to an examinee.

(c) The examiner in charge shall give the examinee a copy of the order issued under this Subsection (1).

(d) (i) The commissioner may alter the scope or nature of [~~the~~] an examination at any time without advance notice to the examinee [~~but~~].

(ii) If the commissioner amends an order described in this Subsection (1), the commissioner shall provide a copy of any amended order to the examinee.

(e) Statements in the commissioner's examination order concerning examination scope are for the examiner's guidance only.

(f) Examining relevant matters not mentioned in [~~the~~] an order issued under this Subsection (1) is not a violation of this title.

(2) The commissioner shall, whenever practicable, cooperate with the insurance regulators of other states by conducting joint examinations of multistate insurers doing business in this state.

(3) An examiner authorized by the commissioner shall, when necessary to the purposes of the examination, have access at all reasonable hours to the premises and to any books, records, files, securities, documents, or property of:

(a) the examinee; and [~~to those of~~]

(b) any of the following if the premises, books, records, files, securities, documents, or property relate to the affairs of the examinee:

(i) an officer [~~or~~] of the examinee;

(ii) any other person who:

(A) has executive authority over the examinee; or

(B) is in charge of any segment of the examinee's affairs[~~,~~]; or [~~of~~]

(iii) any affiliate of the examinee under Subsection 31A-2-203 (1)(b)[~~, if they relate to the affairs of the examinee~~].

(4) (a) The officers, employees, and agents of the examinee and of persons under Subsection 31A-2-203(1)(b) shall comply with every reasonable request of the examiners for assistance in any matter relating to the examination. [~~No~~]

(b) A person may not obstruct or interfere with the examination except by legal process.

(5) If the commissioner finds the accounts or records to be inadequate for proper examination of the condition and affairs of the examinee or improperly kept or posted, the commissioner may employ experts to rewrite, post, or balance the accounts or records at the expense of the examinee.

(6) (a) The examiner in charge of an examination shall make a report of the examination

no later than 60 days after the completion of the examination that shall include:

(i) the information and analysis ordered under Subsection (1)[~~, together with~~]; and

(ii) the examiner's recommendations.

(b) At the option of the examiner in charge, preparation of the report may include conferences with the examinee or [~~its~~] representatives of the examinee.

(c) The report is confidential until [~~it~~] the report becomes a public document under Subsection (7), [~~but~~] except the commissioner may use information from the report as a basis for action under Chapter 27, Insurers Rehabilitation and Liquidation.

(7) (a) The commissioner shall serve a copy of the examination report described in Subsection (6) upon the examinee.

(b) Within 20 days after service, the examinee shall [~~either~~]:

(i) accept the examination report as written; or

(ii) request agency action to modify the examination report.

(c) The report is considered accepted under this Subsection (7) if the examinee does not file a request for agency action to modify the report within 20 days after service of the report.

(d) If the examination report is accepted[~~, it~~]:

(i) the examination report immediately becomes a public document; and

(ii) the commissioner shall distribute [~~it~~] the examination report to all jurisdictions in which the examinee is authorized to do business.

(e) (i) Any adjudicative proceeding held as a result of the examinee's request for agency action shall, upon the examinee's demand, be closed to the public, [~~but~~] except that the commissioner need not exclude any participating examiner from this closed hearing.

(ii) Within 20 days after the hearing held under this Subsection (7)(e), the commissioner shall:

(A) adopt the examination report with any necessary modifications; and

(B) serve a copy of the adopted report upon the examinee. [~~The~~]

(iii) Unless the examinee seeks judicial relief, the adopted examination report:

(A) shall become a public document ten days after service[~~,~~]; and

(B) may be distributed as described in this section[~~, unless the examinee seeks judicial relief~~].

(8) The examinee shall promptly furnish copies of the adopted examination report

described in Subsection (7) to each member of [~~its~~] the examinee's board.

(9) [~~The~~] After an examination report becomes a public document under Subsection (7), the commissioner may furnish, without cost or at a reasonable price set under Section 31A-3-103, a copy of the examination report to interested persons, including:

(a) a member of the board of the examinee; or

(b) one or more newspapers in this state[~~, after the report becomes a public document under Subsection (7)~~].

(10) (a) In a proceeding by or against the examinee, or any officer or agent of the examinee, the examination report as adopted by the commissioner is admissible as evidence of the facts stated in the report.

(b) In any proceeding commenced under Chapter 27, Insurers Rehabilitation and Liquidation, the examination report, whether adopted by the commissioner or not, is admissible as evidence of the facts stated in [~~it~~] the examination report.

Section 4. Section **31A-2-215** is amended to read:

31A-2-215. Consumer education.

(1) In furtherance of the purposes in Section 31A-1-102, the commissioner may educate consumers about insurance and provide consumer assistance.

(2) Consumer education may include:

(a) outreach activities; and

(b) the production or collection and dissemination of educational materials.

(3) (a) Consumer assistance may include explaining:

(i) the terms of a policy;

(ii) a policy's complaint, [~~and~~] grievance, or adverse benefit determination procedure; and

(iii) the fundamentals of self-advocacy.

(b) Notwithstanding Subsection (3)(a), consumer assistance may not include testifying or representing a consumer in any grievance or adverse benefit determination, arbitration, judicial, or related proceeding, unless the proceeding is in connection with an enforcement action brought under Section 31A-2-308.

(4) The commissioner may adopt rules necessary to implement the requirements of this section.

Section 5. Section **31A-2-216** is amended to read:

31A-2-216. Office of Consumer Health Assistance.

(1) The commissioner shall establish:

(a) an Office of Consumer Health Assistance before July 1, 1999; and

(b) a committee to advise the commissioner on consumer assistance rendered under this section.

(2) The office shall:

(a) be a resource for health care consumers concerning health care coverage or the need for such coverage;

(b) help health care consumers understand:

(i) contractual rights and responsibilities;

(ii) statutory protections; and

(iii) available remedies;

(c) educate health care consumers:

(i) by producing or collecting and disseminating educational materials to consumers, health insurers, and health benefit plans; and

(ii) through outreach and other educational activities;

(d) for health care consumers that have difficulty in accessing their health insurance policies because of language, disability, age, or ethnicity, provide services, directly or through referral, such as:

(i) information and referral; and

(ii) [~~grievance~~] adverse benefit determination process initiation;

(e) analyze and monitor federal and state consumer health-related statutes, rules, and regulations; and

(f) summarize information gathered under this section and make the summaries available to the public, government agencies, and the Legislature.

(3) The office may:

(a) obtain data from health care consumers as necessary to further the office's duties under this section;

(b) investigate complaints and attempt to resolve complaints at the lowest possible level; and

(c) assist, but not testify or represent, a consumer in [~~a grievance~~] an adverse benefit

determination, arbitration, judicial, or related proceeding, unless the proceeding is in connection with an enforcement action brought under Section 31A-2-308.

(4) The commissioner may adopt rules necessary to implement the requirements of this section.

Section 6. Section **31A-3-103** is amended to read:

31A-3-103. Fees.

(1) [~~The fees~~] For purposes of this section:

(a) "Regulatory fee" is as defined in Section 63-38-3.2.

(b) "Services" means functions that are reasonable and necessary to enable the commissioner to perform the duties imposed by this title including:

(i) issuing and renewing licenses and certificates of authority;

(ii) filing policy forms;

(iii) reporting agent appointments and terminations; and

(iv) filing annual statements.

(c) Fees related to the renewal of licenses may be imposed no more frequently than once each year.

(2) (a) A regulatory fee charged by the department shall be set in accordance with Section 63-38-3.2.

(b) Fees shall be set and collected for services provided by the department.

(3) (a) For a fee authorized by this chapter that is not a regulatory fee, the department may adopt a schedule of fees provided that each fee in the schedule of fees is:

(i) reasonable and fair; and

(ii) submitted to the Legislature as part of the department's annual appropriations request.

(b) If a fee schedule described in Subsection (3)(a) is submitted as part of the department's annual appropriations request, the Legislature may, in a manner substantially similar to Section 63-38-3.2:

(i) approve any fee in the fee schedule;

(ii) (A) increase or decrease any fee in the fee schedule; and

(B) approve any fee in the fee schedule as changed by the Legislature; or

(iii) reject any fee in the fee schedule.

(c) (i) Except as provided in Subsection (3)(c)(ii), a fee approved by the Legislature

pursuant to this Subsection (3) shall be deposited into the General Fund for appropriation by the Legislature.

(ii) **§ [~~A~~] BEGINNING ON JULY 1, 2002 AND ENDING ON JUNE 30, 2006, A §** fee approved by the Legislature pursuant to this Subsection (3) that relates to the use of electronic or other similar technology to provide the services of the department shall be deposited into the General Fund as a dedicated credit to be used by the department to provide services through use of electronic commerce or other similar technology.

[~~(2)~~] (4) The commissioner shall separately publish the schedule of fees approved by the Legislature and make it available upon request for $1 per copy. This fee schedule shall also be included in any compilation of rules promulgated by the commissioner.

[~~(3) (a) Fees shall be set and collected for services provided by the department. "Services" include issuing and renewing licenses and certificates of authority, filing policy forms, reporting agent appointments and terminations, filing annual statements, and other functions that are reasonable and necessary to enable the commissioner to perform the duties imposed by the Insurance Code.~~]

[~~(b) Fees related to the renewal of licenses may be imposed no more frequently than once each year.~~]

[~~(4)~~] (5) The commissioner shall, by rule, establish the deadlines for payment of [~~each of the various fees~~] any fee established by the department in accordance with this section.

Section 7. Section **31A-3-104** is enacted to read:

31A-3-104. Electronic commerce dedicated fees.

(1) The department may charge a fee for requests for information:

(a) that is obtained from an electronic database of the department; or

(b) derived from data that is generated by electronic means.

(2) In addition to any fee authorized in this title, the department shall impose a supplemental fee on the issuance or renewal of any of the following issued by the department:

(a) a license;

(b) a registration; or

(c) a certificate of authority.

(3) A fee imposed under this section shall be:

(a) established in accordance with Subsection 31A-3-103(3); and

(b) deposited into the General Fund as a dedicated credit in accordance with Subsection

31A-3-103(3).

(4) In accordance with Section 63-55-231, this section is repealed on July 1, 2006.

Section 8. Section **31A-3-401** is amended to read:

31A-3-401. Retaliation against insurers of foreign state or country.

(1) Except as provided in Section 31A-3-402, when, under the laws of another state or foreign country any taxes, licenses, other fees, deposit requirements, or other material obligations, prohibitions, or restrictions are or would be imposed on Utah insurers, or on the agents or representatives of Utah insurers, [~~which~~] that are in excess of the taxes, licenses, other fees, deposit requirements, or other obligations, prohibitions, or restrictions directly imposed upon similar insurers, or upon the agents or representatives of those insurers, of that other state or country under the statutes of this state, as long as the laws of that other state or country continue in force or are so applied, the same taxes, licenses, other fees, deposit requirements, or other material obligations, prohibitions, or restrictions of any kind shall be imposed, collected, and enforced by the State Tax Commission, with the assistance of the commissioner, upon the insurers, or upon the agents or representatives of those insurers, of that other state or country doing business or seeking to do business in this state.

(2) Any tax, license, or other obligation imposed by any city, county, or other political subdivision or agency of another state or country on Utah insurers, their agents, or representatives is considered as being imposed by that state or country within the meaning of this section.

(3) The commissioner may by rule waive the retaliatory requirements for [~~an individual or agency licensee~~] a person that is:

(a) doing business in this state; or

(b) seeking to do business in this state.

Section 9. Section **31A-4-107** is amended to read:

31A-4-107. Other business.

(1) As used in this section, "business reasonably incidental to insurance business" includes:

(a) in the case of an insurer authorized to transact title insurance:

(i) preparing or selling abstracts of title and related documents; and

(ii) providing escrow[~~, settlement, or closing~~] services in connection with real estate transactions, or other services incidental to the sale or transfer of insurance related to the sale or transfer of real property, except the sale of other kinds of insurance related to the sale or transfer

of real property; and

(b) the business that could be done through subsidiaries authorized under Subsection 31A-5-218(3) or, in the case of a nondomestic insurer, through corporations that would be authorized under Subsection 31A-5-218(3) if the insurer were a domestic insurer.

(2) No domestic insurer may engage, directly or indirectly, in any business other than insurance and business reasonably incidental to its insurance business, except as specifically authorized by Section 31A-5-218 or other law in this state.

(3) No nondomestic insurer may engage in this state in any business forbidden to a domestic insurer, nor may the insurer engage in that type of business elsewhere if the commissioner orders the nondomestic insurer to cease doing that type of business upon finding that doing that business is not consistent with the interests of its insureds, creditors, or the public in this state.

Section 10. Section **31A-4-115** is amended to read:

31A-4-115. Plan of orderly withdrawal.

(1) (a) When an insurer intends to withdraw from writing a line of insurance in this state or to reduce its total annual premium volume by 75% or more, [~~it~~] the insurer shall file with the commissioner a plan of orderly withdrawal.

(b) For purposes of this section, a discontinuance of a health benefit plan pursuant to one of the following provisions is a withdrawal from a line of insurance:

(i) Subsection 31A-30-107(3)(e); or

(ii) Subsection 31A-30-107.1(3)(e).

(2) An insurer's plan of orderly withdrawal shall:

(a) indicate the date the insurer intends to begin and complete its withdrawal plan; and

(b) include provisions for:

(i) meeting the insurer's contractual obligations;

(ii) providing services to its Utah policyholders and claimants; [~~and~~]

(iii) meeting any applicable statutory obligations[~~.~~]; and

(iv) (A) the payment of a withdrawal fee of $50,000 to the Utah Comprehensive Health Insurance Pool if:

(I) the insurer is an accident and health insurer; and

(II) the insurer's line of business is not assumed or placed with another insurer approved

by the commissioner; or

(B) the payment of a withdrawal fee of $50,000 to the department if:

(I) the insurer is not an accident and health insurer; and

(II) the insurer's line of business is not assumed or placed with another insurer approved by the commissioner.

(3) The commissioner shall approve a plan of orderly withdrawal if [~~it~~] the plan adequately demonstrates that the insurer will:

(a) protect the interests of the people of the state;

(b) meet [~~its~~] the insurer's contractual obligations;

(c) provide service to [~~its~~] the insurer's Utah policyholders and claimants; and

(d) meet any applicable statutory obligations.

(4) Section 31A-2-302 governs the commissioner's approval or disapproval of a plan for orderly withdrawal.

(5) The commissioner may require an insurer to increase the deposit maintained in accordance with Section 31A-4-105 or Section 31A-4-105.5 and place the deposit in trust in the name of the commissioner upon finding, after an adjudicative proceeding that:

(a) there is reasonable cause to conclude that the interests of the people of the state are best served by such action; and

(b) the insurer:

(i) has filed a plan of orderly withdrawal; or

(ii) intends to:

(A) withdraw from writing a line of insurance in this state; or

(B) reduce [~~its~~] the insurer's total annual premium volume by 75% or more.

(6) An insurer [~~that~~] is subject to the civil penalties under Section 31A-2-308, if the insurer:

(a) (i) withdraws from writing insurance in this state; or [~~that~~]

(ii) reduces its total annual premium volume by 75% or more in any year without having submitted a plan or receiving the commissioner's approval [~~is subject to the civil penalties under Section 31A-2-308~~].

(7) An insurer that withdraws from writing all lines of insurance in this state may not resume writing insurance in this state for five years [~~without~~] unless:

(a) [~~the approval of~~] the commissioner finds that the prohibition should be waived because the waiver is:

(i) in the public interest to promote competition; or

(ii) to resolve inequity in the marketplace; and

(b) [~~complying~~] the insurer complies with Subsection 31A-30-108(5), if applicable.

(8) The commissioner shall adopt rules necessary to implement [~~the provisions of~~] this section.

Section 11. Section **31A-4-116** is amended to read:

31A-4-116. Adverse benefit determination procedures.

(1) If an insurer has established a complaint resolution body or grievance appeal board, the body or board shall include at least one consumer representative.

(2) [~~Grievance~~] Adverse benefit determination procedures for health insurance policies and health maintenance organization contracts shall be established in accordance Section 31A-22-629.

Section 12. Section **31A-5-405** is amended to read:

31A-5-405. Meetings of mutuals and mutual policyholders' and members' voting rights.

(1) (a) Subject to this section, Sections 16-6a-701, 16-6a-702, 16-6a-704, and 16-6a-714 apply to the meetings of members, the notice, and the voting in mutuals.

(b) Subject to this section and Section 31A-5-409, Section 16-6a-711 applies to the voting of members of mutuals.

(2) (a) Policyholders or voting members in all mutuals have the right to vote on:

(i) conversion[~~,~~];

(ii) voluntary dissolution[~~,~~];

(iii) amendment of the articles[~~,~~]; and

(iv) the election of directors except public directors appointed [~~under Subsection~~] in accordance with Subsections 31A-5-409(1) and (2).

(b) The mutual may adopt reasonable provisions in its bylaws to determine:

(i) which individual among joint policyholders may exercise a voting right; and

(ii) how to deal with cases where the same individual is one of several joint policyholders in various policies.

[~~(b)~~] (c) The articles of any mutual may give the policyholders or voting members

additional voting rights. These articles may require a greater percentage of affirmative votes to approve an action than the statutes require.

(3) (a) The articles or bylaws shall contain rules governing voting procedures and voting eligibility consistent with Subsection (1). [~~No~~]

(b) An amendment to [~~these rules~~] a rule described in this Subsection (3) is not effective until at least 30 days after [~~it~~] the rule has been filed with the commissioner.

(4) (a) The articles or bylaws may provide for regular or special meetings of the policyholders or voting members, and, if meetings are not provided for, then mail elections shall be provided for in lieu of elections at meetings.

(b) Notice of the time and place of regular meetings or elections shall be given to each policyholder or voting member in a reasonable manner as the commissioner approves or requires. Changes may be made by written notice mailed, properly addressed, and stamped, to the last-known address of all policyholders or voting members.

(5) (a) The articles may provide that representatives or delegates selected by the policyholders or voting members shall be from specific geographical districts or defined classes of policyholders or voting members, as determined on a reasonable basis.

(b) After the representative assembly has been selected by the policyholder or voting members, the assembly or the respective classes of policyholders or voting members may choose replacements for members unable to complete their terms, if the articles provide for their replacement.

(c) The vote of a person holding a valid proxy is treated as the vote of the policyholders or voting members who gave the proxy.

Section 13. Section **31A-5-409** is amended to read:

31A-5-409. Selection and removal of directors and officers of mutuals.

(1) The articles or bylaws of a mutual [~~may provide that any~~] shall state:

(a) the number of directors of the mutual including the directors that are:

(i) appointed as public directors under this Subsection (1) and Subsection (2); or

(ii) elected under Subsection (3);

(b) the number of [~~the~~] directors [~~are~~] of the mutual that may be appointed as public directors [~~chosen under a plan proposed by the corporation and approved by the commissioner.~~]; and

(c) the plan that specifies the manner in which:

(i) a public director is to be appointed; and

(ii) a director who is not a public director is to be elected.

(2) (a) The plan for the appointment of public directors specified in Subsection (1) shall assure true public representation on the board. [~~The persons nominated as directors~~]

(b) A person appointed as a public director shall have insurance business or [~~general~~] other business or professional experience that qualifies [~~them~~] that person to serve responsibly and impartially as a director.

(c) A public director may be an uncompensated member of the board of directors.

(d) Notwithstanding Subsection (2)(c), a public director shall meet the qualifications of Subsection (2)(b).

[~~(2)~~] (3) (a) [~~Directors not chosen under Subsection (1) are~~] A director who is not a public director shall be elected by:

(i) the policyholders; or

(ii) voting members.

(b) If the directors who are not public directors are divided into classes, one class shall be elected:

(i) at least every four years[~~,~~]; and

(ii) for a term not exceeding six years.

[~~(3)~~] (4) A director may be removed from office for cause by an affirmative vote of a majority of the full board at a meeting of the board called for that purpose.

[~~(4)~~] (5) Subject to Subsections (1)[~~, (2), and (3)~~] through (4), Section 16-6a-810 applies to vacancies on the governing board.

Section 14. Section **31A-5-410** is amended to read:

31A-5-410. Supervision of management changes.

(1) (a) [~~The~~] Immediately after the selection of a person as a director or principal officer, the insurer shall report to the commissioner:

(i) the name of [~~a~~] the person selected as a director or principal officer of a corporation[~~, together with~~]; and

(ii) pertinent biographical and other data that the commissioner requires by rule[~~, shall be reported to the commissioner immediately after the selection~~].

(b) For five years after the initial issuance of a certificate of authority to a corporation, the commissioner may, within 30 days after receipt of a report under Subsection (1)(a), disapprove any person selected who fails to satisfy the commissioner that [~~he~~] the person:

(i) is trustworthy; and

(ii) has the competence and experience necessary to discharge [~~his~~] that person's responsibilities.

(2) (a) Whenever a director or principal officer of a corporation is removed under [~~Section 16-10a-808 or 16-10a-832, Subsections 16-6a-820(4) and 31A-5-409(3),~~] a provision listed in Subsection (2)(b), the insurer shall immediately report to the commissioner:

(i) the removal [~~shall be reported to the commissioner immediately, together with~~]; and

(ii) a statement of the reasons for the removal.

(b) Subsection (2)(a) applies to a removal under:

(i) Subsection 16-6a-820(4);

(ii) Section 16-10a-808;

(iii) Section 16-10a-832; and

(iv) Subsection 31A-5-409(4).

(3) [~~If~~] The commissioner may order the removal of a director or officer if the commissioner finds, after a hearing, that:

(a) a director or officer:

(i) is incompetent [~~or~~];

(ii) untrustworthy[~~, or~~];

(iii) is not qualified under Section 31A-5-409; or

(iv) has wilfully violated:

(A) this [~~code,~~] title;

(B) a rule adopted under Subsection 31A-2-201(3)[~~,~~]; or

(C) an order issued under Subsection 31A-2-201(4)[~~,~~]; and [~~that the incompetence, untrustworthiness, or the violation~~]

(b) the circumstances described in Subsection (3)(a) endangers the interests of:

(i) insureds; or

(ii) the public[~~, he may order the removal of the director or officer~~].

Section 15. Section **31A-8-101** is amended to read:

31A-8-101. Definitions.

For purposes of this chapter:

(1) "Basic health care services" means:

(a) emergency care;

(b) inpatient hospital and physician care;

(c) outpatient medical services; and

(d) out-of-area coverage.

(2) "Director of health" means:

(a) the executive director of the Department of Health; or [~~his~~]

(b) the authorized representative of the executive director of the Department of Health.

(3) "Enrollee" means an individual:

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

(b) in whose behalf an arrangement for health care has been made.

(4) "Health care" is as defined in Section 31A-1-301.

(5) "Health maintenance organization" means any person:

(a) other than:

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

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

(b) that:

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

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

(6) (a) "Limited health plan" means, except as limited under Subsection (6)(b), any person who furnishes, either directly or through arrangements with others, services:

(i) of:

(A) dentists;

(B) optometrists;

(C) physical therapists;

(D) podiatrists;

(E) psychologists;

(F) physicians;

(G) chiropractic physicians;

(H) naturopathic physicians;

(I) osteopathic physicians;

(J) social workers;

(K) family counselors;

(L) other health care providers; or

(M) reasonable combinations of the services described in this Subsection [~~(1)~~] (6)(a)(i);

(ii) to an enrollee;

(iii) in return for prepaid periodic payments agreed to in amount prior to the time during which the services may be furnished; and

(iv) for which the person is obligated to the enrollee to arrange for or directly provide the available and accessible [~~the~~] services described in this Subsection (6)(a).

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

(i) a health maintenance organization;

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

(iii) an individual who contracts to render professional or personal services that [~~he~~] the individual performs [~~himself~~].

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

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

(8) "Organization" means a health maintenance organization and limited health plan, unless used in the context of:

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

(b) "organization expenses," [~~in~~] which [~~case see~~] is described in Section 31A-8-208.

(9) "Participating provider" means a provider as defined in Subsection (10) who, under a contract with the health maintenance organization, [~~has agreed~~] agrees to provide health care services to enrollees with an expectation of receiving payment, directly or indirectly, from the health maintenance organization, other than copayment.

(10) "Provider" means any person who:

(a) furnishes health care directly to the enrollee; and [~~who~~]

(b) is licensed or otherwise authorized to furnish [~~this~~] the health care in this state.

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

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

Section 16. Section **31A-8-103** is amended to read:

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

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

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

(i) is wholly exempt from [~~Chapters~~]:

(A) Chapter 7,[~~, 9, 10, 11, 12, 13, 19, and 28~~] Nonprofit Health Service Insurance Corporations;

(B) Chapter 9, Insurance Fraternals;

(C) Chapter 10, Annuities;

(D) Chapter 11, Motor Clubs;

(E) Chapter 12, State Risk Management Fund;

(F) Chapter 13, Employee Welfare Funds and Plans;

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

(H) Chapter 28, Guaranty Associations; and

(ii) not subject to:

[~~(i)~~] (A) Chapter 3, Department Funding, Fees, and Taxes, except for Part I;

[~~(ii)~~] (B) Section 31A-4-107;

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

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

[~~(v)~~] (E) Chapter 17, Determination of Financial Condition, except:

[~~(A) Part~~] (I) Parts II and VI; or

[~~(B)~~] (II) as made applicable by the commissioner by rule consistent with this chapter;

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

[~~(vii)~~] (G) Chapter 22, Contracts in Specific Lines, except for Parts VI, VII, and XII.

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

(a) enrollees;

(b) investors; or

(c) the public.

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

(a) this chapter;

(b) a provision referenced under this chapter; or

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

(4) (a) Whenever in this chapter, Chapter 5, or Chapter 14 is made applicable to an organization, the application is:

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

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

(b) When Chapter 5 or 14 is made applicable to an organization under this chapter, "mutual" means nonprofit organization.

(5) Solicitation of enrollees by an organization is not a violation of any provision of law

relating to solicitation or advertising by health professionals if that solicitation is made in accordance with:

(a) this chapter; and

(b) Chapter 23, Insurance Marketing - Licensing Agents, Brokers, Consultants, and Reinsurance Intermediaries.

(6) [~~Nothing in this title prohibits~~] This title does not prohibit any health maintenance organization from meeting the requirements of any federal law that enables the health maintenance organization to:

(a) receive federal funds; or

(b) obtain or maintain federal qualification status.

(7) Except as provided in Section 31A-8-501, an organization is exempt from statutes in this title or department rules that restrict or limit [~~its~~] the organization's freedom of choice in contracting with or selecting health care providers, including Section 31A-22-618.

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

Section 17. Section **31A-8-205** is amended to read:

31A-8-205. Organization permit and certificate of incorporation.

(1) Section 31A-5-204 applies to the formation of organizations, except that "Section 31A-5-211" in Subsection 31A-5-204(5) shall be read "Section 31A-8-209."

(2) In addition to the requirements of Section 31A-5-204, the application for a permit shall include a description of the initial locations of facilities where health care will be available to enrollees, the hours during which various services will be provided, the types of health care personnel to be used at each location and the approximate number of each personnel type to be available at each location, the methods to be used to monitor the quality of health care furnished, the method of resolving [~~grievances~~] adverse benefit determinations initiated by enrollees or providers, the method used to give enrollees an opportunity to participate in matters of policy, the medical records system, and the method for documentation of utilization of health care by persons insured.

Section 18. Section **31A-8-209** is amended to read:

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

(1) (a) A health maintenance organization being organized or operating under this chapter

shall have and maintain a minimum capital or minimum permanent surplus of $100,000.

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

(i) the health maintenance organization's liabilities;

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

(iii) the greater of:

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

(B) $1,300,000.

(2) (a) The minimum required capital or minimum permanent surplus for a limited health plan may not:

(i) [~~is at least~~] be less than $10,000; [~~and~~] or

(ii) [~~may not~~] exceed $100,000.

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

(i) a hearing; and

(ii) consideration of:

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

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

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

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

(I) insolvency insurance;

(II) reinsurance;

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

(IV) personal and corporate financial guarantees;

(V) provider withholds and assessments;

(VI) surety bonds;

(VII) hold harmless agreements in provider contracts; and

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

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

[~~(3) Before beginning operations, a health maintenance organization licensed under this chapter shall have total adjusted capital in excess of the company action level RBC as defined in Subsection 31A-17-601(8)(b).~~]

[~~(4) Each health maintenance organization authorized to do business in this state shall maintain assets in an amount equal to the total of the health maintenance organization's:~~]

[~~(a) liabilities;~~]

[~~(b) minimum capital or minimum permanent surplus required by Subsection (1) or (2);~~ ~~and~~]

[~~(c) the company action level RBC as defined in Subsection 31A-17-601(8)(b).~~]

[~~(5) As a prerequisite to receiving an original certificate of authority to do business in this state, a health maintenance organization shall have initial surplus at least $400,000 in excess of the capital and surplus required by Subsection (4).~~]

[~~(6)~~] (3) The commissioner may allow the minimum capital or permanent surplus account of an organization to be designated by some other name.

[~~(7)~~] (4) A pattern of persistent deviation from the accounting and investment standards under this section may be grounds for the commissioner to find that the one or more persons with authority to make the organization's accounting or investment decisions are incompetent for purposes of Subsection 31A-5-410(3).

Section 19. Section **31A-8-211** is amended to read:

31A-8-211. Deposit.

(1) Except as provided in Subsection (2), each health maintenance organization authorized in this state shall maintain a deposit with the commissioner under Section 31A-2-206 in an amount equal to the sum of:

(a) [~~the health maintenance organization's minimum capital or minimum permanent surplus requirement of Subsection 31A-8-209(1) or (2)~~] $100,000; and

(b) 50% of the greater of:

(i) $900,000;

(ii) 2% of the annual premium revenues as reported on the most recent annual financial statement filed with the commissioner; or

(iii) an amount equal to the sum of three months uncovered health care expenditures as reported on the most recent financial statement filed with the commissioner.

(2) (a) After a hearing the commissioner may exempt a health maintenance organization from the deposit requirement of Subsection (1) if:

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

(ii) the health maintenance organization has been continuously authorized to do business in this state for at least five years; and

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

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

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

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

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

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

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

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

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

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

(4) A deposit required by this section may be counted toward the minimum capital or

minimum permanent surplus required under Section 31A-8-209.

Section 20. Section **31A-8-401** is amended to read:

31A-8-401. Enrollee participation.

Every organization shall provide a reasonable procedure, consistent with Section 31A-4-116, for allowing enrollees to participate in matters of policy of the organization and for resolving complaints and [~~grievances~~] adverse benefit determinations initiated by enrollees or providers.

Section 21. Section **31A-8-402.3** is enacted to read:

31A-8-402.3. Discontinuance, nonrenewal, or changes to group health benefit plans.

(1) Except as otherwise provided in this section, a group health benefit plan for a plan sponsor is renewable and continues in force:

(a) with respect to all eligible employees and dependents; and

(b) at the option of the plan sponsor.

(2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed:

(a) for a network plan, if:

(i) there is no longer any enrollee under the group health plan who lives, resides, or works in:

(A) the service area of the insurer; or

(B) the area for which the insurer is authorized to do business; and

(ii) in the case of the small employer market, the insurer applies the same criteria the insurer would apply in denying enrollment in the plan under Subsection 31A-30-108(6); or

(b) for coverage made available in the small or large employer market only through an association, if:

(i) the employer's membership in the association ceases; and

(ii) the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

(3) A health benefit plan for a plan sponsor may be discontinued if:

(a) a condition described in Subsection (2) exists;

(b) the plan sponsor fails to pay premiums or contributions in accordance with the terms of the contract;

(c) the plan sponsor:

(i) performs an act or practice that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact under the terms of the coverage;

(d) the insurer:

(i) elects to discontinue offering a particular health benefit product delivered or issued for delivery in this state; and

(ii) (A) provides notice of the discontinuation in writing:

(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

(II) at least 90 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner; and

(II) at least three working days prior to the date the notice is sent to the affected plan sponsors, employees, and dependents of the plan sponsors or employees;

(C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase:

(I) all other health benefit products currently being offered by the insurer in the market; or

(II) in the case of a large employer, any other health benefit product currently being offered in that market; and

(D) in exercising the option to discontinue that product and in offering the option of coverage in this section, acts uniformly without regard to:

(I) the claims experience of a plan sponsor;

(II) any health status-related factor relating to any covered participant or beneficiary; or

(III) any health status-related factor relating to any new participant or beneficiary who may become eligible for the coverage; or

(e) the insurer:

(i) elects to discontinue all of the insurer's health benefit plans in:

(A) the small employer market;

(B) the large employer market; or

(C) both the small employer and large employer markets; and

(ii) (A) provides notice of the discontinuation in writing:

(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

(II) at least 180 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner in each state in which an affected insured individual is known to reside; and

(II) at least 30 working days prior to the date the notice is sent to the affected plan sponsors, employees, and the dependents of the plan sponsors or employees;

(C) discontinues and nonrenews all plans issued or delivered for issuance in the market; and

(D) provides a plan of orderly withdrawal as required by Section 31A-4-115.

(4) A health benefit plan for a plan sponsor may be nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) for noncompliance with the insurer's:

(i) minimum participation requirements; or

(ii) employer contribution requirements.

(5) (a) Except as provided in Subsection (5)(d), an eligible employee may be discontinued if after issuance of coverage the eligible employee:

(i) engages in an act or practice in connection with the coverage that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact in connection with the coverage.

(b) An eligible employee that is discontinued under Subsection (5)(a) may reenroll:

(i) 12 months after the date of discontinuance; and

(ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies to reenroll.

(c) At the time the eligible employee's coverage is discontinued under Subsection (5)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is discontinued.

(d) An eligible employee may not be discontinued under this Subsection (5) because of a fraud or misrepresentation that relates to health status.

(6) For purposes of this section, a reference to "plan sponsor" includes a reference to the employer:

(a) with respect to coverage provided to an employer member of the association; and

(b) if the health benefit plan is made available by an insurer in the employer market only

through:

(i) an association;

(ii) a trust; or

(iii) a discretionary group.

(7) An insurer may modify a health benefit plan for a plan sponsor only:

(a) at the time of coverage renewal; and

(b) if the modification is effective uniformly among all plans with that product.

Section 22. Section **31A-8-402.5** is enacted to read:

31A-8-402.5. Individual discontinuance and nonrenewal.

(1) (a) Except as otherwise provided in this section, a health benefit plan offered on an individual basis is renewable and continues in force:

(i) with respect to all individuals or dependents; and

(ii) at the option of the individual.

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

(i) whether the contract is issued through:

(A) a trust;

(B) an association;

(C) a discretionary group; or

(D) other similar grouping; or

(ii) the situs of delivery of the policy or contract.

(2) A health benefit plan may be discontinued or nonrenewed:

(a) for a network plan, if:

(i) the individual no longer lives, resides, or works in:

(A) the service area of the insurer; or

(B) the area for which the insurer is authorized to do business; and

(ii) coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual; or

(b) for coverage made available through an association, if:

(i) the individual's membership in the association ceases; and

(ii) the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

(3) A health benefit plan may be discontinued if:

(a) a condition described in Subsection (2) exists;

(b) the individual fails to pay premiums or contributions in accordance with the terms of the health benefit plan, including any timeliness requirements;

(c) the individual:

(i) performs an act or practice in connection with the coverage that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact under the terms of the coverage;

(d) the insurer:

(i) elects to discontinue offering a particular health benefit product delivered or issued for delivery in this state; and

(ii) (A) provides notice of the discontinuation in writing:

(I) to each individual provided coverage; and

(II) at least 90 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner; and

(II) at least three working days prior to the date the notice is sent to the affected individuals;

(C) offers to each covered individual on a guaranteed issue basis, the option to purchase all other individual health benefit products currently being offered by the insurer for individuals in that market; and

(D) acts uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage; or

(e) the insurer:

(i) elects to discontinue all of the insurer's health benefit plans in the individual market; and

(ii) (A) provides notice of the discontinuation in writing:

(I) to each individual provided coverage; and

(II) at least 180 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner in each state in which an affected insured individual is known to

reside; and

(II) at least 30 working days prior to the date the notice is sent to the affected individuals;

(C) discontinues and nonrenews all health benefit plans the insurer issues or delivers for insurance in the individual market; and

(D) acts uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.

Section 23. Section **31A-8-402.7** is enacted to read:

31A-8-402.7. Discontinuance and nonrenewal limitations.

(1) Subject to Section 31A-4-115, an insurer that elects to discontinue offering a health benefit plan under Subsections 31A-8-402.3(3)(e) and 31A-8-402.5(3)(e) is prohibited from writing new business:

(a) in the market in this state for which the insurer discontinues or does not renew; and

(b) for a period of five years beginning on the date of discontinuation of the last coverage that is discontinued.

(2) If an insurer is doing business in one established geographic service area of the state, Sections 31A-8-402.3 and 31A-8-402.5 apply only to the insurer's operations in that service area.

(3) Notwithstanding whether Chapter 22, Part VII, Group Accident and Health Insurance, requires a conversion policy be available for certain persons who are no longer entitled to group coverage, an organization may not be required to provide a conversion policy to a person residing outside of the organization's service area.

(4) The commissioner may, by rule or order, define the scope of service area.

Section 24. Section **31A-8-407** is amended to read:

31A-8-407. Written contracts -- Limited liability of enrollee.

(1) (a) Every contract between an organization and a participating provider of health care services shall be in writing and shall set forth that if the organization:

(i) fails to pay for health care services as set forth in the contract, the enrollee may not be liable to the provider for any sums owed by the organization; and

(ii) the organization becomes insolvent, the rehabilitator or liquidator may require the participating provider of health care services to:

(A) continue to provide health care services under the contract between the participating provider and the organization until the [~~later~~] earlier of:

(I) 90 days [~~from~~] after the date of the filing of a petition for rehabilitation or the petition for liquidation; or

(II) the date the term of the contract ends; and

(B) subject to Subsection (1)(c), reduce the fees the participating provider is otherwise entitled to receive from the organization under the contract between the participating provider and the organization during the time period described in Subsection (1)(a)(ii)(A).

(b) If the conditions of Subsection (1)(c) are met, the participating provider shall:

(i) accept the reduced payment as payment in full; and

(ii) relinquish the right to collect additional amounts from the insolvent organization's enrollee.

(c) Notwithstanding Subsection (1)(a)(ii)(B):

(i) the rehabilitator or liquidator may not reduce a fee to less than 75% of the regular fee set forth in the participating provider contract; and

(ii) the enrollee shall continue to pay the same copayments, deductibles, and other payments for services received from the participating provider that the enrollee was required to pay before the filing of:

(A) the petition for reorganization; or

(B) the petition for liquidation.

(2) A participating provider may not collect or attempt to collect from the enrollee sums owed by the organization or the amount of the regular fee reduction authorized under Subsection (1)(a)(ii) if the participating provider contract:

(a) is not in writing as required in Subsection (1); or

(b) fails to contain the language required by Subsection (1).

(3) (a) A person listed in Subsection (3)(b) may not bill or maintain any action at law against an enrollee to collect:

(i) sums owed by the organization; or

(ii) the amount of the regular fee reduction authorized under Subsection (1)(a)(ii).

(b) Subsection (3)(a) applies to:

(i) a participating provider;

(ii) an agent;

(iii) a trustee; or

(iv) an assignee of a person described in Subsections (3)(b)(i) through (iii).

Section 25. Section **31A-8-408** is amended to read:

31A-8-408. Organizations offering point of service or point of sales products.

Effective July 1, 1991, a health maintenance organization offering products that permit members the option of obtaining covered services from a noncontracted provider, which is a point of service or point of sale product, shall comply with the requirements of Subsections (1) through (7).

(1) The cost of an encounter with a noncontracted provider is considered an uncovered expenditure as defined in Section 31A-8-101.

(2) [~~Any~~] (a) An organization [~~offering to sell point of service products~~] shall report to the commissioner on a monthly basis the number of encounters with contracted and noncontracted providers [~~to the commissioner on a monthly basis~~] if the organization offers to sell a:

(i) point of service product; or

(ii) point of sale product.

(b) The commissioner shall:

(i) define the form, content, and due date of the report required by this Subsection (2); and [~~shall~~]

(ii) require audited reports of the information on a yearly basis.

(3) An organization may not offer a point of service [~~products~~] product or a point of sale product unless [~~it~~] the organization has secured contracts with participating providers located within the organization's service area for each covered service other than those unusual or infrequently used health services that are not available from the organization's health care providers.

(4) An organization may not enroll [~~members~~] a member who [~~do~~] does not work or reside in the service area as defined by rule, except this Subsection (4) does not apply to [~~dependents~~] a dependent of [~~enrollees~~] an enrollee.

(5) Any organization that exceeds the 10% limit of unusual or infrequently used health services as defined in Section 31A-8-101 is subject to a forfeiture of up to $50 per encounter.

(6) An organization shall disclose to employees and members the existence of the 10% limit:

(a) at enrollment; or

(b) prior to enrollment.

(7) The commissioner shall hold hearings and adopt rules providing any additional limitations or requirements necessary to secure the public interest in conformity with this section.

Section 26. Section **31A-17-505** is amended to read:

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

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

(a) [~~For~~] for individual annuity and pure endowment contracts issued prior to April 2, 1980, excluding any accident and health and accidental death benefits in [~~such~~] the contracts:

(i) (A) the 1971 Individual Annuity Mortality Table[~~,~~]; or

(B) any modification of [~~this table~~] the 1971 Individual Annuity Mortality Table approved by the commissioner[~~, and~~];

(ii) 6% interest for single premium immediate annuity contracts[~~,~~]; and

(iii) 4% interest for all other individual annuity and pure endowment contracts[~~.~~];

(b) [~~For~~] for individual single premium immediate annuity contracts issued on or after April 2, 1980, excluding any accident and health and accidental death benefits in [~~such~~] the contracts: [~~the 1971 Individual Annuity Mortality Table or~~]

(i) (A) any individual annuity mortality table[~~, adopted after 1980 by the National Association of Insurance Commissioners~~] that is approved by rule [~~promulgated~~] by the commissioner for use in determining the minimum standard of valuation for such contracts[~~,~~]; or

(B) any modification of [~~these tables~~] a table described in Subsection (1)(b)(i)(A) approved by the commissioner[~~,~~]; and

(ii) 7.5% interest[~~.~~];

(c) [~~For~~] for individual annuity and pure endowment contracts issued on or after April 2, 1980, other than single premium immediate annuity contracts, excluding any accident and health and accidental death benefits in [~~such~~] the contracts: [~~the 1971 Individual Annuity Mortality Table or~~]

(i) (A) any individual annuity mortality table [~~adopted after 1980 by the National Association of Insurance Commissioners,~~] that is approved by rule [~~promulgated~~] by the commissioner for use in determining the minimum standard of valuation for such contracts[~~,~~]; or

(B) any modification of [~~these tables~~] a table described in Subsection (1)(c)(i)(A) approved by the commissioner[~~, and~~];

(ii) 5.5% interest for single premium deferred annuity and pure endowment contracts; and

(iii) 4.5% interest for all other such individual annuity and pure endowment contracts[~~.~~];

(d) [~~For~~] for all annuities and pure endowments purchased prior to April 2, 1980, under group annuity and pure endowment contracts, excluding any accident and health and accidental death benefits purchased under [~~such~~] the contracts:

(i) (A) the 1971 Group Annuity Mortality Table; or

(B) any modification of [~~this table~~] the 1971 Group Annuity Mortality Table approved by the commissioner[~~,~~]; and

(ii) 6.5% interest[~~.~~]; and

(e) [~~For~~] for all annuities and pure endowments purchased on or after April 2, 1980, under group annuity and pure endowment contracts, excluding any accident and health and accidental death benefits purchased under [~~such~~] the contracts: [~~the 1971 Group Annuity Mortality Table, or~~]

(i) (A) any group annuity mortality table [~~adopted after 1980 by the National Association of Insurance Commissioners,~~] that is approved by rule [~~and promulgated~~] by the commissioner for use in determining the minimum standard of valuation for such annuities and pure endowments[~~,~~]; or

(B) any modification of [~~these tables~~] a table described in Subsection (1)(e)(i)(A) approved by the commissioner[~~,~~]; and

(ii) 7.5% interest.

(2) (a) After June 1, 1973, any company may file with the commissioner a written notice of its election to comply with [~~the provisions of~~] this section after a specified date before January 1, 1979, which shall be the operative date of this section for [~~such~~] the company[~~, provided, if~~].

(b) If a company [~~makes no such~~] does not make an election under Subsection (2)(a), the operative date of this section for [~~such~~] the company shall be January 1, 1979.

Section 27. Section **31A-17-506** is amended to read:

31A-17-506. Computation of minimum standard by calendar year of issue.

(1) Applicability of Section 31A-17-506: The interest rates used in determining the minimum standard for the valuation shall be the calendar year statutory valuation interest rates as defined in this section for:

(a) all life insurance policies issued in a particular calendar year, on or after the operative date of Subsection 31A-22-408(6)(d);

(b) all individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, [~~1994~~] 1982;

(c) all annuities and pure endowments purchased in a particular calendar year on or after January 1, [~~1994~~] 1982, under group annuity and pure endowment contracts; and

(d) the net increase, if any, in a particular calendar year after January 1, [~~1994~~] 1982, in amounts held under guaranteed interest contracts.

(2) Calendar year statutory valuation interest rates:

(a) The calendar year statutory valuation interest rates, "I," shall be determined as follows and the results rounded to the nearer 1/4 of 1%:

(i) For life insurance:

I =.03 + W(R1 -.03) + (W/2)(R2 -.09);

(ii) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options:

I =.03 + W(R -.03),

where R1 is the lesser of R and.09,

R2 is the greater of R and.09,

R is the reference interest rate defined in Subsection (4), and

W is the weighting factor defined in this section;

(iii) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in Subsection (ii), the formula for life insurance stated in Subsection (i) shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of ten years, and the formula for single premium immediate annuities stated in Subsection (ii) shall apply to annuities and guaranteed interest contracts with guarantee duration of ten years or less;

(iv) For other annuities with no cash settlement options and for guaranteed interest

contracts with no cash settlement options, the formula for single premium immediate annuities stated in Subsection (ii) shall apply.

(v) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in Subsection (ii) shall apply.

(b) However, if the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than 1/2 of 1% the calendar year statutory valuation interest rate for such life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the immediately preceding sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980, using the reference interest rate defined in 1979, and shall be determined for each subsequent calendar year regardless of when Subsection 31A-22-408(6)(d) becomes operative.

(3) Weighting factors:

(a) The weighting factors referred to in the formulas stated in Subsection (2) are given in the following tables:

(i) Weighting factors for life insurance:

Guarantee Duration (Years)	Weighting Factors
10 or less:	.50
More than 10, but less than 20:	.45
More than 20:	.35

For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values or both which are guaranteed in the original policy;

(ii) Weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options: .80

(iii) Weighting factors for other annuities and for guaranteed interest contracts, except as stated in Subsection (ii), shall be as specified in Tables (A), (B), and (C) below, according to the

rules and definitions in (D), (E), and (F) below:

(A) For annuities and guaranteed interest contracts valued on an issue year basis:

Guarantee Duration (Years)	Weighting Factors for Plan Type		
	A	B	C
5 or less:	.80	.60	.50
More than 5, but not more than 10:	.75	.60	.50
More than 10, but not more than 20:	.65	.50	.45
More than 20:	.45	.35	.35

(B) For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in (A) above increased by:

	Plan Type		
	A	B	C
	.15	.25	.05

(C) For annuities and guaranteed interest contracts valued on an issue year basis, other than those with no cash settlement options, which do not guarantee interest on considerations received more than one year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis which do not guarantee interest rates on considerations received more than 12 months beyond the valuation date, the factors shown in (A) or derived in (B) increased by:

	Plan Type		
	A	B	C
	.05	.05	.05

(D) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of 20 years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the

guaranteed duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

(E) Plan type as used in the above tables is defined as follows:

Plan Type A: At any time policyholder may withdraw funds only:

(I) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (II) without such adjustment but installments over five years or more, or (III) as an immediate life annuity, or (IV) no withdrawal permitted.

Plan Type B: Before expiration of the interest rate guarantee, policyholder withdraw funds only:

(I) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (II) without such adjustment but in installments over five years or more, or (III) no withdrawal permitted. At the end of interest rate guarantee, funds may be withdrawn without such adjustment in a single sum or installments over less than five years.

Plan Type C: Policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than five years either:

(I) without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (II) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(F) A company may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change in fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue year basis. As used in this section, an issue year basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract, and the change in fund basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

(4) Reference interest rate: "Reference interest rate" referred to in Subsection (2)(a) is defined as follows:

(a) For all life insurance, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year next preceding the year of issue, of the Monthly Average of the composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.

(b) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or year of purchase, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.

(c) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in Subsection (b), with guarantee duration in excess of ten years, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.

(d) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in Subsection (b), with guarantee duration of ten years or less, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.

(e) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.

(f) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in Subsection (b), the average over a period of 12 months, ending on June 30 of the calendar year of the change in the fund, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.

(5) Alternative method for determining reference interest rates: In the event that the Monthly Average of the Composite Yield on Seasoned Corporate Bonds is no longer published

by Moody's Investors Service, Inc. or in the event that the National Association of Insurance Commissioners determines that the Monthly Average of the Composite Yield on Seasoned Corporate Bonds as published by Moody's Investors Service, Inc. is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate, which is adopted by the National Association of Insurance Commissioners and approved by rule promulgated by the commissioner, may be substituted.

Section 28. Section **31A-19a-101** is amended to read:

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

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

(2) (a) (i) Except as provided in Subsection (2)(a)(ii), this chapter applies to all kinds and lines of direct insurance written on risks or operations in this state by an insurer authorized to do business in this state.

(ii) This chapter does not apply to:

(A) life insurance [~~other than~~];

(B) credit life insurance;

[~~(B)~~] (C) variable and fixed annuities;

[~~(C)~~] (D) health and accident and health insurance [~~other than~~];

(E) credit accident and health insurance; and

[~~(D)~~] (F) reinsurance.

(b) This chapter applies to all insurers authorized to do any line of business, except those specified in Subsection (2)(a)(ii).

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

(a) protect policyholders and the public against the adverse effects of excessive, inadequate, or unfairly discriminatory rates;

(b) encourage independent action by and reasonable price competition among insurers so that rates are responsive to competitive market conditions;

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

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

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

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

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

(g) regulate the business of insurance in a manner that, under the McCarran-Ferguson Act, 15 U.S.C. Secs. 1011 through 1015, will preclude application of federal antitrust laws.

(4) Rate filings made prior to July 1, 1986, under former Title 31, Chapter 18, are continued. Rate filings made after July 1, 1986, are subject to the requirements of this chapter.

Section 29. Section **31A-19a-209** is amended to read:

31A-19a-209. Special provisions for title insurance.

(1) In addition to the considerations in determining compliance with rate standards and rating methods as set forth in Sections 31A-19a-201 and 31A-19a-202, the commissioner shall also consider the costs and expenses incurred by title insurance companies, agencies, and agents peculiar to the business of title insurance including:

(a) the maintenance of title plants; and

(b) the searching and examining of public records to determine insurability of title to real property.

(2) (a) Every title insurance company, agency, and title insurance agent shall file with the commissioner a schedule of the escrow[~~, settlement, and closing~~] charges that it proposes to use in this state for services performed in connection with the issuance of policies of title insurance.

(b) The filing required by Subsection (2)(a) shall state the effective date of this schedule, which may not be less than 30 calendar days after the date of filing.

(3) A title insurance company, agency, or agent may not file or use any rate or other charge relating to the business of title insurance, including rates or charges filed for escrow[~~, settlement, and closing charges~~] that would cause the title insurance company, agency, or agent to:

(a) operate at less than the cost of doing:

(i) the insurance business; or

(ii) the escrow[~~, settlement, and closing~~] business; or

(b) fail to adequately underwrite a title insurance policy.

(4) (a) All or any of the schedule of rates or schedule of charges, including the schedule of escrow[~~, settlement, and closing~~] charges, may be changed or amended at any time, subject to the limitations in this Subsection (4).

(b) Each change or amendment shall:

(i) be filed with the commissioner; and

(ii) state the effective date of the change or amendment, which may not be less than 30 calendar days after the date of filing.

(c) Any change or amendment remains in force for a period of at least 90 calendar days from its effective date.

(5) While the schedule of rates and schedule of charges are effective, a copy of each shall be:

(a) retained in each of the offices of:

(i) the insurance company in this state;

(ii) its agents in this state; and

(iii) upon request, furnished to the public.

(6) Except in accordance with the schedules of rates and charges filed with the commissioner, a title insurance company, agency, or agent may not make or impose any premium or other charge:

(a) in connection with the issuance of a policy of title insurance; or

(b) for escrow[~~, settlement, or closing~~] services performed in connection with the issuance of a policy of title insurance.

Section 30. Section **31A-21-104** is amended to read:

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

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

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

(c) Except as provided in Subsections (6), (7), and (8), any insurance provided in violation of this Subsection (1) is subject to Subsection (5).

(2) As used in this chapter:

(a) (i) "Insurable interest" in a person means[~~,~~]:

(A) for persons closely related by blood or by law, a substantial interest engendered by love and affection[~~,~~]; or

(B) in the case of other persons, a lawful and substantial interest in having the life, health,

and bodily safety of the person insured continue.

(ii) Policyholders in group insurance contracts do not need [~~no~~] an insurable interest if certificate holders or persons other than group policyholders who are specified by the certificate holders are the recipients of the proceeds of the policies.

(iii) Each person has an unlimited insurable interest in [~~his~~] the person's own life and health.

(iv) A shareholder or partner has an insurable interest in the life of other shareholders or partners for purposes of insurance contracts that are an integral part of a legitimate buy-sell agreement respecting shares or a partnership interest in the business.

(v) Subject to Subsection (9), an employer or an employer sponsored trust for the benefit of the employer's employees:

(A) has an insurable interest in the lives of the employer's:

(I) directors;

(II) officers;

(III) managers;

(IV) nonmanagement employees; and

(V) retired employees; and

(B) may insure the lives listed in Subsection (2)(a)(v)(A):

(I) on an individual or group basis; and

(II) with the written consent of the insured.

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

(c) "Viatical settlement" means a written contract:

(i) entered into by a person who is the policyholder of a life insurance policy insuring the life of a terminally ill person[~~,~~];

(ii) under which the insured assigns, transfers ownership, irrevocably designates a specific person or otherwise alienates all control and right in the insurance policy to another person[~~,~~ ~~when~~]; and

(iii) the proceeds or a part of the proceeds of the contract is paid to the policyholder of the insurance policy or the policyholder's designee prior to the death of the subject.

(3) (a) Except as provided in Subsection (4), an insurer may not knowingly issue an

individual life or accident and health insurance policy to a person other than the one whose life or health is at risk unless that person, who is 18 years of age or older and not under guardianship under Title 75, Chapter 5, Protection of Persons Under Disability and Their Property, has given written consent to the issuance of the policy. [~~The~~]

(b) A person shall express consent [~~either~~]:

(i) by signing an application for the insurance with knowledge of the nature of the document[~~,~~]; or

(ii) in any other reasonable way.

(c) Any insurance provided in violation of this Subsection (3) is subject to Subsection (5).

(4) (a) A life or accident and health insurance policy may be taken out without consent in [~~the following cases:~~] a circumstance described in this Subsection (4)(a).

(i) A person may obtain insurance on a dependent who does not have legal capacity.

(ii) A creditor may, at the creditor's expense, obtain insurance on the debtor in an amount reasonably related to the amount of the debt.

(iii) A person may obtain life and accident and health insurance on an immediate family [~~members~~] member who is living with or dependent on the person.

(iv) A person may obtain an accident and health insurance policy on others that would merely indemnify the policyholder against expenses [~~he~~] the person would be legally or morally obligated to pay.

(v) The commissioner may adopt rules permitting issuance of insurance for a limited term on the life or health of a person serving outside the continental United States who is in the public service of the United States, if the policyholder is related within the second degree by blood or by marriage to the person whose life or health is insured.

(b) Consent may be given by another in [~~the following cases:~~] a circumstance described in this Subsection (4)(b).

(i) A parent, a person having legal custody of a minor, or a guardian of [~~the~~] a person under Title 75, Chapter 5, Protection of Persons Under Disability and Their Property, may consent to the issuance of a policy on a dependent child or on a person under guardianship under Title 75, Chapter 5, Protection of Persons Under Disability and Their Property.

(ii) A grandparent may consent to the issuance of life or accident and health insurance on a grandchild.

(iii) A court of general jurisdiction may give consent to the issuance of a life or accident and health insurance policy on an ex parte application showing facts the court considers sufficient to justify the issuance of that insurance.

(5) (a) An insurance policy is not invalid because the policyholder lacks insurable interest or because consent has not been given[~~, but~~].

(b) Notwithstanding Subsection (5)(a), a court with appropriate jurisdiction may:

(i) order the proceeds to be paid to some person who is equitably entitled to [~~them~~] the proceeds, other than the one to whom the policy is designated to be payable[~~,~~]; or [~~it may~~]

(ii) create a constructive trust in the proceeds or a part of [~~them~~] the proceeds on behalf of such a person, subject to all the valid terms and conditions of the policy other than those relating to insurable interest or consent.

(6) This section does not prevent any organization described under 26 U.S.C. Sec. 501(c)(3), (e), or (f), as amended, and the regulations made under this section, and which is regulated under Title 13, Chapter 22, Charitable Solicitations Act, from soliciting and procuring, by assignment or designation as beneficiary, a gift or assignment of an interest in life insurance on the life of the donor or assignor or from enforcing payment of proceeds from that interest.

(7) This section does not prevent:

(a) any policyholder of life insurance, whether or not the policyholder is also the subject of the insurance, from entering into a viatical settlement;

(b) any person from soliciting a person to enter into a viatical settlement; or

(c) a person from enforcing payment of proceeds from the interest obtained under a viatical settlement.

(8) Notwithstanding Subsection (1), an insurer authorized under this title to issue a workers' compensation policy may issue a workers' compensation policy to a sole proprietorship, corporation, or partnership that elects not to include any owner, corporate officer, or partner as an employee under the policy even if at the time the policy is issued the sole proprietorship, corporation, or partnership has no employees.

(9) The extent of an employer's or employer sponsored trust's insurable interest for a nonmanagement and retired employee under Subsection (2)(a)(v) is limited to an amount commensurate with the employer's unfunded liabilities.

Section 31. Section **31A-21-106** is amended to read:

31A-21-106. Incorporation by reference.

(1) (a) Except as provided in Subsection (1)(b), an insurance policy may not contain any agreement or incorporate any provision not fully set forth in the policy or in an application or other document attached to and made a part of the policy at the time of its delivery, unless the policy, application, or agreement accurately reflects the terms of the incorporated agreement, provision, or attached document.

(b) (i) A policy may by reference incorporate rate schedules and classifications of risks and short-rate tables filed with the commissioner.

(ii) By rule or order, the commissioner may authorize incorporation by reference of provisions for:

(A) administrative arrangements[~~,~~];

(B) premium schedules[~~,~~]; and

(C) payment procedures for complex contracts.

(c) (i) A policy of title insurance insuring the mortgage or deed of trust of an institutional lender may, if requested by an institutional lender, incorporate by reference generally applicable policy terms that are contained in a specifically identified policy that has been filed with the commissioner.

(ii) As used in Subsection (1)(c)(i), "institutional lender" means a person that regularly engages in the business of making loans secured by real estate.

(d) A policy may incorporate by reference the following by citing in the policy:

(i) a federal law or regulation;

(ii) a state law or rule; or

(iii) a public directive of a federal or state agency.

(2) [~~Except as provided in Subsection (3) or (4), or as otherwise mandated by law, no~~] A purported modification of a contract during the term of the policy [~~affects~~] may not affect the obligations of a party to the contract:

(a) unless the modification is:

(i) in writing; and

(ii) agreed to by the party against whose interest the modification operates[~~.~~]; and

(b) except:

(i) as provided in:

(A) Subsection (3) or (4);

(B) Subsection 31A-8-402.3(7);

(C) Subsection 31A-22-721(8); or

(D) Subsection 31A-30-107(7); or

(ii) as otherwise mandated by law.

(3) Subsection (2) does not prevent a change in coverage under group contracts resulting from:

(a) provisions of an employer eligibility rule;

(b) the terms of a collective bargaining agreement; or

(c) provisions in federal Employee Retirement Income Security Act plan documents.

(4) Subsection (2) does not prevent a premium increase at any renewal date that is applicable uniformly to all comparable persons.

Section 32. Section **31A-21-311** is amended to read:

31A-21-311. Group and blanket insurance.

(1) (a) (i) Except under Subsection (1)(d), an insurer issuing a group insurance policy other than a blanket insurance policy shall, as soon as practicable after the coverage is effective, provide a certificate for each member of the insured group, except that only one certificate need be provided for the members of a family unit.

(ii) The certificate required by this Subsection (1) shall contain a summary of the essential features of the insurance coverage, including:

(A) any rights of conversion to an individual policy; and[~~,~~]

(B) in the case of group life insurance, any:

(I) continuation of coverage during total disability[~~.~~]; and

(II) incontestability provision.

(iii) Upon receiving a written request, the insurer shall [~~also~~] inform any insured how the insured may inspect, during normal business hours at a place reasonably convenient to the insured, a copy of the policy or a summary of the policy containing all the details [~~which~~] that are relevant to the certificate holder.

(b) The commissioner may by rule impose a [~~similar~~] requirement similar to Subsection (1)(a) on any class of blanket insurance policies for which the commissioner finds that the group of persons covered is constant enough for that type of action to be practicable and not unreasonably

expensive.

(c) [~~The~~] (i) A certificate shall be provided in a manner reasonably calculated to bring [~~it~~] the certificate to the attention of the certificate holder.

(ii) The insurer may deliver or mail [~~the certificates~~] a certificate:

(A) directly to the certificate holders[~~,~~]; or [~~may deliver or mail them~~]

(B) in bulk to the policyholder to transmit to certificate holders.

(iii) An affidavit by the insurer that [~~it has~~] the insurer mailed the certificates in the usual course of business creates a rebuttable presumption that [~~it~~] the insurer has done so.

(d) The commissioner may by rule or order prescribe substitutes for delivery or mailing of certificates that are reasonably calculated to inform a certificate holder of the certificate holder's rights, including:

(i) booklets describing the coverage[~~,~~];

(ii) the posting of notices in the place of business[~~,~~]; or

(iii) publication in a house organ[~~, if the substitutes are reasonably calculated to inform certificate holders of their rights~~].

(2) Unless a certificate or an authorized substitute has been made available to the certificate holder when required by this section, [~~no~~] an act or omission forbidden to or required of the certificate holder by the certificate after the coverage has become effective as to the certificate holder, other than intentionally causing the loss insured against or failing to make required contributory premium payments, [~~affects~~] may not affect the insurer's obligations under the insurance contract.

Section 33. Section **31A-22-400** is amended to read:

31A-22-400. Scope of part.

Part IV applies to all life insurance policies and contracts, including:

(1) an annuity contract;

(2) a credit life[~~,~~] contract;

(3) a franchise[~~,~~] contract;

(4) a group[~~,~~] contract; and

(5) a blanket [~~contracts, except where the application of a provision is specifically limited~~] contract.

Section 34. Section **31A-22-402** is amended to read:

31A-22-402. Grace period.

(1) (a) Every life insurance policy other than a group policy shall contain a provision entitling the policyholder to a grace period within which the payment of any premium may be made after the first payment of any premium.

(b) During the grace period described in Subsection (1)(a), the policy continues in full force.

(2) The grace period required by Subsection (1) may not be less than:

(a) 31 days; or

(b) four weeks for policies whose premiums are payable more frequently than monthly.

(3) The insurer may impose an interest charge during the grace period not in excess of the interest rate:

(a) set by the policy for policy loans; or

(b) in the absence of a provision described in Subsection (3)(a), a rate set by the commissioner by rule.

(4) If a claim arises under the policy during the grace period, an insurer may deduct from the policy proceeds:

(a) the amount of any premium due or overdue;

(b) interest at the rate provided in this section; and

(c) any deferred installment of the annual premium.

(5) The insurer shall send written notice of termination of coverage:

(a) to the policyholder's last-known address; and

(b) at least 30 days before the date that the coverage is terminated.

Section 35. Section **31A-22-403** is amended to read:

31A-22-403. Incontestability.

(1) This section does not apply to group policies.

(2) [~~Each~~] (a) Except as provided in Subsection (3), a life insurance policy is[~~, and shall state that,~~] incontestable after [~~it~~] the policy has been in force [~~during the lifetime of the insured~~] for a period of two years from [~~its~~] the policy's date of issue[~~, it is incontestable except for the following~~]:

(i) during the lifetime of the insured; or

(ii) for a survivorship life insurance policy, during the lifetime of the surviving insured.

(b) A life insurance policy shall state that the life insurance policy is incontestable after the time period described in Subsection (2)(a).

[~~(a) The policy~~] (3) (a) A life insurance policy described in Subsection (2) may be contested for nonpayment of premiums.

[~~(b) The policy~~] (b) A life insurance policy described in Subsection (2) may be contested as to:

(i) provisions relating to accident and health benefits allowed under Section 31A-22-609; and

(ii) additional benefits in the event of death by accident.

(c) If [~~the policy~~] a life insurance policy described in Subsection (2) allows the insured, after the policy's issuance and for an additional premium, to obtain a death benefit [~~which~~] that is larger than when the policy was originally issued, [~~then~~] the payment of the additional increment of benefit is contestable:

(i) until two years after the incremental increase of benefits[~~, but the~~]; and

(ii) based only on a ground [~~of contest~~] that may arise [~~is~~] in connection with the incremental increase.

[~~(3)~~] (4) (a) A reinstated life insurance policy or annuity contract may be contested:

(i) for two years following reinstatement on the same basis as at original issuance[~~, but~~]; and

(ii) only as to matters arising in connection with the reinstatement.

(b) Any grounds for contest available at original issuance continue to be available for contest until the policy has been in force for a total of two years:

(i) during the lifetime of the insured[~~.~~]; and

(ii) for a survivorship life insurance policy, during the lifetime of the surviving insured.

[~~(4)~~] (5) (a) The limitations on incontestability under this section:

(i) preclude only a contest of the validity of the policy[~~.~~]; and

(ii) do not preclude the good faith assertion at any time of defenses based upon provisions in the policy [~~which~~] that exclude or qualify coverage, whether or not those qualifications or exclusions are specifically excepted in the policy's incontestability clause. [~~Provisions~~]

(b) A provision on which the contestable period would normally run may not be reformulated as a coverage [~~exclusions~~] exclusion or [~~restrictions~~] restriction to take advantage of

this Subsection [~~(4)~~] (5).

(6) In accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, the commissioner may make rules to implement this section.

Section 36. Section **31A-22-404** is amended to read:

31A-22-404. Suicide.

(1) (a) Suicide is not a defense to a claim under a life insurance policy that has been in force as to a policyholder or certificate holder for two years from the date of issuance of the later of:

(i) the policy[~~,~~]; or

(ii) the certificate.

(b) Subsection (1)(a) applies whether:

(i) the suicide was voluntary or involuntary; or

(ii) the insured was sane or insane.

[~~(b)~~] (c) If a suicide occurs within the two-year period described in Subsection (1)(a), the insurer shall pay to the beneficiary an amount not less than the premium paid for the life insurance policy.

(2) (a) If after a life insurance policy is in effect the policy allows the insured to obtain a death benefit that is larger than when the policy was originally effective for an additional premium, the payment of the additional increment of benefit may be limited in the event of a suicide within a two-year period beginning on the date the increment increase takes effect.

(b) If a suicide occurs within the two-year period described in Subsection (2)(a), the insurer shall pay to the beneficiary an amount not less than the additional premium paid for the additional increment of benefit.

(3) This section does not apply to:

(a) [~~policies~~] a policy insuring against death by accident only; or

(b) the accident or double indemnity provisions of an insurance policy.

Section 37. Section **31A-22-405** is amended to read:

31A-22-405. Misstated age or gender.

(1) Subject to Subsection (2), if the age or gender of the person whose life is at risk is misstated in an application for a policy of life insurance, and the error is not adjusted during the person's lifetime, the amount payable under the policy is what the premium paid would have

purchased if the age or gender had been stated correctly.

(2) If the person whose life is at risk was, at the time the insurance was applied for, beyond the maximum age limit designated by the insurer, the insurer shall refund at least the amount of the premiums collected under the policy.

Section 38. Section **31A-22-409** is amended to read:

31A-22-409. Standard Nonforfeiture Law for Individual Deferred Annuities.

(1) This section is known as the "Standard Nonforfeiture Law for Individual Deferred Annuities."

(2) This section does not apply to:

(a) any reinsurance group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer, [~~(~~]including a partnership or sole proprietorship[~~)~~], or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 [~~of the~~], Internal Revenue Code[~~, as now or hereafter amended,~~];

(b) a premium deposit fund[~~,~~];

(c) a variable annuity[~~,~~];

(d) an investment annuity[~~,~~];

(e) an immediate annuity[~~,~~];

(f) a deferred annuity contract after annuity payments have commenced[~~,~~]; or

(g) a reversionary annuity[~~, nor to~~]; or

(h) any contract [~~which~~] that shall be delivered outside this state through an agent or other representative of the company issuing the contract.

(3) (a) [~~In the case of policies~~] If a policy is issued after this section takes effect as set forth in Subsection (12), [~~no~~] a contract of annuity, except as stated in Subsection (2), [~~shall~~] may not be delivered or issued for delivery in this state unless [~~it~~] the contract of annuity contains in substance:

(i) the [~~following~~] provisions[~~,~~] described in Subsection (3)(b); or [~~corresponding~~]

(ii) provisions [~~which~~] corresponding to the provisions described in Subsection (3)(b) that in the opinion of the commissioner are at least as favorable to the contractholder, governing cessation of payment of consideration under the contract[~~:~~].

(b) Subsection (3)(a)(i) requires the following provisions:

[~~(a) That~~] (i) upon cessation of payment of consideration under a contract, the company will grant a paid-up annuity benefit on a plan stipulated in the contract of such a value as specified in Subsections (5), (6), (7), (8), and (10)[~~.~~];

[~~(b) If~~] (ii) if a contract provides for a lump-sum settlement at maturity, or at any other time, [~~that~~] upon surrender of the contract at or before the commencement of any annuity payments, the company will pay in lieu of any paid-up annuity benefit a cash surrender benefit of such amount as is specified in Subsections (5), (6), (8), and (10)[~~. The~~];

(iii) the company shall reserve the right to defer the payment of the cash surrender benefit under Subsection (3)(b)(ii) for a period of six months after demand [~~therefor~~] for the payment of the cash surrender benefit with surrender of the contract[~~.~~];

[~~(c) A~~] (iv) a statement of the mortality table, if any, and interest rates used in calculating any of the following that are guaranteed under the contract:

(A) minimum paid-up annuity[~~,~~] benefits;

(B) cash surrender benefits; or

(C) death benefits [~~that are guaranteed under the contract, together with~~];

(v) sufficient information to determine the amounts of [~~such~~] the benefits[~~.~~] described in Subsection (3)(b)(iv);

[~~(d) A~~] (vi) a statement that any paid-up annuity, cash surrender, or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered; and

(vii) an explanation of the manner in which the benefits described in Subsection (3)(b)(vi) are altered by the existence of any:

(A) additional amounts credited by the company to the contract[~~, any~~];

(B) indebtedness to the company on the contract; or [~~any~~]

(C) prior withdrawals from or partial surrender of the contract.

(c) Notwithstanding the requirements of this Subsection (3), any deferred annuity contract may provide that if no consideration has been received under a contract for a period of two full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from consideration paid before the period would be less than $20 monthly[~~,~~]:

(i) the company may at [~~its~~] the company's option terminate the contract by payment in cash of the then present value of such portion of the paid-up annuity benefit, calculated on the

basis of the mortality table specified in the contract, if any, and the interest rate specified in the contract for determining the paid-up annuity benefit[~~,~~]; and [~~by such~~]

(ii) the payment [~~shall be relieved~~] described in Subsection (3)(c)(i), relieves the company of any further obligation under the contract.

(4) The minimum values as specified in Subsections (5), (6), (7), (8), and (10) of any paid-up annuity, cash surrender, or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as established in this section.

(a) (i) With respect to contracts providing for flexible considerations, the minimum nonforfeiture amount at any time at or before the commencement of any annuity payments shall be equal to an accumulation up to such time, at a rate of interest of 3% per annum of percentages of the net considerations [~~(as hereinafter defined)~~] paid prior to such time[~~,~~]:

(A) decreased by the sum of: [~~(i)~~]

(I) any prior withdrawals from or partial surrenders of the contract accumulated at a rate of interest of 3% per annum[~~,~~]; and [~~(ii)~~]

(II) the amount of any indebtedness to the company on the contract, including interest due and accrued[~~,~~]; and

(B) increased by any existing additional amounts credited by the company to the contract.

[~~The~~] (ii) For purposes of this Subsection (4)(a), the net consideration for a given contract year used to define the minimum nonforfeiture amount shall be:

(A) an amount not less than zero; and [~~shall be~~]

(B) equal to the corresponding gross considerations credited to the contract during that contract year less:

(I) an annual contract charge of $30; and [~~less~~]

(II) a collection charge of $1.25 per consideration credited to the contract during that contract year.

(iii) The percentages of net considerations shall be:

(A) 65% of the net consideration for the first contract year; and

(B) 87-1/2% of the net considerations for the second and later contract years.

(iv) Notwithstanding [~~the provisions of the preceding sentence~~] Subsection (4)(a)(iii), the percentage shall be 65% of the portion of the total net consideration for any renewal contract year [~~which~~] that exceeds by not more than two times the sum of those portions of the net

considerations in all prior contract years for which the percentage was 65%.

(b) [~~With~~] (i) Except as provided in Subsections (4)(b)(ii) and (iii), with respect to contracts providing for fixed scheduled consideration, minimum nonforfeiture amounts shall be:

(A) calculated on the assumption that considerations are paid annually in advance; and [~~shall be~~]

(B) defined as for contracts with flexible considerations [~~which~~] that are paid annually [~~with two exceptions:~~].

[~~(i)~~] (ii) The portion of the net consideration for the first contract year to be accumulated shall be equal to an amount that is the sum of:

(A) 65% of the net consideration for the first contract year [~~plus~~]; and

(B) 22-1/2% of the excess of the net consideration for the first contract year over the lesser of the net considerations for:

(I) the second contract year; and

(II) the third contract [~~years~~] year.

[~~(ii)~~] (iii) The annual contract charge shall be the lesser of $30 or 10% of the gross annual consideration.

(c) With respect to contracts providing for a single consideration payment, minimum nonforfeiture amounts shall be defined as for contracts with flexible considerations except that:

(i) the percentage of net consideration used to determine the minimum nonforfeiture amount shall be equal to 90%; and

(ii) the net consideration shall be the gross consideration less a contract charge of $75.

(5) (a) Any paid-up annuity benefit available under a contract shall be such that [~~its~~] the contract's present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. [~~Such~~]

(b) The present value described in Subsection (5)(a) shall be computed using the mortality table, if any, and the interest rate specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

(6) (a) For contracts [~~which~~] that provide cash surrender benefits, the cash surrender benefits available before maturity may not be less than the present value as of the date of surrender of that portion of the cash surrender value [~~which~~] that would be provided under the contract at maturity arising from considerations paid before the time of cash surrender reduced by the amount

appropriate to reflect any prior withdrawals from or partial surrender of the contract, the present value being calculated on the basis of an interest rate not more than 1% higher than the interest rate specified in the contract for accumulating the net considerations to determine the maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract.

(b) In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time.

(c) The death benefit under these contracts shall be at least equal to the cash surrender benefit.

(7) (a) For contracts [~~which~~] that do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity may not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid before the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, this present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine maturity value, and increased by any existing additional amounts credited by the company to the contract.

(b) For contracts [~~which~~] that do not provide any death benefits before commencement of any annuity payments, the present values shall be calculated on the basis of the interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. [~~However, in~~]

(c) In no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.

(8) (a) For the purpose of determining the benefits calculated under Subsections (6) and (7), [~~in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates,~~] the maturity date shall be considered to be the latest date [~~for which election shall be~~] permitted by the contract, [~~but~~] except that it may not be considered to be later than the later of:

(i) the anniversary of the contract next following the annuitant's 70th birthday; or

(ii) the tenth anniversary of the contract[~~, whichever is later~~].

(b) For a contract that provides cash surrender benefits on or past the maturity date, the cash surrender value shall be equal to the amount used to determine the annuity benefit payments.

(c) A surrender charge may not be imposed on or past maturity.

(9) Any contract [~~which~~] that does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount before the commencement of any annuity payments shall include a statement in a prominent place in the contract that [~~such~~] these benefits are not provided.

(10) Any paid-up annuity, cash surrender, or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

(11) (a) For any contract [~~which~~] that provides, within the same contract by rider or supplemental contract provisions, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall:

(i) be equal to the sum of:

(A) the minimum nonforfeiture benefits for the annuity portion; and

(B) the minimum nonforfeiture benefits, if any, for the life insurance portion; and

(ii) computed as if each portion were a separate contract.

(b) (i) Notwithstanding [~~the provisions of~~] Subsections (5), (6), (7), (8), and (10), additional benefits payable[~~: (a) in the event of total and permanent disability, (b) as reversionary annuity or deferred reversionary annuity benefits, or (c) as other policy benefits additional to life insurance, endowment, and annuity benefits, and considerations for all such additional benefits~~], as described in Subsection (11)(b)(ii), and consideration for the additional benefits payable, shall be disregarded in ascertaining, if required by this section:

(A) the minimum nonforfeiture amounts[~~,~~];

(B) paid-up annuity[~~,~~];

(C) cash surrender[~~,~~]; and

(D) death benefits [~~that may be required by this section~~].

(ii) For purposes of this Subsection (11), an additional benefit is a benefit payable:

(A) in the event of total and permanent disability;

(B) as reversionary annuity or deferred reversionary annuity benefits; or

(C) as other policy benefits additional to life insurance, endowment, and annuity benefits.

(iii) The inclusion of [~~these~~] the additional benefits described in this Subsection (11) may not be required in any paid-up benefits, unless the additional benefits separately would require:

(A) minimum nonforfeiture amounts[~~,~~];

(B) paid-up annuity[~~,~~];

(C) cash surrender; and

(D) death benefits.

(12) (a) After this section takes effect, any company may file with the commissioner a written notice of its election to comply with [~~the provisions of~~] this section after a specified date before [~~the second anniversary of the date this section takes effect. The provisions of this~~] July 1, 1988.

(b) This section [~~apply~~] applies to annuity contracts of a company issued on or after the date the company specifies in the notice.

(c) If a company makes no [~~such~~] election under Subsection (12)(a), the operative date of this section for such company is [~~the second anniversary of the effective date of this section~~] July 1, 1988.

Section 39. Section **31A-22-522** is amended to read:

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

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

(a) in writing;

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

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

(ii) the rights the employee or group member has to [~~continue~~] convert coverage upon termination.

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

(a) include a statement of a policyholder's obligations under Subsection (1) in the insurer's

monthly notice to the policyholder of premium payments due; and

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

Section 40. Section **31A-22-602** is amended to read:

31A-22-602. Premium rates.

(1) This section does not apply to group accident and health insurance.

(2) The benefits in an accident and health insurance policy shall be reasonable in relation to the premiums charged.

(3) The commissioner shall [~~disapprove~~] prohibit the use of an accident and health insurance policy form or rates if [~~it does~~] the form or rates do not satisfy Subsection (2).

Section 41. Section **31A-22-617** is amended to read:

31A-22-617. Preferred provider contract provisions.

Health insurance policies may provide for insureds to receive services or reimbursement under the policies in accordance with preferred health care provider contracts as follows:

(1) Subject to restrictions under this section, any insurer or third party administrator may enter into contracts with health care providers as defined in Section 78-14-3 under which the health care providers agree to supply services, at prices specified in the contracts, to persons insured by an insurer.

(a) A health care provider contract may require the health care provider to accept the specified payment as payment in full, relinquishing the right to collect additional amounts from the insured person.

(b) The insurance contract may reward the insured for selection of preferred health care providers by:

(i) reducing premium rates;

(ii) reducing deductibles;

(iii) coinsurance;

(iv) other copayments; or

(v) in any other reasonable manner.

(c) If the insurer is a managed care organization, as defined in Subsection 31A-27-311.5(1)(f):

(i) the insurance contract and the health care provider contract shall provide that in the event the managed care organization becomes insolvent, the rehabilitator or liquidator may:

(A) require the health care provider to continue to provide health care services under the contract until the [~~later~~] earlier of:

(I) 90 days [~~from~~] after the date of the filing of a petition for rehabilitation or the petition for liquidation; or

(II) the date the term of the contract ends; and

(B) subject to Subsection (1)(c)(v), reduce the fees the provider is otherwise entitled to receive from the managed care organization during the time period described in Subsection (1)(c)(i)(A);

(ii) the provider is required to:

(A) accept the reduced payment under Subsection (1)(c)(i)(B) as payment in full; and

(B) relinquish the right to collect additional amounts from the insolvent managed care organization's enrollee, as defined in Section 31A-27-311.5(1)(b);

(iii) if the contract between the health care provider and the managed care organization has not been reduced to writing, or the contract fails to contain the language required by Subsection (1)(c)(i), the provider may not collect or attempt to collect from the enrollee:

(A) sums owed by the insolvent managed care organization; or

(B) the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B);

(iv) the following may not bill or maintain any action at law against an enrollee to collect sums owed by the insolvent managed care organization or the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B):

(A) a provider;

(B) an agent;

(C) a trustee; or

(D) an assignee of a person described in Subsections (1)(c)(iv)(A) through (C); and

(v) notwithstanding Subsection (1)(c)(i):

(A) a rehabilitator or liquidator may not reduce a fee by less than 75% of the provider's regular fee set forth in the contract; and

(B) the enrollee shall continue to pay the copayments, deductibles, and other payments for services received from the provider that the enrollee was required to pay before the filing of:

(I) a petition for rehabilitation; or

(II) a petition for liquidation.

(2) (a) Subject to Subsections (2)(b) through (2)(f), an insurer using preferred health care provider contracts shall pay for the services of health care providers not under the contract, unless the illnesses or injuries treated by the health care provider are not within the scope of the insurance contract. As used in this section, "class of health care providers" means all health care providers licensed or licensed and certified by the state within the same professional, trade, occupational, or facility licensure or licensure and certification category established pursuant to Titles 26 and 58.

(b) When the insured receives services from a health care provider not under contract, the insurer shall reimburse the insured for at least 75% of the average amount paid by the insurer for comparable services of preferred health care providers who are members of the same class of health care providers. The commissioner may adopt a rule dealing with the determination of what constitutes 75% of the average amount paid by the insurer for comparable services of preferred health care providers who are members of the same class of health care providers.

(c) When reimbursing for services of health care providers not under contract, the insurer may make direct payment to the insured.

(d) Notwithstanding Subsection (2)(b), an insurer using preferred health care provider contracts may impose a deductible on coverage of health care providers not under contract.

(e) When selecting health care providers with whom to contract under Subsection (1), an insurer may not unfairly discriminate between classes of health care providers, but may discriminate within a class of health care providers, subject to Subsection (7).

(f) For purposes of this section, unfair discrimination between classes of health care providers shall include:

(i) refusal to contract with class members in reasonable proportion to the number of insureds covered by the insurer and the expected demand for services from class members; and

(ii) refusal to cover procedures for one class of providers that are:

(A) commonly utilized by members of the class of health care providers for the treatment of illnesses, injuries, or conditions;

(B) otherwise covered by the insurer; and

(C) within the scope of practice of the class of health care providers.

(3) Before the insured consents to the insurance contract, the insurer shall fully disclose to the insured that it has entered into preferred health care provider contracts. The insurer shall provide sufficient detail on the preferred health care provider contracts to permit the insured to

agree to the terms of the insurance contract. The insurer shall provide at least the following information:

(a) a list of the health care providers under contract and if requested their business locations and specialties;

(b) a description of the insured benefits, including any deductibles, coinsurance, or other copayments;

(c) a description of the quality assurance program required under Subsection (4); and

(d) a description of the [~~grievance~~] adverse benefit determination procedures required under Subsection (5).

(4) (a) An insurer using preferred health care provider contracts shall maintain a quality assurance program for assuring that the care provided by the health care providers under contract meets prevailing standards in the state.

(b) The commissioner in consultation with the executive director of the Department of Health may designate qualified persons to perform an audit of the quality assurance program. The auditors shall have full access to all records of the organization and its health care providers, including medical records of individual patients.

(c) The information contained in the medical records of individual patients shall remain confidential. All information, interviews, reports, statements, memoranda, or other data furnished for purposes of the audit and any findings or conclusions of the auditors are privileged. The information is not subject to discovery, use, or receipt in evidence in any legal proceeding except hearings before the commissioner concerning alleged violations of this section.

(5) An insurer using preferred health care provider contracts shall provide a reasonable procedure for resolving complaints and [~~grievances~~] adverse benefit determinations initiated by the insureds and health care providers.

(6) An insurer may not contract with a health care provider for treatment of illness or injury unless the health care provider is licensed to perform that treatment.

(7) (a) A health care provider or insurer may not discriminate against a preferred health care provider for agreeing to a contract under Subsection (1).

(b) Any health care provider licensed to treat any illness or injury within the scope of the health care provider's practice, who is willing and able to meet the terms and conditions established by the insurer for designation as a preferred health care provider, shall be able to apply for and

receive the designation as a preferred health care provider. Contract terms and conditions may include reasonable limitations on the number of designated preferred health care providers based upon substantial objective and economic grounds, or expected use of particular services based upon prior provider-patient profiles.

(8) Upon the written request of a provider excluded from a provider contract, the commissioner may hold a hearing to determine if the insurer's exclusion of the provider is based on the criteria set forth in Subsection (7)(b).

(9) Insurers are subject to the provisions of Sections 31A-22-613.5, 31A-22-614.5, and 31A-22-618.

(10) Nothing in this section is to be construed as to require an insurer to offer a certain benefit or service as part of a health benefit plan.

(11) This section does not apply to catastrophic mental health coverage provided in accordance with Section 31A-22-625.

Section 42. Section **31A-22-624** is amended to read:

31A-22-624. Primary care physician.

An accident and health insurance policy that requires an insured to select a primary care physician to receive optimum coverage:

(1) shall permit an insured to select a participating provider who:

(a) is an:

(i) obstetrician[~~/~~];

(ii) gynecologist; or

(iii) pediatrician; and

(b) is qualified and willing to provide primary care services, as defined by the health care plan, as the insured's provider from whom primary care services are received;

(2) shall clearly state in literature explaining the policy the option available to [~~female~~] insureds under Subsection (1); and

(3) may not impose a higher premium, higher copayment requirement, or any other additional expense on an insured [~~by virtue of~~] because the insured [~~selecting~~] selected a primary care physician in accordance with Subsection (1).

Section 43. Section **31A-22-625** is amended to read:

31A-22-625. Catastrophic coverage of mental health conditions.

(1) As used in this section:

(a) (i) "Catastrophic mental health coverage" means coverage in a health insurance policy or health maintenance organization contract that does not impose any lifetime limit, annual payment limit, episodic limit, inpatient or outpatient service limit, or maximum out-of-pocket limit that places a greater financial burden on an insured for the evaluation and treatment of a mental health condition than for the evaluation and treatment of a physical health condition.

(ii) "Catastrophic mental health coverage" may include a restriction on cost sharing factors, such as deductibles, copayments, or coinsurance, prior to reaching any maximum out-of-pocket limit.

(iii) "Catastrophic mental health coverage" may include one maximum out-of-pocket limit for physical health conditions and another maximum out-of-pocket limit for mental health conditions, provided that, if separate out-of-pocket limits are established, the out-of-pocket limit for mental health conditions may not exceed the out-of-pocket limit for physical health conditions.

(b) (i) "50/50 mental health coverage" means coverage in a health insurance policy or health maintenance organization contract that pays for at least 50% of covered services for the diagnosis and treatment of mental health conditions.

(ii) "50/50 mental health coverage" may include a restriction on episodic limits, inpatient or outpatient service limits, or maximum out-of-pocket limits.

(c) "Large employer" [~~means an employer that does not come within the definition of "small employer."~~] is as defined in Section 31A-1-301.

(d) (i) "Mental health condition" means any condition or disorder involving mental illness that falls under any of the diagnostic categories listed in the Diagnostic and Statistical Manual, as periodically revised.

(ii) "Mental health condition" does not include the following when diagnosed as the primary or substantial reason or need for treatment:

(A) marital or family problem;

(B) social, occupational, religious, or other social maladjustment;

(C) conduct disorder;

(D) chronic adjustment disorder;

(E) psychosexual disorder;

(F) chronic organic brain syndrome;

(G) personality disorder;

(H) specific developmental disorder or learning disability; or

(I) mental retardation.

(e) "Small employer" is as defined in Section [~~31A-30-103~~] 31A-1-301.

(2) (a) At the time of purchase and renewal, an insurer shall offer to each small employer that it insures or seeks to insure a choice between catastrophic mental health coverage and 50/50 mental health coverage.

(b) In addition to Subsection (2)(a), an insurer may offer to provide:

(i) catastrophic mental health coverage, 50/50 mental health coverage, or both at levels that exceed the minimum requirements of this section; or

(ii) coverage that excludes benefits for mental health conditions.

(c) A small employer may, at its option, choose either catastrophic mental health coverage, 50/50 mental health coverage, or coverage offered under Subsection (2)(b), regardless of the employer's previous coverage for mental health conditions.

(d) An insurer is exempt from the 30% index rating restriction in Subsection 31A-30-106(1)(b) and, for the first year only that catastrophic mental health coverage is chosen, the 15% annual adjustment restriction in Subsection 31A-30-106(1)(c)(ii), for any small employer with 20 or less enrolled employees who chooses coverage that meets or exceeds catastrophic mental health coverage.

(3) (a) At the time of purchase and renewal, an insurer shall offer catastrophic mental health coverage to each large employer that it insures or seeks to insure.

(b) In addition to Subsection (3)(a), an insurer may offer to provide catastrophic mental health coverage at levels that exceed the minimum requirements of this section.

(c) A large employer may, at its option, choose either catastrophic mental health coverage, coverage that excludes benefits for mental health conditions, or coverage offered under Subsection (3)(b).

(4) (a) An insurer may provide catastrophic mental health coverage through a managed care organization or system in a manner consistent with the provisions in Chapter 8, Health Maintenance Organizations and Limited Health Plans, regardless of whether the policy or contract uses a managed care organization or system for the treatment of physical health conditions.

(b) (i) Notwithstanding any other provision of this title, an insurer may:

(A) establish a closed panel of providers for catastrophic mental health coverage; and

(B) refuse to provide any benefit to be paid for services rendered by a nonpanel provider unless:

(I) the insured is referred to a nonpanel provider with the prior authorization of the insurer; and

(II) the nonpanel provider agrees to follow the insurer's protocols and treatment guidelines.

(ii) If an insured receives services from a nonpanel provider in the manner permitted by Subsection (4)(b)(i)(B), the insurer shall reimburse the insured for not less than 75% of the average amount paid by the insurer for comparable services of panel providers under a noncapitated arrangement who are members of the same class of health care providers.

(iii) Nothing in this Subsection (4)(b) may be construed as requiring an insurer to authorize a referral to a nonpanel provider.

(c) To be eligible for catastrophic mental health coverage, a diagnosis or treatment of a mental health condition must be rendered:

(i) by a mental health therapist as defined in Section 58-60-102; or

(ii) in a health care facility licensed or otherwise authorized to provide mental health services pursuant to Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act, or Title 62A, Chapter 2, Licensure of Programs and Facilities, that provides a program for the treatment of a mental health condition pursuant to a written plan.

(5) The commissioner may disapprove any policy or contract that provides mental health coverage in a manner that is inconsistent with the provisions of this section.

(6) The commissioner shall:

(a) adopt rules as necessary to ensure compliance with this section; and

(b) provide general figures on the percentage of contracts and policies that include no mental health coverage, 50/50 mental health coverage, catastrophic mental health coverage, and coverage that exceeds the minimum requirements of this section.

(7) The Health and Human Services Interim Committee shall review:

(a) the impact of this section on insurers, employers, providers, and consumers of mental health services before January 1, 2004; and

(b) make a recommendation as to whether the provisions of this section should be modified and whether the cost-sharing requirements for mental health conditions should be the

same as for physical health conditions.

(8) (a) An insurer shall offer catastrophic mental health coverage as part of a health maintenance organization contract that is governed by Chapter 8, Health Maintenance Organizations and Limited Health Plans, that is in effect on or after January 1, 2001.

(b) An insurer shall offer catastrophic mental health coverage as a part of a health insurance policy that is not governed by Chapter 8, Health Maintenance Organizations and Limited Health Plans, that is in effect on or after July 1, 2001.

(c) This section does not apply to the purchase or renewal of an individual insurance policy or contract.

(d) Notwithstanding Subsection (8)(c), nothing in this section may be construed as discouraging or otherwise preventing insurers from continuing to provide mental health coverage in connection with an individual policy or contract.

(9) This section shall be repealed in accordance with Section 63-55-231.

Section 44. Section **31A-22-629** is amended to read:

31A-22-629. Adverse benefit determination review process.

(1) As used in this section:

[~~(a) "Grievance" means a written or, if accepted by the insurer, oral statement that indicates an insured's disagreement with an insurance-related decision of the insurer.~~]

(a) (i) "Adverse benefit determination" means the:

(A) denial of a benefit;

(B) reduction of a benefit;

(C) termination of a benefit; or

(D) failure to provide or make payment, in whole or in part, for a benefit.

(ii) "Adverse benefit determination" includes:

(A) denial, reduction, termination, or failure to provide or make payment that is based on a determination of a insured's or beneficiary's eligibility to participate in a plan;

(B) with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for, a benefit resulting from the application of a utilization review; and

(C) failure to cover an item or service for which benefits are otherwise provided because it is determined to be:

(I) experimental;

(II) investigational; or

(III) not medically necessary or appropriate.

(b) "Independent review" means a process that:

(i) [~~may be created and operated internally by an insurer or externally by a third party~~] is a voluntary option for the resolution of an adverse benefit determination;

(ii) [~~satisfies the requirements of Subsection (4)(b)(ii)~~] is conducted at the discretion of the claimant;

(iii) [~~is designated by the insurer; and~~] is conducted by an independent review organization designated by the insurer;

(iv) renders an independent and impartial decision on [~~a grievance~~] an adverse benefit determination submitted by an insured; and

(v) may not require the insured to pay a fee for requesting the independent review.

(c) "Insured" is as defined in Section 31A-1-301 and includes a person who is authorized to act on the insured's behalf.

(d) "Insurer" is as defined in Section 31A-1-301 and includes:

(i) a health maintenance organization; and

(ii) a third-party administrator that offers, sells, manages, or administers a health insurance policy or health maintenance organization contract that is subject to this title.

(e) "Internal review" means the process an insurer uses to review an insured's [~~grievance~~] adverse benefit determination before the [~~grievance~~] adverse benefit determination is submitted for independent review.

(2) This section applies generally to health insurance policies and health maintenance organization contracts in effect on or after January 1, 2001.

(3) (a) An insured may submit [~~a grievance~~] an adverse benefit determination to the insurer.

(b) The insurer shall conduct an internal review of the insured's [~~grievance~~] adverse benefit determination.

[~~(c) Consistent with rules adopted pursuant to Subsection (4), an insured who disagrees with the results of an internal review may submit the grievance for an independent review if the grievance involves the payment of a claim or the denial of coverage.~~]

(4) Before October 1, 2000, the commissioner shall adopt rules that[~~: (a) establish a maximum flat fee that may be charged to an insured for requesting a decision from an independent review board and the circumstances under which the fee shall be waived on the basis of financial hardship; and (b)~~] establish minimum standards for:

[~~(i)~~] (a) internal reviews;

[~~(ii) internal and external~~]

(b) independent reviews to ensure independence and impartiality;

[~~(iii)~~] (c) the types of [~~grievances~~] adverse benefit determinations that may be submitted to an independent review; and

[~~(iv)~~] (d) the timing of the review process, including an expedited review when medically necessary.

(5) Nothing in this section may be construed as:

(a) expanding, extending, or modifying the terms of a policy or contract with respect to benefits or coverage;

(b) permitting an insurer to charge an insured for the internal review of [~~a grievance~~] an adverse benefit determination;

(c) restricting the use of arbitration in connection with or subsequent to an independent review; or

(d) altering the legal rights of any party to seek court or other redress in connection with:

(i) an adverse decision resulting from an independent review, except that if the insurer is the party seeking legal redress, the insurer shall pay for the reasonable attorneys fees of the insured related to the action and court costs; or

(ii) [~~a grievance~~] an adverse benefit determination or other claim that is not eligible for submission to independent review.

Section 45. Section **31A-22-703** is amended to read:

31A-22-703. Conversion rights on termination of group accident and health insurance coverage.

(1) Except as provided in Subsections (2) through (5), all policies of accident and health insurance offered on a group basis under this title or Title 49, Chapter 8, Group Insurance Program Act, shall provide that a person whose insurance under the group policy has been terminated for any reason, and who has been continuously insured under the group policy or its predecessor for

at least six months immediately prior to termination, is entitled to choose:

(a) a converted individual policy of accident and health insurance from the insurer [~~which~~] that conforms to Section 31A-22-708; or

(b) an extension of benefits under the group policy as provided in Section 31A-22-714.

(2) Subsection (1) does not apply if the policy:

(a) provides:

(i) catastrophic[~~,~~] benefits;

(ii) aggregate stop loss[~~, or~~] benefits;

(iii) specific stop loss benefits; or

[~~(b) provides~~] (iv) benefits for:

(A) specific diseases [~~or for~~];

(B) accidental injuries only[~~,~~]; or

(C) for dental service; or

[~~(c)~~] (b) is an income replacement policy.

(3) An employee or group member does not have conversion rights under Subsection (1) if:

(a) termination of the group coverage occurred because [~~of failure of~~] the group member failed to pay any required individual contribution;

(b) the individual group member acquires other group coverage covering all preexisting conditions including maternity, if the coverage existed under the replaced group coverage; or

(c) the person has:

(i) performed an act or practice that constitutes fraud; or

(ii) made an intentional misrepresentation of material fact under the terms of the coverage.

(4) Notwithstanding Subsections (1), (2), and (3), an employee or group member does not have conversion rights under Subsection (1) if the individual or group member qualifies to continue coverage under [~~his~~] the individual's or group member's existing group policy in accordance with the terms of [~~his~~] the individual's or group member's policy.

(5) (a) Notwithstanding Subsection 31A-22-613(1), an insurer may reduce benefits under a converted policy covering any person to the extent the benefits provided or available to that person under one or more of the sources listed under Subsection (5)(b), together with the benefits provided by the converted policy, would result in coverage that would result in payment of more

than 100% of the amount of the claim.

(b) The benefits sources referred to under Subsection (5)(a) include benefits under:

(i) [~~benefits under~~] another insurance policy; and

(ii) [~~benefits under~~] any arrangement of coverage for individuals in a group, whether on an insured or an uninsured basis.

(6) (a) The conversion policy shall provide maternity benefits equal to the lesser of the maternity benefits of the group policy or the conversion policy until termination of a pregnancy that exists on the date of conversion if:

(i) one of the following is pregnant on the date of the conversion:

(A) the insured;

(B) a spouse of the insured; or

(C) a dependent of the insured; and

(ii) the accident and health policy had maternity benefits.

(b) The requirements of this Subsection (6) do not apply to a pregnancy that occurs after the date of conversion.

Section 46. Section **31A-22-705** is amended to read:

31A-22-705. Provisions in conversion policies.

(1) A converted policy may include a provision under which the insurer may request from the person covered, information in advance of any premium due date as to whether there is other coverage as specified under Subsection 31A-22-703(4).

[~~(2) The converted policy may provide that the insurer may refuse to renew the policy or the coverage of any person insured:~~]

[~~(a) for fraud or intentional misrepresentation of a material fact in applying for any benefits under the converted policy; or~~]

[~~(b) for any other reason approved by the commissioner by rule or order.~~]

(2) (a) Except as provided in Subsection (2)(b), a converted policy is renewable with respect to all individuals or dependents at the option of the individual.

(b) A converted policy may be discontinued if:

(i) the individual fails to pay premiums or contributions in accordance with the terms of the health benefit plan, including any timeliness requirements;

(ii) the individual:

(A) performs an act or practice that constitutes fraud; or

(B) made an intentional misrepresentation of material fact under the terms of the coverage; or

(iii) for network plans:

(A) the individual no longer resides, lives, or works in:

(I) the service area of the insurer; or

(II) the area for which the insurer is authorized to do business; and

(B) coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

(3) An insurer may not be required to issue a converted policy which provides benefits in excess of those provided under the group policy from which conversion is made.

(4) A converted policy may not exclude a preexisting condition not excluded under the group policy.

(5) During the first policy year, the converted policy may provide that the benefits payable under the converted policy, together with the benefits paid for the individual under the group policy, do not exceed those that would have been payable had the individual's insurance under the group policy remained in force and effect.

Section 47. Section **31A-22-708** is amended to read:

31A-22-708. Conversion of health benefit plan.

If the group insurance policy from which the conversion is made is a health benefit plan, as defined in [~~Subsection 31A-30-103(15)~~] Section 31A-1-301, the employee or member must be offered at least basic coverage as defined in [~~Subsection~~] Section 31A-30-103[~~(4)~~].

Section 48. Section **31A-22-714** is amended to read:

31A-22-714. Extension of benefits.

(1) (a) In addition to the right of the employee to have a converted policy issued to the employee, and on the same bases of eligibility as for conversion of coverage under Sections 31A-22-703 and 31A-22-704, the employee has the right to continue the employee's coverage under the group policy for a period of six months, unless the employee:

(i) was terminated for gross misconduct; or

(ii) is eligible for any extension of coverage required by federal law.

(b) This right to continue coverage includes any dependent coverages.

(2) In addition to the terminated insured, those classes of persons defined in Section 31A-22-710 are [~~also~~] entitled to the continuation of coverage as provided in this section.

(3) (a) (i) The employer shall provide the terminated insured written notification of the right to continue group coverage and the payment amounts required for continued coverage, including the manner, place, and time in which the payments shall be made.

(ii) The notice required by this Subsection (3):

(A) may be sent to the terminated insured's home address as shown on the records of the employer[~~. This notice~~]; and

(B) shall be given not more than 30 days after the termination date of the group coverage.

(b) The payment amount for continued group coverage may not exceed 102% of the group rate in effect for a group member, including an employer's contribution, if any, for a group insurance policy.

(4) The insurer shall provide the employee or any eligible dependent the opportunity to continue the group coverage at the payment amount stated in Subsection (3)(b) if:

(a) the employer policyholder does not provide the terminated insured the written notification as required by Subsection (3); and

(b) the employee or other insured eligible for extension contacts the insurer within 30 days of coverage termination.

[~~(4) If~~] (5) (a) Except as provided in Subsection (5)(c), the coverages described in Subsection (5)(b) continues without interruption and may not terminate if the terminated insured or, with respect to a minor, the parent or guardian of the terminated insured:

(i) elects to continue group coverage; and

(ii) tenders the amount required:

(A) (I) to the employer [~~the amount required~~]; or

(II) to the **ĥ [~~insured~~] INSURER ĥ** if the right to continue notice is received from the insurer; and

(B) within 30 days after receiving notice as prescribed by this section[~~;~~].

(b) Subsection (5)(a) applies to coverage of:

(i) the terminated insured [~~and coverage of~~];

(ii) the covered spouse of the terminated insured; and

(iii) dependents of the terminated insured [~~continues without interruption and may not terminate unless:~~].

(c) A coverage described in Subsection (5)(b) may be terminated if:

[~~(a)~~] (i) the terminated insured:

(A) establishes residence outside of this state; or

(B) moves out of the insurer's service area;

[~~(b)~~] (ii) the terminated insured fails to make timely payment of a required contribution;

[~~(c)~~] (iii) the terminated insured violates a material condition of the contract;

[~~(d)~~] (iv) the terminated insured becomes eligible for similar coverage under another group policy; or

[~~(e)~~] (v) the employer's coverage is terminated.

[~~(5)~~] (6) If the employer replaces coverage with similar coverage under another group policy, without interruption, the terminated insured has the right to obtain coverage under the replacement group policy:

(a) for the balance of the period the terminated insured would have continued coverage under the replaced group policy[~~, provided~~]; and

(b) if the terminated insured is otherwise eligible for continuation of coverage.

[~~(6)~~] (7) At the end of the continued benefit period as provided in this section, the covered person:

(a) remains eligible for a converted policy under this chapter; and

(b) shall be [~~so~~] informed that the person remains eligible:

(i) by the employer; and

(ii) in the same manner and according to the same terms as required by Section 31A-22-703.

Section 49. Section **31A-22-721** is enacted to read:

31A-22-721. A health benefit plan for a plan sponsor.

(1) Except as otherwise provided in this section, a health benefit plan for a plan sponsor is renewable and continues in force:

(a) with respect to all eligible employees and dependents; and

(b) at the option of the plan sponsor.

(2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed:

(a) for a network plan, if:

(i) there is no longer any enrollee under the group health plan who lives, resides, or works

in:

(A) the service area of the insurer; or

(B) the area for which the insurer is authorized to do business; and

(ii) in the case of the small employer market, the insurer applies the same criteria the insurer would apply in denying enrollment in the plan under Subsection 31A-30-108(6); or

(b) for coverage made available in the small or large employer market only through an association, if:

(i) the employer's membership in the association ceases; and

(ii) the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

(3) A health benefit plan for a plan sponsor may be discontinued if:

(a) a condition described in Subsection (2) exists;

(b) the plan sponsor fails to pay premiums or contributions in accordance with the terms of the contract;

(c) the plan sponsor:

(i) performs an act or practice that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact under the terms of the coverage;

(d) the insurer:

(i) elects to discontinue offering a particular health benefit product delivered or issued for delivery in this state;

(ii) (A) provides notice of the discontinuation in writing:

(I) to each plan sponsor, employee, and dependent of a plan sponsor or employee; and

(II) at least 90 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner; and

(II) at least three working days prior to the date the notice is sent to the affected plan sponsors, employees, and dependents of plan sponsors or employees;

(C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase any other health benefit products currently being offered:

(I) by the insurer in the market; or

(II) in the case of a large employer, any other health benefit plan currently being offered in that market; and

(D) in exercising the option to discontinue that product and in offering the option of coverage in this section, the insurer acts uniformly without regard to:

(I) the claims experience of a plan sponsor; or

(II) any health status-related factor relating to any covered participant or beneficiary; or

(III) any health status-related factor relating to a new participant or beneficiary who may become eligible for coverage; or

(e) the insurer:

(i) elects to discontinue all of the insurer's health benefit plans:

(A) in the small employer market; or

(B) the large employer market; or

(C) both the small and large employer markets;

(ii) (A) provides notice of the discontinuance in writing:

(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

(II) at least 180 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner in each state in which an affected insured individual is known to reside; and

(II) at least 30 business days prior to the date the notice is sent to the affected plan sponsors, employees, and dependents of a plan sponsor or employee;

(C) discontinues and nonrenews all plans issued or delivered for issuance in the market; and

(D) provides a plan of orderly withdrawal as required by Section 31A-4-115.

(4) A health benefit plan for a plan sponsor may be nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) for noncompliance with the insurer's:

(i) minimum participation requirements; or

(ii) employer contribution requirements.

(5) (a) Except as provided in Subsection (5)(d), an eligible employee may be discontinued if after issuance of coverage the eligible employee:

(i) engages in an act or practice that constitutes fraud in connection with the coverage; or

(ii) makes an intentional misrepresentation of material fact in connection with the coverage.

(b) An eligible employee that is discontinued under Subsection (5)(a) may reenroll:

(i) 12 months after the date of discontinuance; and

(ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies to reenroll.

(c) At the time the eligible employee's coverage is discontinued under Subsection (5)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is discontinued.

(d) An eligible employee may not be discontinued under this Subsection (5) because of a fraud or misrepresentation that relates to health status.

(6) (a) Except as provided in Subsection (6)(b), an insurer that elects to discontinue offering a health benefit plan under Subsection (3)(e) shall be prohibited from writing new business in such market in this state for a period of five years beginning on the date of discontinuation of the last coverage that is discontinued.

(b) The commissioner may waive the prohibition under Subsection (6)(a) when the commissioner finds that waiver is in the public interest:

(i) to promote competition; or

(ii) to resolve inequity in the marketplace.

(7) If an insurer is doing business in one established geographic service area of the state, this section applies only to the insurer's operations in that geographic service area.

(8) An insurer may modify a health benefit plan for a plan sponsor only:

(a) at the time of coverage renewal; and

(b) if the modification is effective uniformly among all plans with a particular product or service.

(9) For purposes of this section, a reference to "plan sponsor" includes a reference to the employer:

(a) with respect to coverage provided to an employer member of the association; and

(b) if the health benefit plan is made available by an insurer in the employer market only through:

(i) an association;

(ii) a trust; or

(iii) a discretionary group.

(10) (a) A small employer that, after purchasing a health benefit plan in the small group market, employs on average more than 50 eligible employees on each business day in a calendar year may continue to renew the health benefit plan § **PURCHASED** § in the small group market.

(b) A large employer that, after purchasing a health benefit plan in the large group market, employs on average less than 51 eligible employees on each business day in a calendar year may continue to renew the health benefit plan purchased in the large group market.

(11) An insurer offering employer sponsored health benefit plans shall comply with the Health Insurance Portability and Accountability Act, P. L. 104-191, 110 Stat. 1962, Sec. 2701 and 2702.

Section 50. Section **31A-23-102** is amended to read:

31A-23-102. Definitions.

As used in this chapter:

(1) "Actuary" means a person who is a member in good standing of the American Academy of Actuaries.

(2) "Agency" means a person other than an individual, and includes a sole proprietorship by which a natural person does business under an assumed name.

(3) "Broker" means an insurance broker or any other person, firm, association, or corporation that for any compensation, commission, or other thing of value acts or aids in any manner in soliciting, negotiating, or procuring the making of any insurance contract on behalf of an insured other than itself.

(4) "Bail bond agent" means an individual:

(a) appointed by an authorized bail bond surety insurer or appointed by a licensed bail bond surety company to execute or countersign undertakings of bail in connection with judicial proceedings; and

(b) who receives or is promised money or other things of value for this service.

(5) "Captive insurer" means:

(a) an insurance company owned by another organization whose exclusive purpose is to insure risks of the parent organization and affiliated companies; or

(b) in the case of groups and associations, an insurance organization owned by the insureds

whose exclusive purpose is to insure risks of member organizations, group members, and their affiliates.

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

(7) "Controlling broker" means a broker who either directly or indirectly controls an insurer.

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

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

ĥ **(i)** ĥ a real estate settlement or real estate closing conducted by a third party pursuant to the requirements of a written agreement between the parties in a real estate transaction ĥ **; OR**

(ii) A SETTLEMENT OR CLOSING INVOLVING:

(A) A MOBILE HOME;

(B) A GRAZING RIGHT;

(C) A WATER RIGHT; OR

(D) OTHER PERSONAL PROPERTY AUTHORIZED BY THE COMMISSIONER ĥ .

[~~(a) a title insurance agency; or~~]

[~~(b) a title insurer.~~]

(b) "Escrow" includes the act of conducting a:

(i) real estate settlement; or

(ii) real estate closing.

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

(a) maintains the insurance producer's principal:

(i) place of residence; or

(ii) place of business; and

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

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

(a) all risk retention groups as defined in:

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

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

(iii) Chapter 15, Part II, Risk Retention Groups Act;

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

(c) all captive insurers.

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

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

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

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

(14) "Limited line insurance" includes:

(a) bail bond;

(b) limited line credit [~~life~~] insurance;

[~~(c) credit disability;~~]

[~~(d) credit property;~~]

[~~(e) credit unemployment;~~]

[~~(f) involuntary unemployment;~~]

[~~(g)~~] (c) legal expense insurance;

[~~(h) mortgage life;~~]

[~~(i) mortgage guaranty;~~]

[~~(j) mortgage disability;~~]

[~~(k)~~] (d) motor club insurance;

[~~(l)~~] (e) rental car-related insurance;

[~~(m)~~] (f) travel insurance; and

[~~(n)~~] (g) any other form of limited insurance [~~or insurance offered in connection with an extension of credit that: (i) is limited to partially or wholly extinguishing that credit obligation; and(ii)~~] that the commissioner determines by rule should be designated a form of limited line insurance.

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

(a) credit life;

(b) credit accident and health;

(c) credit property;

(d) credit unemployment;

(e) involuntary unemployment;

(f) mortgage life;

(g) mortgage guaranty;

(h) mortgage accident and health;

(i) guaranteed automobile protection; and

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

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

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

(16) "Limited line credit insurance producer" means a person who sells, solicits, or negotiates one or more forms of limited line credit insurance coverage to individuals through a master, corporate, group, or individual policy.

(17) "Limited lines insurance" includes:

(a) the lines of insurance listed in Subsection (14); or

(b) any other line of insurance that the commissioner considers necessary to recognize in the public interest.

(18) "Limited lines producer" means a person authorized to sell, solicit, or negotiate limited lines insurance.

[~~(15)~~] (19) (a) "Managing general agent" means any person, firm, association, or corporation that:

(i) manages all or part of the insurance business of an insurer, including the management of a separate division, department, or underwriting office;

(ii) acts as an agent for the insurer whether it is known as a managing general agent, manager, or other similar term;

(iii) with or without the authority, either separately or together with affiliates, directly or indirectly produces and underwrites an amount of gross direct written premium equal to, or more than 5% of, the policyholder surplus as reported in the last annual statement of the insurer in any one quarter or year; and

(iv) (A) adjusts or pays claims in excess of an amount determined by the commissioner; or

(B) negotiates reinsurance on behalf of the insurer.

(b) Notwithstanding Subsection [~~(15)~~] (19)(a), the following persons may not be considered as managing general agent for the purposes of this chapter:

(i) an employee of the insurer;

(ii) a United States manager of the United States branch of an alien insurer;

(iii) an underwriting manager that, pursuant to contract:

(A) manages all the insurance operations of the insurer;

(B) is under common control with the insurer;

(C) is subject to Chapter 16, Insurance Holding Companies; and

(D) is not compensated based on the volume of premiums written; and

(iv) the attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or inter-insurance exchange under powers of attorney.

[~~(16)~~] (20) "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract if the person engaged in that act:

(a) sells insurance; or

(b) obtains insurance from insurers for purchasers.

(21) "Personal lines" means property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes.

[~~(17)~~] (22) "Producer" means a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

[~~(18)~~] (23) "Qualified United States financial institution" means an institution that:

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

(b) is regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

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

(i) the commissioner; or

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

[~~(19)~~] (24) "Reinsurance intermediary" means a reinsurance intermediary-broker or a reinsurance intermediary-manager as these terms are defined in Subsections [~~(20)~~] (25) and [~~(21)~~] (26).

[~~(20)~~] (25) "Reinsurance intermediary-broker" means a person other than an officer or employee of the ceding insurer, firm, association, or corporation who solicits, negotiates, or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of the insurer.

[~~(21)~~] (26) (a) "Reinsurance intermediary-manager" means a person, firm, association, or corporation who:

(i) has authority to bind or who manages all or part of the assumed reinsurance business of a reinsurer, including the management of a separate division, department, or underwriting office; and

(ii) acts as an agent for the reinsurer whether the person, firm, association, or corporation is known as a reinsurance intermediary-manager, manager, or other similar term.

(b) Notwithstanding Subsection [~~(21)~~] (26)(a), the following persons may not be considered reinsurance intermediary-managers for the purpose of this chapter with respect to the reinsurer:

(i) an employee of the reinsurer;

(ii) a United States manager of the United States branch of an alien reinsurer;

(iii) an underwriting manager that, pursuant to contract:

(A) manages all the reinsurance operations of the reinsurer;

(B) is under common control with the reinsurer;

(C) is subject to Chapter 16, Insurance Holding Companies; and

(D) is not compensated based on the volume of premiums written; and

(iv) the manager of a group, association, pool, or organization of insurers that:

(A) engage in joint underwriting or joint reinsurance; and

(B) are subject to examination by the insurance commissioner of the state in which the manager's principal business office is located.

[~~(22)~~] (27) "Reinsurer" means any person, firm, association, or corporation duly licensed in this state as an insurer with the authority to assume reinsurance.

[~~(23)~~] (28) "Search" means a license category that allows a person to issue title insurance commitments or policies on behalf of a title insurer.

[~~(24)~~] (29) "Sell" means to exchange a contract of insurance:

(a) by any means;

(b) for money or its equivalent; and

(c) on behalf of an insurance company.

[~~(25)~~] (30) "Solicit" means:

(a) attempting to sell insurance; or

(b) asking or urging a person to apply:

(i) for a particular kind of insurance; and

(ii) from a particular insurance company.

[~~(26)~~] (31) "Surplus lines broker" means a person licensed under Subsection 31A-23-204(5) to place insurance with unauthorized insurers in accordance with Section 31A-15-103.

[~~(27)~~] (32) "Terminate" means:

(a) the cancellation of the relationship between:

(i) an insurance producer; and

(ii) a particular insurer; or

(b) the termination of the producer's authority to transact insurance on behalf of a particular insurance company.

[~~(28)~~] (33) "Title marketing representative" means a person who:

(a) represents a title insurer in soliciting, requesting, or negotiating the placing of:

(i) title insurance; or

(ii) escrow[~~, settlement, or closing~~] services; and

(b) does not have a search or escrow license as provided in Section 31A-23-204.

[~~(29)~~] (34) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

[~~(30)~~] (35) "Uniform application" means the version of the National Association of Insurance Commissioner's uniform application for resident and nonresident producer licensing at the time the application is filed.

[~~(31)~~] (36) "Uniform business entity application" means the version of the National Association of Insurance Commissioner's uniform business entity application for resident and nonresident business entities at the time the application is filed.

Section 51. Section **31A-23-204** is amended to read:

31A-23-204. License classifications.

A resident or nonresident license issued under this chapter shall be issued under the classifications described under Subsections (1) through (6). These classifications are intended to describe the matters to be considered under any education, examination, and training required of license applicants under Sections 31A-23-206 through 31A-23-208.

(1) An agent and broker license classification includes:

(a) life insurance, including nonvariable contracts;

(b) variable contracts;

(c) accident and health insurance, including contracts issued to policyholders under Chapter 7 or 8;

(d) property/liability insurance, which includes:

(i) property insurance;

(ii) liability insurance;

(iii) surety and other bonds; and

(iv) policies containing any combination of these coverages;

(e) title insurance under one of the following categories:

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

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

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

(iv) title marketing representative only; [~~and~~]

(f) workers' compensation insurance[~~.~~]; and

(g) personal lines.

(2) A limited license classification includes:

(a) limited line credit [~~life and credit accident and health~~] insurance;

(b) travel insurance;

(c) motor club insurance;

(d) car rental related insurance;

[~~(e) credit involuntary unemployment insurance;~~]

[~~(f) credit property insurance;~~]

(e) legal expense insurance;

[~~(g)~~] (f) bail bond agent; and

[~~(h)~~] (g) customer service representative.

(3) A consultant license classification includes:

(a) life insurance, including nonvariable contracts;

(b) variable contracts;

(c) accident and health insurance, including contracts issued to policyholders under Chapter 7 or 8;

(d) property/liability insurance, which includes:

(i) property insurance;

(ii) liability insurance;

(iii) surety and other bonds; and

(iv) policies containing any combination of these coverages; and

(e) workers' compensation insurance.

(4) A holder of licenses under Subsections (1)(a) and (1)(c) has all qualifications necessary to act as a holder of a license under Subsection (2)(a).

(5) (a) Upon satisfying the additional applicable requirements, a holder of a brokers license may obtain a license to act as a surplus lines broker.

(b) A license to act as a surplus lines broker gives the holder the authority to arrange insurance contracts with unauthorized insurers under Section 31A-15-103, but only as to the types of insurance under Subsection (1) for which the broker holds a brokers license.

(6) The commissioner may by rule recognize other agent, broker, limited license, or consultant license classifications as to kinds of insurance not listed under Subsections (1), (2), and (3).

Section 52. Section **31A-23-206** is amended to read:

31A-23-206. Continuing education requirements -- Regulatory authority.

(1) The commissioner shall by rule prescribe the continuing education requirements for each class of agent's license under Subsection 31A-23-204(1), except that the commissioner may not impose a continuing education requirement on a holder of a license under:

(a) Subsection 31A-23-204(2); or

(b) a license classification other than under Subsection 31A-23-204(2) that is recognized by the commissioner by rule as provided in Subsection 31A-23-204(6).

(2) (a) The commissioner may not state a continuing education requirement in terms of formal education.

(b) The commissioner may state a continuing education requirement in terms of classroom hours, or their equivalent, of insurance-related instruction received.

(c) Insurance-related formal education may be a substitute, in whole or in part, for classroom hours, or their equivalent, required under Subsection (2)(b).

(3) (a) The commissioner shall impose continuing education requirements in accordance with a two-year licensing period in which the licensee meets the requirements of this Subsection (3).

(b) Except as provided in Subsection (3)(c), for a two-year licensing period described in Subsection (3)(a) the commissioner shall require that the licensee for each line of authority held by the licensee:

(i) receive [~~six~~] five hours of continuing education; or

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

(c) Notwithstanding Subsection (3)(b):

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

(ii) the commissioner shall require:

(A) a minimum of:

(I) 12 hours of continuing education;

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

(III) a combination of Subsections (3)(c)(ii)(A)(I) and (II);

(B) that the minimum continuing education requirement of Subsection (3)(c)(ii)(A) include:

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

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

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

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

(3)(d)(i) may be obtained through:

(A) home study;

(B) video tape;

(C) experience credit; or

(D) other method provided by rule.

(e) (i) A licensee may obtain continuing education hours at any time during the two-year licensing period.

(ii) The licensee may not take a line of authority continuing education examination more than 90 calendar days before the date on which the licensee's license is renewed.

(f) The commissioner shall make rules for the content and procedures for line of authority continuing education examinations.

(g) (i) Beginning May 3, 1999, a licensee is exempt from continuing education requirements under this section if:

(A) as of April 1, 1990, the licensee has completed 20 years of licensure in good standing;

(B) the licensee requests an exemption from the department; and

(C) the department approves the exemption.

(ii) If the department approves the exemption under Subsection (3)(g)(i), the licensee is not required to apply again for the exemption.

(h) A licensee with a variable contract line of authority is exempt from the requirement for continuing education for that line of authority so long as the:

(i) National Association of Securities Dealers requires continuing education for licensees having a securities license; and

(ii) licensee complies with the National Association of Securities Dealers' continuing education requirements for securities licensees.

(i) The commissioner shall, by rule:

(i) publish a list of insurance professional designations whose continuing education requirements can be used to meet the requirements for continuing education under Subsection (3)(c); and

(ii) authorize professional agent associations to:

(A) offer qualified programs for all classes of licenses on a geographically accessible basis; and

(B) collect reasonable fees for funding and administration of the continuing education program, subject to the review and approval of the commissioner.

(j) (i) The fees permitted under Subsection (3)(i)(ii) that are charged to fund and administer the program shall reasonably relate to the costs of administering the program.

(ii) Nothing in this section prohibits a provider of continuing education programs or courses from charging fees for attendance at courses offered for continuing education credit.

(iii) The fees permitted under Subsection (3)(i)(ii) that are charged for attendance at a professional agent association program may be less for an association member, based on the member's affiliation expense, but shall preserve the right of a nonmember to attend without affiliation.

(4) The commissioner shall designate courses, including those presented by insurers, which satisfy the requirements of this section.

(5) The requirements of this section apply only to applicants who are natural persons.

(6) A nonresident producer is considered to have satisfied this state's continuing education requirements if:

(a) the nonresident producer satisfies the nonresident producer's home state's continuing education requirements for a licensed insurance producer; and

(b) on the same basis as under this Subsection (6) the nonresident producer's home state considers satisfaction of Utah's continuing education requirements for a producer as satisfying the continuing education requirements of the home state.

Section 53. Section **31A-23-211** is amended to read:

31A-23-211. Special requirements for title insurance agents.

Title insurance agents shall be licensed in accordance with this chapter, with the [~~following~~] additional requirements[~~:~~] listed in this section.

(1) (a) Every title insurance agency or agent appointed by an insurer shall maintain:

(i) a fidelity bond [~~or~~];

(ii) a professional liability insurance policy[~~;~~]; or [~~an equivalent~~]

(iii) a financial protection:

(A) equivalent to that described in Subsection (1)(a)(i) or (ii); and

(B) that the commissioner considers adequate. [~~This~~]

(b) The bond or insurance required by this Subsection (1):

(i) shall be supplied under a contract approved by the commissioner to provide protection against the improper performance of any service in conjunction with the issuance of a contract or policy of title insurance[~~. The bond or professional liability policy shall~~]; and

(ii) be in a face amount no less than $50,000.

(c) The commissioner may by rule exempt title insurance agents from the requirements of this Subsection (1) upon a finding that, and only so long as, the required policy or bond is generally unavailable at reasonable rates.

(2) (a) (i) Every title insurance agency or agent appointed by an insurer shall maintain a reserve fund. [~~This~~]

(ii) The reserve fund required by this Subsection (2) shall be:

(A) (I) composed of assets approved by the commissioner [~~and~~];

(II) maintained as a separate account; and

(III) charged as a reserve liability of the title insurance agent in determining the agent's financial condition[~~. The reserve fund shall be~~]; and

(B) accumulated by segregating 1% of all gross income received from the title insurance business.

(iii) Assets accumulated within the reserve fund for more than ten full years shall be:

(A) withdrawn from the fund; and

(B) restored to the income of the agent.

(iv) The title insurance agent may withdraw interest from the reserve fund related to the principal amount as it accrues.

(b) (i) A disbursement may not be made from the reserve fund except as provided in Subsection (2)(a) unless the title insurance agent ceases doing business as a result of:

(A) sale of assets[~~,~~];

(B) merger of the agent with another agent[~~,~~];

(C) termination of the agent's license[~~,~~];

(D) insolvency[~~,~~]; or

(E) any cessation of business by the agent.

(ii) Any disbursements from the reserve fund may be made only to settle claims arising from the improper performance of the title insurance agent in providing services defined in Section 31A-23-307.

(iii) The commissioner shall be notified ten days before any disbursements from the reserve fund.

(iv) The notice [~~must~~] required by this Subsection (2)(b) shall contain:

(A) the amount of claim[~~,~~];

(B) the nature of the claim[~~,~~]; and

(C) the name of the payee.

(c) (i) The reserve fund shall be maintained by the title insurance agent or [~~his~~] the title insurance agent's representative for a period of two years after the agent ceases doing business.

(ii) Any assets remaining in the reserve fund at the end of the two years specified in Subsection (2)(c)(i) may be withdrawn and restored to the former agent.

(3) Any examination for licensure shall include questions regarding the search and examination of title to real property.

(4) A title insurance agent may not perform the functions of escrow[~~, closing, or settlement,~~] unless the agent has been examined on the fiduciary duties and procedures involved in those functions.

(5) The commissioner shall adopt rules outlining an examination that will satisfy this section.

(6) [~~Licenses~~] A license may be issued to a title insurance [~~agents~~] agent who [~~have~~] has qualified:

(a) to perform only searches and examinations of title as specified in Subsection (3)[~~, or to title insurance agents who have qualified~~];

(b) to handle only escrow[~~, settlement, and closing~~] arrangements as specified in Subsection (4)[~~,~~]; or [~~to title insurance agents who have qualified~~]

(c) to act as a title marketing [~~representatives~~] representative.

(7) A person licensed to practice law in Utah is exempt from the requirements of Subsections (1) and (2) if[~~:~~] that person issues 12 or fewer policies in any 12-month period.

[~~(a) (i) the issuance of title insurance is an incidental part of that person's practice of law; and~~]

[~~(ii) that person does not hire employees or independent contractors to investigate title or otherwise assist in the issuance of title insurance; or~~]

[~~(b) that person does not maintain a title plant, or operate primarily as a title insurance~~

~~agent.~~]

Section 54. Section **31A-23-216** is amended to read:

31A-23-216. Termination of license.

(1) A license issued under this chapter remains in force until:

(a) revoked, suspended, or limited under Subsection (2);

(b) lapsed under Subsection (3);

(c) surrendered to and accepted by the commissioner; or

(d) the licensee dies or is adjudicated incompetent as defined under:

(i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

(ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and Minors.

(2) (a) If the commissioner makes a finding under Subsection (2)(b), after an adjudicative proceeding under Title 63, Chapter 46b, Administrative Procedures Act, the commissioner may:

(i) revoke a license of an agent, broker, surplus lines broker, or consultant;

(ii) suspend for a specified period of 12 months or less a license of an agent, broker, surplus lines broker, or consultant; or

(iii) limit in whole or in part the license of any agent, broker, surplus lines broker, or consultant.

(b) The commissioner may take an action described in Subsection (2)(a) if the commissioner finds that the licensee:

(i) is unqualified for a license under Section 31A-23-203;

(ii) has violated:

(A) an insurance statute;

(B) a rule that is valid under Subsection 31A-2-201(3); or

(C) an order that is valid under Subsection 31A-2-201(4);

(iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other delinquency proceedings in any state;

(iv) fails to pay any final judgment rendered against the person in this state within 60 days after the day the judgment became final;

(v) fails to meet the same good faith obligations in claims settlement that is required of admitted insurers;

(vi) is affiliated with and under the same general management or interlocking directorate or ownership as another insurance producer that transacts business in this state without a license;

(vii) refuses to be examined or to produce its accounts, records, and files for examination;

(viii) has an officer who refuses to:

(A) give information with respect to the administrator's affairs; or

(B) perform any other legal obligation as to an examination;

(ix) provided information in the license application that is:

(A) incorrect;

(B) misleading;

(C) incomplete; or

(D) materially untrue;

(x) has violated any insurance law, valid rule, or valid order of another state's insurance department;

(xi) has obtained or attempted to obtain a license through misrepresentation or fraud;

(xii) has improperly withheld, misappropriated, or converted any monies or properties received in the course of doing insurance business;

(xiii) has intentionally misrepresented the terms of an actual or proposed:

(A) insurance contract; or

(B) application for insurance;

(xiv) has been convicted of a felony;

(xv) has admitted or been found to have committed any insurance unfair trade practice or fraud;

(xvi) in the conduct of business in this state or elsewhere has:

(A) used fraudulent, coercive, or dishonest practices; or

(B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;

(xvii) has had an insurance license, or its equivalent, denied, suspended, or revoked in any other state, province, district, or territory;

(xviii) has forged another's name to:

(A) an application for insurance; or

(B) any document related to an insurance transaction;

(xix) has improperly used notes or any other reference material to complete an

examination for an insurance license;

(xx) has knowingly accepted insurance business from an individual who is not licensed;

(xxi) has failed to comply with an administrative or court order imposing a child support obligation;

(xxii) has failed to:

(A) pay state income tax; or

(B) comply with any administrative or court order directing payment of state income tax;

(xxiii) has violated or permitted others to violate the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Secs. 1033 and 1034; or

(xxiv) has engaged in methods and practices in the conduct of business that endanger the legitimate interests of customers and the public.

(3) (a) Any license issued under this chapter shall lapse if the licensee fails:

(i) to pay when due a fee under Section 31A-3-103[~~.~~];

(ii) to complete continuing education requirements under Section 31A-23-206 before submitting the license renewal application;

(iii) to submit a completed renewal application as required by Section 31A-23-202; or

(iv) to submit additional documentation required to complete the licensing process as related to a specific license type.

(b) A licensee whose license lapses due to military service or some other extenuating circumstances such as long-term medical disability may request:

(i) reinstatement of the license; and

(ii) waiver of any of the following imposed for failure to comply with renewal procedures:

(A) an examination requirement;

(B) a fine; or

(C) other sanction imposed for failure to comply with renewal procedures.

(c) The commissioner shall by rule prescribe the license renewal and reinstatement procedures, in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act.

(4) A licensee under this chapter whose license is suspended, revoked, or lapsed, but who continues to act as a licensee, is subject to the penalties for acting as a licensee without a license.

(5) Any person licensed in this state shall immediately report to the commissioner:

(a) a suspension or revocation of that person's license in any other state, District of

Columbia, or territory of the United States;

(b) the imposition of a disciplinary sanction imposed on that person by any other state, District of Columbia, or territory of the United States; and

(c) a judgment or injunction entered against that person on the basis of conduct involving fraud, deceit, misrepresentation, or violation of an insurance law or rule.

(6) (a) An order revoking a license under Subsection (2) may specify a time, not to exceed five years, within which the former licensee may not apply for a new license.

(b) If no time is specified in an order revoking a license under Subsection (2), the former licensee may not apply for a new license for five years without express approval by the commissioner.

(7) (a) Any person whose license is suspended or revoked under Subsection (2) shall, when the suspension ends or a new license is issued, pay all fees that would have been payable if the license had not been suspended or revoked, unless the commissioner by order waives the payment of the interim fees.

(b) If a new license is issued more than three years after the revocation of a similar license, this Subsection (7) applies only to the fees that would have accrued during the three years immediately following the revocation.

(8) The division shall promptly withhold, suspend, restrict, or reinstate the use of a license issued under this part if so ordered by a court.

Section 55. Section **31A-23-302** is amended to read:

31A-23-302. Unfair marketing practices.

(1) (a) (i) Any of the following may not make or cause to be made any communication that contains false or misleading information, relating to an insurance contract, any insurer, or other licensee under this title, including information that is false or misleading because it is incomplete:

(A) a person who is or should be licensed under this title;

(B) an employee or agent of a person described in Subsection (1)(a)(i)(A);

(C) a person whose primary interest is as a competitor of a person licensed under this title; and

(D) a person on behalf of any of the persons listed in this Subsection (1)(a)(i).

(ii) As used in this Subsection (1), "false or misleading information" includes:

(A) assuring the nonobligatory payment of future dividends or refunds of unused

premiums in any specific or approximate amounts, but reporting fully and accurately past experience is not false or misleading information; and

(B) with intent to deceive a person examining it, filing a report, making a false entry in a record, or wilfully refraining from making a proper entry in a record.

(iii) An insurer or other licensee under this title may not:

(A) use any business name, slogan, emblem, or related device that is misleading or likely to cause the insurer or other licensee to be mistaken for another insurer or other licensee already in business; or

(B) use any advertisement or other insurance promotional material that would cause a reasonable person to mistakenly believe that a state or federal government agency:

(I) is responsible for the insurance sales activities of the person;

(II) stands behind the credit of the person;

(III) guarantees any returns on insurance products of or sold by the person; or

(IV) is a source of payment of any insurance obligation of or sold by the person.

(iv) A person who is not an insurer may not assume or use any name that deceptively implies or suggests that it is an insurer.

(v) A person other than persons licensed as health maintenance organizations under Chapter 8 may not use the term "Health Maintenance Organization" or "HMO" in referring to itself.

(b) If an insurance agent or third party administrator distributes cards or documents, exhibits a sign, or publishes an advertisement that violates Subsection (1) (a), with reference to a particular insurer that the agent represents, or for whom the third party administrator processes claims, and if the cards, documents, signs, or advertisements are supplied or approved by that insurer, the agent's or the third party administrator's violation creates a rebuttable presumption that the violation was also committed by the insurer.

(2) (a) (i) An insurer or licensee under this chapter, or an officer or employee of either may not induce any person to enter into or continue an insurance contract or to terminate an existing insurance contract by offering benefits not specified in the policy to be issued or continued, including premium or commission rebates.

(ii) An insurer may not make or knowingly allow any agreement of insurance that is not clearly expressed in the policy to be issued or renewed.

(iii) This Subsection (2)(a) does not preclude:

(A) insurers from reducing premiums because of expense savings;

(B) the usual kinds of social courtesies not related to particular transactions; or

(C) an insurer from receiving premiums under an installment payment plan.

(b) An agent, broker, or insurer may not absorb the tax under Section 31A-3-301.

(c) (i) A title insurer or agent or any officer or employee of either may not pay, allow, give, or offer to pay, allow, or give, directly or indirectly, as an inducement to obtaining any title insurance business, any rebate, reduction, or abatement of any rate or charge made incident to the issuance of the insurance, any special favor or advantage not generally available to others, or any money or other consideration or material inducement.

(ii) "Charge made incident to the issuance of the insurance" includes escrow[~~, settlement, and closing~~] charges, and any other services that are prescribed by the commissioner.

(iii) An insured or any other person connected, directly or indirectly, with the transaction, including a mortgage lender, real estate broker, builder, attorney, or any officer, employee, or agent of any of them, may not knowingly receive or accept, directly or indirectly, any benefit referred to in Subsection (2)(c)(i).

(3) (a) An insurer may not unfairly discriminate among policyholders by charging different premiums or by offering different terms of coverage, except on the basis of classifications related to the nature and the degree of the risk covered or the expenses involved.

(b) Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, blanket, or franchise policy, and the terms of those policies are not unfairly discriminatory merely because they are more favorable than in similar individual policies.

(4) A person who is or should be licensed under this title, an employee or agent of that licensee or person who should be licensed, a person whose primary interest is as a competitor of a person licensed under this title, and one acting on behalf of any of these persons, may not commit or enter into any agreement to participate in any act of boycott, coercion, or intimidation that tends to produce an unreasonable restraint of the business of insurance or a monopoly in that business.

(5) (a) A person may not restrict in the choice of an insurer or insurance agent or broker, another person who is required to pay for insurance as a condition for the conclusion of a contract or other transaction or for the exercise of any right under a contract. The person requiring the coverage may, however, reserve the right to disapprove the insurer or the coverage selected on

reasonable grounds.

(b) The form of corporate organization of an insurer authorized to do business in this state is not a reasonable ground for disapproval, and the commissioner may by rule specify additional grounds that are not reasonable. This Subsection (5) does not bar an insurer from declining an application for insurance.

(6) A person may not make any charge other than insurance premiums and premium financing charges for the protection of property or of a security interest in property, as a condition for obtaining, renewing, or continuing the financing of a purchase of the property or the lending of money on the security of an interest in the property.

(7) (a) An agent may not refuse or fail to return promptly all indicia of agency to the principal on demand.

(b) A licensee whose license is suspended, limited, or revoked under Section 31A-2-308, 31A-23-216, or 31A-23-217 may not refuse or fail to return the license to the commissioner on demand.

(8) A person may not engage in any other unfair method of competition or any other unfair or deceptive act or practice in the business of insurance, as defined by the commissioner by rule, after a finding that they are misleading, deceptive, unfairly discriminatory, provide an unfair inducement, or unreasonably restrain competition.

Section 56. Section **31A-23-307** is amended to read:

31A-23-307. Title insurance agents' business.

(1) A title insurance agent may engage in the escrow[~~, settlement, or closing~~] business[~~, or any combination of such businesses, and operate as escrow, settlement, or closing agent provided that~~] involving real property transactions if all of the following exist:

[~~(1) The~~] (a) the title insurance agent is properly licensed under this chapter[~~.~~];

(b) the title insurance agent is appointed by a title insurer authorized to do business in the state;

(c) one or more of the following is to be issued as part of the transaction:

(i) an owner's policy of title insurance; or

(ii) a lender's policy of title insurance;

[~~(2) (a) (i) All~~] (d) (i) all funds deposited with the agent in connection with any escrow[~~, settlement, or closing~~]:

(A) are deposited:

(I) in a federally insured financial institution; and

(II) in [~~separate~~] a trust [~~accounts, with the funds being~~] account that is separate from all other trust account funds that are not related to real estate transactions; and

(B) are the property of the persons entitled to them under the provisions of the escrow[~~, settlement, or closing.~~]; and

(ii) [~~The funds shall be~~] are segregated escrow by escrow[~~, settlement by settlement, or closing by closing~~] in the records of the agent[~~.~~];

[~~(iii) Earnings~~] (e) earnings on funds held in escrow may be paid out of the escrow account to any person in accordance with the [~~provisions~~] conditions of the escrow [~~agreement if the agreement does not otherwise provide for payment of the earnings or any portion of the earnings on the escrow funds.~~]; and

(f) the escrow does not require the agent to hold:

(i) construction funds; or

(ii) funds held for exchange under Section 1031, Internal Revenue Code.

ĥ (2) NOTWITHSTANDING SUBSECTION (1), A TITLE INSURANCE AGENT MAY ENGAGE IN THE ESCROW BUSINESS IF:

(a) THE ESCROW INVOLVES:

(i) A MOBILE HOME;

(ii) A GRAZING RIGHT;

(iii) A WATER RIGHT; OR

(iv) OTHER PERSONAL PROPERTY AUTHORIZED BY THE COMMISSIONER; AND

(b) THE TITLE INSURANCE AGENT COMPLIES WITH ALL THE REQUIREMENTS OF THIS SECTION EXCEPT FOR THE REQUIREMENT OF SUBSECTION (1)(c). ĥ

[~~(iv)~~] **ĥ [~~(2)~~] (3) ĥ** Funds held in escrow:

[~~(A)~~] (a) are not subject to any debts of the agent; [~~and~~]

[~~(B)~~] (b) may only be used to fulfill the terms of the individual escrow[~~, settlement, or closing~~] under which the funds were accepted[~~.~~]; and

[~~(v) Funds held in escrow~~]

(c) may not be used until all conditions of the escrow[~~, settlement, or closing~~] have been met.

[~~(b)~~] **ĥ [~~(3)~~] (4) ĥ** Assets or property other than escrow funds received by an agent in accordance with an escrow [~~agreement~~] shall be maintained in a manner that will:

[~~(i)~~] (a) reasonably preserve and protect the asset or property from loss, theft, or damages;

and

[~~(ii)~~] (b) otherwise comply with all general duties and responsibilities of a fiduciary or bailee.

[~~(c)~~] **ĥ [~~(4)~~] (5) ĥ** (a) A check may not be drawn, executed or dated, or funds otherwise disbursed

unless the segregated escrow account from which funds are to be disbursed contains a sufficient credit balance consisting of collected or cleared funds at the time the check is drawn, executed or

dated, or funds are otherwise disbursed.

[~~(d)~~] (b) As used in this Subsection [~~(2)~~] ĥ **[~~(4)~~] (5)** ĥ , funds are considered to be "collected or cleared," and may be disbursed as follows:

(i) cash may be disbursed on the same day [~~it~~] the cash is deposited;

(ii) a wire [~~transfers~~] transfer may be disbursed on the same day [~~they are~~] the wire transfer is deposited;

(iii) [~~cashier's checks, certified checks, teller's checks, U.S. Postal Service money orders, and checks drawn on a Federal Reserve Bank or Federal Home Loan Bank~~] the following may be disbursed on the day following the date of deposit:

(A) a cashier's check;

(B) a certified check;

(C) a teller's check;

(D) a U.S. Postal Service money order; and

(E) a check drawn on a Federal Reserve Bank or Federal Home Loan Bank; and

(iv) any other [~~checks~~] check or [~~deposits~~] deposit may be disbursed:

(A) within the time limits provided under the Expedited Funds Availability Act, 12 U.S.C. Section 4001 et seq., as amended, and related regulations of the Federal Reserve System; or

(B) upon written notification from the financial institution to which the funds have been deposited, that final settlement has occurred on the deposited item.

[~~(3)~~] ĥ **[~~(5)~~] (6)** ĥ The title insurance agent shall maintain records of all receipts and disbursements of escrow[~~, settlement, and closing~~] funds.

[~~(4)~~] ĥ **[~~(6)~~] (7)** ĥ The title insurance agent shall comply with:

(a) Section 31A-23-310; and

(b) any rules adopted by the commissioner [~~governing~~] in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, that govern escrows[~~, settlements, or closings~~].

Section 57. Section **31A-23-308** is amended to read:

31A-23-308. Liability of title insurers for acts of title insurance agents.

Any title company, represented by one or more title insurance agents, is directly and primarily liable to others dealing with the title insurance agents for the receipt and disbursement of funds deposited in escrows[~~, closings, or settlements~~] with the title insurance agents in all those transactions where a commitment or binder for or policy or contract of title insurance of that title

insurance company has been ordered, or a preliminary report of the title insurance company has been issued or distributed. This liability does not modify, mitigate, impair, or affect the contractual obligations between the title insurance agents and the title insurance company.

Section 58. Section **31A-23-503** is amended to read:

31A-23-503. Duties of insurers.

(1) The insurer shall have on file an independent financial examination, in a form acceptable to the commissioner, of each managing general agent with which [~~it~~] the insurer has done business.

(2) (a) If a managing general agent establishes loss reserves, the insurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the managing general agent. [~~This~~]

(b) The requirement of Subsection (2)(a) is in addition to any other required loss reserve certification.

(3) The insurer shall at least semiannually conduct an on-site review of the underwriting and claims processing operations of the managing general agent.

(4) Binding authority for all reinsurance contracts or participation in insurance or reinsurance syndicates shall rest with an officer of the insurer, who may not be affiliated with the managing general agent.

(5) (a) Within 30 days after entering into or terminating a contract with a managing general agent, the insurer shall provide written notification of the appointment or termination to the commissioner.

(b) A notice of appointment of a managing general agent shall include:

[~~(a)~~] (i) a statement of duties that the applicant is expected to perform on behalf of the insurer;

[~~(b)~~] (ii) the lines of insurance for which the applicant is to be authorized to act; and

[~~(c)~~] (iii) any other information the commissioner may request.

(6) (a) An insurer shall review [~~its~~] the insurer's books and records each quarter to determine if any producer, as defined [~~by Subsection~~] in Section 31A-23-102[~~(17)~~], has become a managing general agent as defined in [~~Subsection~~] Section 31A-23-102[~~(15)~~].

(b) If the insurer determines that a producer has become a managing general agent[~~,~~]:

(i) the insurer shall promptly notify the producer and the commissioner of the

determination[~~. The~~]; and

(ii) the insurer and producer shall fully comply with the provisions of this chapter within 30 days.

(7) (a) An insurer may not appoint officers, directors, employees, subproducers, or controlling shareholders of [~~its~~] the insurer's managing general agents to [~~its~~] the insurer's board of directors.

(b) This Subsection (7) does not apply to relationships governed by [~~Title 31A,~~]:

(i) Chapter 16, Insurance Holding Companies[~~,~~]; or

(ii) Chapter 23, Part 6, Broker Controlled Insurers, if it applies.

Section 59. Section **31A-23-601** is amended to read:

31A-23-601. Applicability.

(1) This part applies to licensed insurers, as defined in [~~Subsection~~] Section 31A-23-102[~~(11), which~~], that are [~~either~~]domiciled:

(a) in this state; or [~~domiciled~~]

(b) in a state that does not have a substantially similar law.

(2) All provisions of [~~Title 31A,~~] Chapter 16, Insurance Holding Companies, to the extent they are not superseded by this part, continue to apply to all parties within holding company systems subject to this part.

Section 60. Section **31A-25-205** is amended to read:

31A-25-205. Financial responsibility.

(1) Every person licensed under this chapter shall[~~, while licensed and for one year after that date,~~] maintain an insurance policy or surety bond[~~,~~]:

(a) (i) while licensed; and

(ii) for one year after the person is licensed; and

(b) issued:

(i) by an authorized insurer[~~,~~];

(ii) in an amount specified under Subsection (2)[~~,~~]; and

(iii) on a policy or contract form [~~which~~] that is acceptable under Subsection (3).

(2) (a) Insurance policies or surety bonds satisfying the requirement of Subsection (1) shall be in a face amount equal to:

(i) at least the greater of:

(A) 10% of the total funds handled by the administrator[~~. However, no policy or bond under this Subsection (2)(a) may be in a face amount of less than~~]; or

(B) $5,000 [~~nor more than~~]; and

(ii) may not exceed $500,000.

(b) In fixing the policy or bond face amount under Subsection (2)(a), the total funds handled is:

(i) the greater of:

(A) the premiums received during the previous calendar year; or

(B) claims paid through the administrator during the previous calendar year; or

(ii) if no funds were handled during the preceding year, the total funds reasonably anticipated to be handled by the administrator during the current calendar year.

(c) This section does not prohibit any person dealing with the administrator from requiring, by contract, insurance coverage in amounts greater than the insurance coverage required under this section.

(3) (a) Insurance policies or surety bonds issued to satisfy Subsection (1) shall:

(i) be on forms approved by the commissioner[~~. The policies or bonds shall~~]; and

(ii) require the insurer to pay, up to the policy or bond face amount, any judgment:

(A) obtained by participants in or beneficiaries of plans administered by the insured licensee [~~which arise~~]; and

(B) that arises from the negligence or culpable acts of the licensee or any employee or agent of the licensee in connection with the activities [~~described under Subsection~~] of a third party administrator as defined in Section 31A-1-301[~~(111)~~].

(b) The commissioner may require that policies or bonds issued to satisfy the requirements of this section require the insurer to give the commissioner 20 day prior notice of policy cancellation.

(4) The commissioner shall establish annual reporting requirements and forms to monitor compliance with this section.

(5) This section may not be construed as limiting any cause of action an insured would otherwise have against the insurer.

Section 61. Section **31A-26-202 (Effective 07/01/02)** is amended to read:

31A-26-202 (Effective 07/01/02). Application for license.

(1) (a) The application for a license as an independent adjuster or public adjuster shall be:

(i) made to the commissioner on forms and in a manner the commissioner prescribes; and

(ii) accompanied by the applicable fee, which is not refunded if the application is denied.

(b) The application shall provide:

(i) information about the applicant's identity[~~;~~], including:

[~~(ii)~~] (A) the applicant's:

[~~(A)~~] (I) social security number; or

[~~(B)~~] (II) federal employer identification number;

[~~(iii)~~] (B) the applicant's personal history, experience, education, and business record;

[~~(iv)~~] (C) if the applicant is a natural person, whether the applicant is 18 years of age or older; and

[~~(v)~~] (D) whether the applicant has committed an act that is a ground for denial, suspension, or revocation as set forth in Section 31A-25-208; and

[~~(vi)~~] (ii) any other information as the commissioner reasonably requires.

(2) The commissioner may require documents reasonably necessary to verify the information contained in the application.

(3) The following are private records under Subsection 63-2-302(1)(a)(vii):

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

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

Section 62. Section **31A-26-202 (Superseded 07/01/02)** is amended to read:

31A-26-202 (Superseded 07/01/02). Application for license.

(1) (a) The application for a license as an independent adjuster or public adjuster shall be:

(i) made to the commissioner on forms and in a manner the commissioner prescribes; and

(ii) accompanied by the applicable fee, which is not refunded if the application is denied.

(b) The application shall provide:

(i) information about the applicant's identity[~~;~~], including:

[~~(ii)~~] (A) the applicant's:

[~~(A)~~] (I) social security number; or

[~~(B)~~] (II) federal employer identification number;

[~~(iii)~~] (B) the applicant's personal history, experience, education, and business record;

[~~(iv)~~] (C) if the applicant is a natural person, whether the applicant is 18 years of age or

older; and

[~~(v)~~] (D) whether the applicant has committed an act that is a ground for denial, suspension, or revocation as set forth in Section 31A-25-208; and

[~~(vi)~~] (ii) any other information as the commissioner reasonably requires.

(2) The commissioner may require documents reasonably necessary to verify the information contained in the application.

(3) The following are private records under Subsection 63-2-302(1)(g):

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

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

Section 63. Section **31A-26-206** is amended to read:

31A-26-206. Continuing education requirements.

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

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

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

(i) receive [~~six~~] five hours of continuing education; or

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

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

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

(ii) the commissioner shall require:

(A) a minimum of:

(I) 12 hours of continuing education;

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

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

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

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

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

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

(ii) The hours not completed through classroom hours in accordance with Subsection (2)(d)(i) may be obtained through:

(A) home study;

(B) video tape;

(C) experience credit; or

(D) other method provided by rule.

(e) (i) A licensee may obtain continuing education hours at any time during the two-year licensing period.

(ii) The licensee may not take a line of authority continuing education examination more than 90 calendar days before the date on which the licensee's license is renewed.

(f) The commissioner shall make rules for the content and procedures for line of authority continuing education examinations.

(g) (i) Beginning May 3, 1999, a licensee is exempt from the continuing education requirements of this section if:

(A) as of April 1, 1990, the licensee has completed 20 years of licensure in good standing;

(B) the licensee requests an exemption from the department; and

(C) the department approves the exemption.

(ii) If the department approves the exemption under Subsection (2)(g)(i), the licensee is not required to apply again for the exemption.

(h) A licensee with a variable annuity line of authority is exempt from the requirement for continuing education for that line of authority so long as:

(i) the National Association of Securities Dealers requires continuing education for licensees having a securities license; and

(ii) the licensee complies with the National Association of Securities Dealers' continuing education requirements for securities licensees.

(i) The commissioner shall by rule:

(i) publish a list of insurance professional designations whose continuing education requirements can be used to meet the requirements for continuing education under Subsection (2)(c); and

(ii) authorize professional adjuster associations to:

(A) offer qualified programs for all classes of licenses on a geographically accessible basis; and

(B) collect reasonable fees for funding and administration of the continuing education programs, subject to the review and approval of the commissioner.

(j) (i) The fees permitted under Subsection (2)(i) that are charged to fund and administer a program shall reasonably relate to the costs of administering the program.

(ii) Nothing in this section shall prohibit a provider of continuing education programs or courses from charging fees for attendance at courses offered for continuing education credit.

(iii) The fees permitted under Subsection (2)(i)(ii) that are charged for attendance at an association program may be less for an association member, based on the member's affiliation expense, but shall preserve the right of a nonmember to attend without affiliation.

(3) The requirements of this section apply only to licensees who are natural persons.

(4) The requirements of this section do not apply to members of the Utah State Bar.

(5) The commissioner shall designate courses that satisfy the requirements of this section, including those presented by insurers.

(6) A nonresident adjuster is considered to have satisfied this state's continuing education requirements if:

(a) the nonresident adjuster satisfies the nonresident producer's home state's continuing education requirements for a licensed insurance adjuster; and

(b) on the same basis the nonresident adjuster's home state considers satisfaction of Utah's continuing education requirements for a producer as satisfying the continuing education requirements of the home state.

Section 64. Section **31A-26-213** is amended to read:

31A-26-213. Termination of license.

(1) A license issued under this chapter remains in force until:

(a) revoked, suspended, or limited under Subsection (2);

(b) lapsed under Subsection (3);

(c) surrendered to and accepted by the commissioner; or

(d) the licensee dies or is adjudicated incompetent as defined under Title 75, Chapter 5, Part 3 or 4.

(2) (a) After an adjudicative proceeding under Title 63, Chapter 46b, Administrative Procedures Act, if the commissioner makes a finding described in Subsection (2)(b), the commissioner may:

(i) revoke[~~,~~] a license of an adjustor;

(ii) suspend a license of an adjustor for a specified period of 12 months or less[~~,~~]; or

(iii) limit in whole or in part the license of any adjuster[~~, found to:~~].

(b) The commissioner may take an action described in Subsection (2)(a) if the commissioner finds that the adjustor:

[~~(a) be~~] (i) is unqualified for a license under Section 31A-26-203;

[~~(b) have~~] (ii) has violated:

[~~(i)~~] (A) an insurance statute;

[~~(ii)~~] (B) a valid rule under Subsection 31A-2-201(3); or

[~~(iii)~~] (C) a valid order under Subsection 31A-2-201(4);

[~~(c) be~~] (iii) is insolvent, or the subject of receivership, conservatorship, rehabilitation, or other delinquency proceedings in any state;

[~~(d) fail~~] (iv) has failed to pay any final judgment rendered against [~~it~~] the adjustor in this state within 60 days after the judgment became final;

[~~(e) fail~~] (v) has failed to meet the same good faith obligations in claims settlement as that required of admitted insurers;

[~~(f) be~~] (vi) is affiliated with and under the same general management or interlocking directorate or ownership as another adjuster [~~which~~] that transacts business in this state without a license;

[~~(g) refuse~~] (vii) refuses to be examined or to produce [~~its~~] the adjustor's accounts, records, and files for examination;

[~~(h) have~~] (viii) has an officer who:

[~~(i)~~] (A) refuses to give information with respect to the administrator's affairs; or

[~~(ii)~~] (B) refuses to perform any other legal obligation as to an examination;

[~~(i) have~~] (ix) has provided incorrect, misleading, incomplete, or materially untrue information in the license application;

[~~(j) have~~] (x) has violated any insurance law, valid rule, or valid order of another state's insurance department;

[~~(k) have~~] (xi) has obtained or attempted to obtain a license through misrepresentation or fraud;

[~~(l) have~~] (xii) has improperly withheld, misappropriated, or converted any monies or properties received in the course of doing insurance business;

[~~(m) have~~] (xiii) has intentionally misrepresented the terms of an actual or proposed insurance contract or application for insurance;

[~~(n) have~~] (xiv) has been convicted of a felony;

[~~(o) have~~] (xv) has admitted or been found to have committed any insurance unfair trade practice or fraud;

[~~(p) have~~] (xvi) has used fraudulent, coercive, or dishonest practices in the conduct of business in this state or elsewhere;

[~~(q) have~~] (xvii) has demonstrated incompetence, untrustworthiness, or financial irresponsibility in the conduct of business in this state or elsewhere;

[~~(r) have~~] (xviii) has had an insurance license, or its equivalent, denied, suspended, or revoked in any other state, province, district, or territory;

[~~(s) have~~] (xix) has forged another's name to:

[~~(i)~~] (A) an application for insurance; or

[~~(ii)~~] (B) any document related to an insurance transaction;

[~~(t) have~~] (xx) has improperly used notes or any other reference material to complete an examination for an insurance license;

[~~(u) have~~] (xxi) has knowingly accepted insurance business from an individual who is not licensed;

[~~(v) have~~] (xxii) has failed to comply with an administrative or court order imposing a child support obligation;

[~~(w) have~~] (xxiii) has failed to:

[~~(i)~~] (A) pay state income tax; or

[~~(ii)~~] (B) comply with any administrative or court order directing payment of state income tax;

[~~(x) have~~] (xxiv) has violated or permitted others to violate the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Secs. 1033 and 1034; or

[~~(y) have~~] (xxv) has engaged in methods and practices in the conduct of business [~~which~~] that endanger the legitimate interests of customers and the public.

(3) (a) Any license issued under this chapter [~~lapses~~] shall lapse if the licensee fails to:

(i) pay [~~when due~~] any fee that is due under Section 31A-3-103[~~.~~] or 31A-3-104;

(ii) complete continuing education requirements under Section 31A-26-206 before submitting the license renewal application; or

(iii) submit a completed renewal application as required by Section 31A-26-202.

(b) A licensee whose license lapses due to military service or some other extenuating circumstance such as a long-term medical disability may request:

(i) reinstatement; and

(ii) a waiver of any of the following imposed for failure to comply with renewal procedures:

(A) an examination requirement;

(B) a fine; or

(C) other sanction.

(c) The commissioner shall by rule prescribe the license renewal and reinstatement procedures, in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act.

(4) A licensee under this chapter whose license is suspended, revoked, or lapsed, but who continues to act as a licensee, is subject to the penalties for conducting an insurance business without a license.

(5) (a) An order revoking a license under Subsection (2) may specify a time not to exceed five years within which the former licensee may not apply for a new license.

(b) If no time is specified in the order revoking a license under Subsection (2), the former licensee may not apply for a new license for five years without the express approval of the commissioner.

(6) (a) Any person whose license is suspended or revoked under Subsection (2) shall, when

the suspension ends or a new license is issued, pay all fees that would have been payable if the license had not been suspended or revoked, unless the commissioner by order waives the payment of the interim fees.

(b) If a new license is issued more than three years after the revocation of a similar license, this Subsection (6) applies only to the fees that would have accrued during the three years immediately following the revocation.

(7) The [~~division~~] commissioner shall promptly withhold, suspend, restrict, or reinstate the use of a license issued under this part if so ordered by a court.

Section 65. Section **31A-26-301.6** is amended to read:

31A-26-301.6. Health care provider claims practices.

(1) As used in this section:

(a) "Articulable reason" may include a determination regarding:

(i) eligibility for coverage;

(ii) preexisting conditions;

(iii) applicability of other public or private insurance;

(iv) medical necessity; and

(v) any other reason that would justify an extension of the time to investigate a claim.

(b) "Health care provider" means a person licensed to provide health care under:

(i) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act[~~,~~]; or

(ii) Title 58, Occupations and Professions.

(c) "Insurer" means an admitted or authorized insurer, as defined in Section 31A-1-301, and includes:

(i) a health maintenance organization; and

(ii) a third-party administrator that is subject to this title, provided that nothing in this section may be construed as requiring a third party administrator to use its own funds to pay claims that have not been funded by the entity for which the third party administrator is paying claims.

(d) "Provider" means a health care provider to whom an insurer is obligated to pay directly in connection with a claim by virtue of:

(i) an agreement between the insurer and the provider;

(ii) a health insurance policy or contract of the insurer; or

(iii) state or federal law.

(2) An insurer shall timely pay every valid insurance claim submitted by a provider in accordance with this section.

(3) (a) Within 30 days of receiving a written claim, an insurer shall do one of the following:

(i) pay the claim unless Subsection (3)(a)(ii), (iii), (iv), or (v) applies;

(ii) provide a written explanation if the claim is denied;

(iii) specifically describe and request any additional information from the provider that is necessary to process the claim;

(iv) inform the provider, pursuant to Subsection (4), of the 30-day extension of the insurer's investigation of the claim; or

(v) request additional information and inform the provider of the 30-day extension if both Subsections (3)(a)(iii) and (iv) apply.

(b) A provider shall respond to each request by an insurer for additional necessary information made under Subsection (3)(a)(iii) or (v) within 30 days of receipt of the request by providing the requested information that is in the possession of the provider, unless:

(i) the provider has requested and received the permission of the insurer to extend the 30-day period; or

(ii) the provider explains to the insurer in writing that additional time, which may not exceed 30 days, is necessary to comply with the request for information.

(c) Subsection (7) shall apply after an insurer has received the information requested.

(4) The time to investigate a claim may be extended by the insurer for an additional 30-days if:

(a) the investigation of the claim cannot reasonably be completed within the initial 30-day period of Subsection (3)(a);

(b) before the end of the 30-day period in Subsection (3)(a), the insurer informs the provider in writing of the reason for the payment delay, the nature of the investigation, the timelines for investigations established in this section, and the anticipated completion date.

(5) Notwithstanding Subsection (4), the time to investigate a claim may be extended beyond the initial 30-day period and the extended 30-day period if:

(a) due to matters beyond the control of the insurer, the investigation cannot reasonably be completed within 60 days as to some part or all of the claim;

(b) before the end of the combined 60-day period, the insurer makes a written request to the commissioner for an extension, including the reason for the delay, the nature of the investigation, the anticipated completion date, and the amount of any partial payment of the claim made pursuant to Subsection (5)(d);

(c) before the end of the combined 60-day period, the commissioner informs the insurer that the request for an extension has been granted, based on a finding that:

(i) there is a good faith and articulable reason to believe that the insurer is not obligated to pay some part or all of the claim; and

(ii) the investigation cannot reasonably be completed within 60 days; and

(d) the insurer identifies and pays all sums the insurer is obligated to pay on the claim and which are not subject to the extension requested under this Subsection (5).

(6) An extension granted by the commissioner under Subsection (5)(c) shall include the completion date for the investigation.

(7) (a) An insurer shall pay all sums to the provider that the insurer is obligated to pay on the claim, and provide a written explanation of any part of the claim that is denied within 20 days of:

(i) receiving the information requested under Subsection (3)(a)(iii);

(ii) completing an investigation under Subsection (4) or (5); or

(iii) the latter of Subsection (3)(a)(iii) or (iv), if Subsection (3)(a)(v) applies.

(b) (i) Except as provided in Subsection (7)(c), an insurer may send a follow-up request for additional information within the 20-day time period in Subsection (7)(a) if the previous response of the provider was not sufficient for the insurer to make a decision on the claim.

(ii) A follow-up request for additional necessary information shall state with specificity:

(A) the reason why the previous response was insufficient;

(B) the information that is necessary to comply with the request for information; and

(C) the reason why the requested information is necessary to process the claim.

(c) Unless an insurer has an extension for an investigation pursuant to Subsection (4) or (5), the insurer shall pay all sums it is obligated to pay on a claim and provide a written explanation of any part of the claim that is denied within [~~15~~] 20 days of receiving a notice from the provider that the provider has submitted all requested information in the provider's possession that is related to the claim.

(8) (a) Whenever an insurer makes a payment to a provider on any part of a claim under this section, the insurer shall also send to the insured an explanation of benefits paid.

(b) Whenever an insurer denies any part of a claim under this section, the insurer shall also send to the insured a written explanation of the part of the claim that was denied and notice of the [~~grievance~~] adverse benefit determination review process established under Section 31A-22-629.

(c) This Subsection (8) does not apply to a person receiving benefits under the state Medicaid program as defined in Section 26-18-2, unless required by the Department of Health or federal law.

(9) (a) Beginning with health care claims submitted on or after January 1, 2002, a late fee shall be imposed on:

(i) an insurer that fails to timely pay a claim in accordance with this section; and

(ii) a provider that fails to timely provide information on a claim in accordance with this section.

(b) For the first 90 days that a claim payment or a provider response to a request for information is late, the late fee shall be determined by multiplying together:

(i) the total amount of the claim;

(ii) the total number of days the response or the payment is late; and

(iii) .1%.

(c) For a claim payment or a provider response to a request for information that is 91 or more days late, the late fee shall be determined by adding together:

(i) the late fee for a 90-day period under Subsection (9)(b); and

(ii) the following [~~sum~~] multiplied together:

(A) the total amount of the claim;

(B) the total number of days the response or payment was late beyond the initial 90-day period; and

(C) the rate of interest set in accordance with Section 15-1-1.

(d) Any late fee paid or collected under this section shall be separately identified on the documentation used by the insurer to pay the claim.

(e) For purposes of this Subsection (9), "late fee" does not include an amount that is less than $1.

(10) Each insurer shall establish a [~~grievance~~] review process to resolve claims-related

disputes between the insurer and providers.

(11) No insurer or person representing an insurer may engage in any unfair claim settlement practice with respect to a provider. Unfair claim settlement practices include:

(a) knowingly misrepresenting a material fact or the contents of an insurance policy in connection with a claim;

(b) failing to acknowledge and substantively respond within 15 days to any written communication from a provider relating to a pending claim;

(c) denying or threatening to deny the payment of a claim for any reason that is not clearly described in the insured's policy;

(d) failing to maintain a payment process sufficient to comply with this section;

(e) failing to maintain claims documentation sufficient to demonstrate compliance with this section;

(f) failing, upon request, to give to the provider written information regarding the specific rate and terms under which the provider will be paid for health care services;

(g) failing to timely pay a valid claim in accordance with this section as a means of influencing, intimidating, retaliating, or gaining an advantage over the provider with respect to an unrelated claim, an undisputed part of a pending claim, or some other aspect of the contractual relationship;

(h) failing to pay the sum when required and as required under Subsection (9) when a violation has occurred;

(i) threatening to retaliate or actual retaliation against a provider for availing himself of the provisions of this section;

(j) any material violation of this section; and

(k) any other unfair claim settlement practice established in rule or law.

(12) (a) The provisions of this section shall apply to each contract between an insurer and a provider for the duration of the contract.

(b) Notwithstanding Subsection (12)(a), this section may not be the basis for a bad faith insurance claim.

(c) Nothing in Subsection (12)(a) may be construed as limiting the ability of an insurer and a provider from including provisions in their contract that are more stringent than the provisions of this section.

(13) (a) Pursuant to Chapter 2, Part 2, Duties and Powers of Commissioner, and beginning January 1, 2002, the commissioner may conduct examinations to determine an insurer's level of compliance with this section and impose sanctions for each violation.

(b) The commissioner may adopt rules only as necessary to implement this section.

(c) After December 31, 2002, the commissioner may establish rules to facilitate the exchange of electronic confirmations when claims-related information has been received.

(d) Notwithstanding the provisions of Subsection (13)(b), the commissioner may not adopt rules regarding the [~~grievance~~] review process required by Subsection (10).

(14) Nothing in this section may be construed as limiting the collection rights of a provider under Section 31A-26-301.5.

(15) Nothing in this section may be construed as limiting the ability of an insurer to:

(a) recover any amount improperly paid to a provider:

(i) in accordance with Section 31A-31-103 or any other provision of state or federal law;

(ii) within 36 months for a coordination of benefits error; or

(iii) within 18 months for any other reason not identified in Subsection (15)(a)(i) or (ii);

(b) take any action against a provider that is permitted under the terms of the provider contract and not prohibited by this section;

(c) report the provider to a state or federal agency with regulatory authority over the provider for unprofessional, unlawful, or fraudulent conduct; or

(d) enter into a mutual agreement with a provider to resolve alleged violations of this section through mediation or binding arbitration.

Section 66. Section **31A-27-102** is amended to read:

31A-27-102. Definitions.

(1) As used in this chapter:

(a) "Alien insurer domiciled in Utah" means an insurer domiciled outside the United States whose entry into the United States is through Utah.

(b) "Ancillary state" means any state other than an insurer's state of domicile.

(c) "Contingent claims" means a claim or demand upon which:

(i) a right of action has accrued at the date of the order of liquidation; and

(ii) liability has not been determined.

(d) "Date of liquidation" means the date of the filing of a petition for liquidation that

results in an order for liquidation.

(e) "Delinquency proceeding" means any:

(i) proceeding commenced against an insurer for the purpose of liquidating, rehabilitating, reorganizing, or conserving the insurer; and

(ii) summary proceeding under Sections 31A-27-201 through 31A-27-203.

(f) "Domestic insurer" includes, for purposes of this chapter, foreign insurers commercially domiciled in this state under Section 31A-14-206.

(g) (i) "Estate" or "property of the estate" means:

(A) all legal or equitable interests of an insurer that are the subject of a rehabilitation, liquidation, conservation, or other proceeding under this chapter in property as of the date of filing of the petition for rehabilitation, liquidation, or conservation;

(B) any interest in property recoverable by the receiver under the provisions of this title;

(C) any interest in property acquired after the date of filing of the petition; and

(D) all proceeds, products, rents, and profits from this property.

(ii) "Estate" or "property of the estate" includes property in which the insurer holds only legal title, but no equitable interest, only to the extent of the insolvent insurer's interest.

(h) "Fair consideration" is given for property or an obligation:

(i) when in exchange for the property or obligation, as a fair equivalent for it, and in good faith:

(A) property is conveyed;

(B) services are rendered;

(C) an obligation is incurred; or

(D) an antecedent debt is satisfied; or

(ii) when the property or obligation is received in good faith to secure a present advance or an antecedent debt in amount not disproportionately small compared to the value of the property or obligation obtained.

(i) (i) "General assets" means all property not encumbered by a security agreement for the security or benefit of specified persons or classes of persons.

(ii) "General assets" does not include separate account assets under Section 31A-5-217.

(iii) For encumbered property, "general assets" includes all that property or its proceeds which is in excess of the amount necessary to discharge the sums secured by the property.

(iv) Assets held in trust or on deposit for the security or benefit of all policyholders, or all policyholders and creditors, in more than a single state, are general assets.

(j) "Guaranty association" means:

(i) the applicable association under Chapter 28, Guaranty Associations; or

(ii) the similar association under the laws of another state.

(k) "Immature claim" means a claim or demand upon which payment is due, except for the passage of time.

(l) "Insolvency" has the same meaning as in Section 31A-1-301.

(m) "Insurer" means any person who is doing, has done, purports to do, or is licensed to do an insurance business on its own account and is or has been subject to the authority of, or to liquidation, rehabilitation, reorganization, or supervision by, a commissioner. A separate account created under Section 31A-5-217 is an "insurer" for purposes of Chapter 27, Insurers Rehabilitation and Liquidation.

(n) "Preferred claim" means any claim that the law gives priority of payment from the general assets of the insurer.

(o) "Receiver" means receiver, liquidator, rehabilitator, or conservator[~~,~~]:

(i) as the context requires[~~.~~]; and

(ii) is consistent with the definition of "receiver" in Subsections 31A-27-110(1)(c)(i) through (vii).

(p) "Reciprocal state" means any state other than this state:

(i) in which in substance Subsection 31A-27-310(1), Subsections 31A-27-403(1) and (3), Sections 31A-27-404 and 31A-27-406 through 31A-27-409 are in force;

(ii) which has laws requiring the commissioner to be the receiver of a delinquent insurer; and

(iii) which has laws for the avoidance of fraudulent conveyances and preferential transfers by the receiver of a delinquent insurer.

(q) "Secured claim" means any claim secured by mortgage, trust deed, security agreement, pledge, deposit as security, escrow or otherwise, but not including special deposit claims. The term also includes claims that have become liens upon specific assets through judicial processes.

(r) "Separate account assets" means those assets allocated to separate accounts under Section 31A-5-217.

(s) "Special deposit claim" means any claim secured by a deposit in trust made pursuant to this title for the security or benefit of one or more limited classes of persons.

(t) "Transfer" means every mode, direct or indirect, absolute or conditional, voluntarily or involuntarily, by or without judicial proceedings, of disposing of or parting with property or with an interest in property. The retention of a security interest in or title to property delivered to a debtor is considered a transfer by the debtor.

(u) "Unliquidated claim" means a claim or demand upon which:

(i) a right of action has accrued at the date of the order of liquidation; and

(ii) liability has been established but the amount of which has not been determined.

(2) If the subject of a rehabilitation or liquidation proceeding under this chapter is an insurer engaged in a surety business, then as used in this chapter:

(a) "Policy" includes a bond issued by a surety.

(b) "Policyholder" includes a principal on a bond.

(c) "Beneficiary" includes an obligee of a bond.

(d) "Insured" includes both the principal and obligee of a bond.

Section 67. Section **31A-27-103** is amended to read:

31A-27-103. Jurisdiction and venue.

(1) Except as provided in Subsection (2), [~~no~~] a delinquency proceeding may not be commenced under this chapter by anyone other than the Utah commissioner.

(2) (a) Three or more judgment creditors holding unrelated judgments against an insurer, which judgments aggregate more than $5,000 in excess of any security held by those creditors may commence proceedings against the insurer under the conditions and in the manner prescribed in this Subsection (2), by serving notice upon the commissioner and the insurer of intention to file a petition for liquidation under Section 31A-27-307 or 31A-27-402.

(b) Each of the judgments described in Subsection (2)(a):

(i) shall have been rendered against the insurer by a Utah court having jurisdiction over the subject matter and the insurer;

(ii) shall have been entered more than 60 days before the service of notice under Subsection (2)(a);

(iii) may not have been satisfied in full;

(iv) may not be the subject of a valid contract between the insurer and any judgment

creditor for payment of the judgment, unless that contract has been breached by the insurer;

(v) may not be a judgment assigned in order to institute proceedings under this Subsection (2); and

(vi) may not be a judgment on which an appeal or review is pending or may yet be brought.

[~~(b)~~] (c) If any one of the judgments in favor of a petitioning creditor remains unpaid for 30 days after service of the notice under Subsection (2)(a), and the commissioner has not then filed a petition for liquidation[~~,~~]:

(i) the creditor may file a verified petition for liquidation of the insurer:

(A) in the manner prescribed by Section 31A-27-307 or 31A-27-402[~~,~~]; and

(B) alleging the conditions stated in this Subsection[~~. The~~] (2); and

(ii) the commissioner shall be served and joined in the action.

(3) [~~No~~] Except in accordance with this chapter, a court of this state [~~has~~] does not have jurisdiction to entertain, hear, or determine any complaint praying for:

(a) the dissolution, liquidation, rehabilitation, sequestration, conservation, or receivership of any insurer[~~,~~]; or [~~praying for~~]

(b) an injunction or restraining order or other relief preliminary to, incidental to, or relating to [~~that~~] the type of proceedings [~~other than in accordance with this chapter~~] described in Subsection (3)(a).

(4) (a) Venue for proceedings arising under this chapter shall be laid initially as specified in the sections providing for those proceedings.

(b) All other actions and proceedings initiated by the receiver may be commenced and tried where:

(i) the delinquency proceedings are then pending[~~,~~]; or [~~where~~]

(ii) venue would be laid by applicable Utah law.

(c) All other actions and proceedings against the receiver shall be commenced and tried in the county where the delinquency proceedings are pending.

(d) Upon motion of any party, venue may be changed by order of the court or the presiding judge of the court to any other district court in Utah, whenever the convenience of the parties and witnesses and the ends of justice require it.

(e) This Subsection (4) relates only to venue and is not jurisdictional.

(5) In addition to other grounds for jurisdiction provided by the law of Utah, a Utah court

having jurisdiction of the subject matter has jurisdiction over a person properly served in an action brought by the receiver of a domestic insurer or an alien insurer domiciled in Utah:

(a) if the person served is obligated to the insurer in any way as an incident to any agency or brokerage arrangement that may exist or has existed between them, in any action on or incident to the obligation;

(b) if the person served is a reinsurer who has at any time written a policy of reinsurance for an insurer against which a rehabilitation or liquidation order is in effect when the action is commenced[~~, or~~];

(c) if the person served is an agent of or broker for the reinsurer described in Subsection (5)(b), in any action on or incident to the reinsurance contract; or

[~~(c)~~] (d) if the person served is or has been an officer, manager, trustee, organizer, promoter, or person in a position of comparable authority or influence in an insurer against which a rehabilitation or liquidation order is in effect when the action is commenced, in any action resulting from the relationship with the insurer.

(6) (a) Subject to Sections 31A-27-305 and 31A-27-317, the court in which a delinquency proceeding is pending has exclusive jurisdiction for:

(i) all actions and proceedings brought against the receiver of a rehabilitation or liquidation estate of the insurer; or

(ii) any action or proceeding in any way related to a rehabilitation or liquidation estate of an insurer.

(b) An action described in Subsection (6)(a) shall be commenced and tried in the court having exclusive jurisdiction.

[~~(6)~~] (7) If the court on the motion of any party finds that any action commenced under Subsection (5) should, as a matter of substantial justice, be tried in a forum outside Utah, the court may enter an order to stay further proceedings on the action in Utah.

Section 68. Section **31A-27-305** is amended to read:

31A-27-305. Actions by and against rehabilitator.

(1) [~~The~~] (a) An order for rehabilitation under Section 31A-27-303 [~~automatically~~] stays any action or proceeding [~~in this state in which the insurer is a party or is obligated to defend a party. The stay continues until the rehabilitator obtains proper representation and prepares for further proceedings. The court that entered the rehabilitation order shall order the rehabilitator~~

~~to take that action respecting pending litigation and other proceedings as the court considers necessary in the interests of justice and for the protection of creditors, policyholders, and the public. The rehabilitator shall immediately evaluate all litigation or other proceedings pending outside this state and shall petition the courts or agencies having jurisdiction over that litigation or those proceedings for stays whenever the rehabilitator determines it necessary to protect the estate of the insurer.~~]:

(i) (A) at law;

(B) in equity; or

(C) in arbitration;

(ii) brought against the insurer or rehabilitator; and

(iii) regardless of whether the action is brought in this state or elsewhere.

(b) An action or proceeding existing at the time the order for rehabilitation is issued may not be enforced, perfected, maintained, or further presented after issuance of the order for rehabilitation.

(c) The stay of all actions or proceedings provided in this Subsection (1) is automatic.

(d) The rehabilitator may not intervene or defend in an action or proceeding except as provided in this section.

(2) (a) If the rehabilitator determines that the protection of the estate of the insurer necessitates intervention in an action pending against the insurer, the rehabilitator may intervene in the action.

(b) An action described in Subsection (1)(a) is not stayed if:

(i) the rehabilitator applies to the court for:

(A) leave to intervene or defend; or

(B) for ratification by the court of intervention; and

(ii) the court grants the application.

(c) The estate of the insurer may be charged for the expenses incurred if the rehabilitator is defending any action in which the rehabilitator intervenes under this section.

[~~(2)~~] (3) (a) No statute of limitations runs and no defense of laches arises with respect to any action by or against an insurer between the filing of a petition for rehabilitation against an insurer and the denial of the petition or an order of rehabilitation.

(b) Any action by the insurer that might have been commenced when the petition was filed

may be commenced by the insurer or rehabilitator for:

(i) at least 60 days after:

(A) the order of rehabilitation is entered; or

(B) the petition is denied[~~,~~]; or [~~for~~]

(ii) a longer period if ordered by the court.

(c) This Subsection (3) does not limit the powers of the rehabilitator to bring actions under Sections 31A-27-319, 31A-27-320, 31A-27-321, 31A-27-322, and other provisions of this chapter.

Section 69. Section **31A-27-311.5** is amended to read:

31A-27-311.5. Continuance of coverage -- Health maintenance organizations.

(1) As used in this section:

(a) "basic health care services" is as defined in Section 31A-8-101;

(b) "enrollee" is as defined in Section 31A-8-101;

(c) "health care" is as defined in Section 31A-1-301;

(d) "health maintenance organization" is as defined in Section 31A-8-101;

(e) "limited health plan" is as defined in Section 31A-8-101;

(f) (i) "managed care organization" means any entity licensed by, or holding a certificate of authority from, the department to furnish health care services or health insurance;

(ii) "managed care organization" includes:

(A) a limited health plan;

(B) a health maintenance organization;

(C) a preferred provider organization;

(D) a fraternal benefit society; or

(E) any entity similar to an entity described in Subsections (1)(f)(ii)(A) through (D);

(iii) "managed care organization" does not include:

(A) an insurer or other person that is eligible for membership in a guaranty association under Chapter 28, Guaranty Associations;

(B) a mandatory state pooling plan;

(C) a mutual assessment company or any entity that operates on an assessment basis; or

(D) any entity similar to an entity described in Subsections (1)(f)(iii)(A) through (C);

(g) "participating provider" means a provider who, under a contract with a managed care organization authorized under Section 31A-8-407, [~~has agreed~~] agrees to provide health care

services to enrollees with an expectation of receiving payment, directly or indirectly, from the managed care organization, other than copayment;

(h) "participating provider contract" means the agreement between a participating provider and a managed care organization authorized under Section 31A-8-407;

(i) "preferred provider" means a provider who agrees to provide health care services under an agreement authorized under Subsection 31A-22-617(1);

(j) "preferred provider contract" means the written agreement between a preferred provider and a managed care organization authorized under Subsection 31A-22-617(1);

(k) (i) except as provided in Subsection (1)(k)(ii), "preferred provider organization" means any person[~~, other than an insurer licensed under Chapter 7 or an individual who contracts to render professional or personal services that the individual performs himself,~~] that:

[~~(i)~~] (A) furnishes at a minimum, through preferred providers, basic health care services to an enrollee in return for prepaid periodic payments in an amount agreed to prior to the time during which the health care may be furnished;

[~~(ii)~~] (B) is obligated to the enrollee to arrange for the services described in Subsection (1)(k)(i)(A); and

[~~(iii)~~] (C) permits the enrollee to obtain health care services from providers who are not preferred providers; and

(ii) "preferred provider organization" does not include:

(A) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance Corporation; or

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

(l) "provider" is as defined in Section 31A-8-101; and

(m) "uncovered expenditure" means the costs of health care services that are covered by an organization for which an enrollee is liable in the event of the managed care organization's insolvency.

(2) The rehabilitator or liquidator may take one or more of the actions described in Subsections (2)(a) through (f) to assure continuation of health care coverage for enrollees of an insolvent managed care organization.

(a) (i) Subject to Subsection (2)(a)(ii), a rehabilitator or liquidator may require a

participating provider and preferred provider of health care services to continue to provide the health care services the provider is required to provide under the [~~respective~~] provider's participating provider contract or preferred provider contract until the [~~later~~] earlier of:

(A) 90 days [~~from~~] after the date of the filing of:

(I) a petition for rehabilitation; or [~~the~~]

(II) a petition for liquidation; or

(B) the date the term of the contract ends.

(ii) A requirement by the rehabilitator or liquidator under Subsection (2)(a)(i) that a participating provider or preferred provider continue to provide health care services under a provider's participating provider contract or preferred providers contract expires when health care coverage for all enrollees of the insolvent managed care organization is obtained from another managed care organization or insurer.

(b) (i) Subject to Subsection (2)(b)(ii), a rehabilitator or liquidator may reduce the fees a participating provider or preferred provider is otherwise entitled to receive from the managed care organization under its participating provider contract or preferred provider contract during the time period in Subsection (2)(a)(i).

(ii) Notwithstanding Subsection (2)(b)(i) a rehabilitator or liquidator may not reduce a fee to less than 75% of the regular fee set forth in the respective participating provider contract or preferred provider contract.

(iii) An enrollee shall continue to pay the same copayments, deductibles, and other payments for services received from the participating provider or preferred provider that the enrollee was required to pay before the date of filing of:

(A) the petition for rehabilitation; or

(B) the petition for liquidation.

(c) (i) A participating provider or preferred provider shall:

(A) accept the amounts specified in Subsection (2)(b) as payment in full; and

(B) relinquish the right to collect additional amounts from the insolvent managed care organization's enrollee.

(ii) [~~Subsection~~] Subsections (2)(b) and [~~Subsections~~] (2)(c)(i)[~~(A) and (B)~~] shall apply to the fees paid to a provider who agrees to provide health care services to an enrollee but is not a preferred or participating provider.

(d) If the managed care organization is a health maintenance organization, Subsections (2)(d)(i) through [~~(v)~~] (vi) apply.

(i) Subject to Subsections (2)(d)(ii), (iii), and [~~(iv)~~] (v), upon notification from and subject to the direction of the rehabilitator or liquidator of a health maintenance organization licensed under Chapter 8, Health Maintenance Organizations and Limited Health Plans, a solvent health maintenance organization licensed under Chapter 8, Health Maintenance Organizations and Limited Health Plans, and operating within a portion of the insolvent health maintenance organization's service area shall extend to the enrollees all rights, privileges, and obligations of being an enrollee in the accepting health maintenance organization[~~, except that~~].

(ii) Notwithstanding Subsection (2)(d)(i), the accepting health maintenance organization shall give credit to an enrollee for any waiting period already satisfied under the provisions of the enrollee's contract with the insolvent health maintenance organization.

[~~(ii)~~] (iii) A health maintenance organization accepting an enrollee of an insolvent health maintenance organization under Subsection (2)(d)(i) shall charge the enrollee the premiums applicable to the existing business of the accepting health maintenance organization.

[~~(iii)~~] (iv) A health maintenance organization's obligation to accept an enrollee under Subsection (2)(d)(i) is limited in number to [~~its~~] the accepting health maintenance organization's pro rata share of all health maintenance organization enrollees in this state, as determined after excluding the enrollees of the insolvent insurer.

[~~(iv)~~] (v) (A) The rehabilitator or liquidator of an insolvent health maintenance organization shall take those measures that are possible to ensure that no health maintenance organization is required to accept more than its pro rata share of the adverse risk represented by the enrollees of the insolvent health maintenance organization. [~~As long as~~]

(B) If the methodology used by the rehabilitator or liquidator to assign an enrollee is one [~~which~~] that can be expected to produce a reasonably equitable distribution of adverse risk, that methodology and its results are acceptable under this Subsection (2)(d)[~~(iv)~~](v).

[~~(v)~~] (vi) (A) Notwithstanding Section 31A-27-311, the rehabilitator or liquidator may require all solvent health maintenance organizations to pay for the covered claims incurred by the enrollees of the insolvent health maintenance organization.

(B) As determined by the rehabilitator or liquidator, payments required under this Subsection (2)(d)[~~(v)~~](vi) may:

(I) begin as of the filing of the petition for reorganization or the petition for liquidation; and

(II) continue for a maximum period through the time all enrollees are assigned pursuant to this section.

(C) If the rehabilitator or liquidator makes an assessment under this Subsection (2)(d)[~~(v)~~](vi), the rehabilitator or liquidator shall assess each solvent health maintenance organization its pro rata share of the total assessment based upon its premiums from the previous calendar year.

(D) (I) A solvent health maintenance organization required to pay for covered claims under this Subsection (2)(d)(vi) shall be entitled to file a claim against the estate of the insolvent health maintenance organization.

(II) Any claim described in Subsection (2)(a)(vi)(D)(I), if allowed by the rehabilitator or liquidator, shall share in any distributions from the estate of the insolvent health maintenance organization as a Class 3 claim.

(e) (i) A rehabilitator or liquidator may transfer, through sale, or otherwise, the group and individual health care obligations of the insolvent managed care organization to other managed care organizations or other insurers, if those other managed care organizations and other insurers are licensed or have a certificate of authority to provide the same health care services in this state that is held by the insolvent managed care organization [~~has~~].

[~~(i)~~] (ii) The rehabilitator or liquidator may combine group and individual health care obligations of the insolvent managed care organization in any manner the rehabilitator or liquidator considers best to provide for continuous health care coverage for the maximum number of enrollees of the insolvent managed care organization.

[~~(ii)~~] (iii) If the terms of a proposed transfer of the same combination of group and individual policy obligations to more than one other managed care organization or insurer are otherwise equal, the rehabilitator or liquidator shall give preference to the transfer of the group and individual policy obligations of an insolvent managed care organization as follows:

(A) from one category of managed care organization to another managed care organization of the same category, as follows:

(I) from a limited health plan to a limited health plan;

(II) from a health maintenance organization to a health maintenance organization;

(III) from a preferred provider organization to a preferred provider organization;

(IV) from a fraternal benefit society to a fraternal benefit society; and

(V) from any entity similar to any of the above to a category that is similar;

(B) from one category of managed care organization to another managed care organization, regardless of the category of the transferee managed care organization; and

(C) from a managed care organization to a nonmanaged care provider of health care coverage, including insurers.

(f) A rehabilitator or liquidator may use the insolvent managed care organization's required capital or permanent surplus, and compulsory surplus, to continue to provide coverage for the insolvent managed care organization's enrollees, including paying uncovered expenditures.

Section 70. Section **31A-27-315** is amended to read:

31A-27-315. Notice to creditors and others.

(1) (a) The liquidator shall give notice of the liquidation order as soon as possible:

(i) by first-class mail and [~~either by telegram or telephone~~] electronic communication to the insurance commissioner of each jurisdiction in which the insurer is [~~licensed to do~~] doing business;

(ii) by first-class mail and [~~by telephone~~] electronic communication to any guaranty fund or association [~~which~~] that may become obligated [~~because~~] as a result of the liquidation;

[~~(iii) by first class mail and by telephone to the Labor Commission of this state if the insurer is or has been an insurer of workers' compensation;~~]

[~~(iv)~~] (iii) by first-class mail to all insurance agents [~~and~~], brokers, and reinsurers doing business with the insurer;

[~~(v)~~] (iv) by first-class mail to the persons designated in Subsection 31A-2-212(5), if the insurer does a surety business;

[~~(vi)~~] (v) by first-class mail to the last known address of all persons known or reasonably expected from the insurer's records to have claims against the insurer, including all policyholders; and

[~~(vii)~~] (vi) unless the court orders otherwise, by publication under Section 31A-2-303, with the last publication being not less than three months before the earliest deadline specified in the notice under Subsection (2).

(b) Notice to policyholders shall include:

(i) notice of impairment and termination of coverage under Section 31A-27-311[~~. When it is~~]; and

(ii) when applicable[~~, notice to policyholders shall also include~~]:

[~~(i)~~] (A) notice of withdrawal of the insurer from the defense of any case in which the insured is interested; and

[~~(ii)~~] (B) information about the existence of any:

(I) applicable assigned risk plans or residual market facilities [~~and of a~~]; or

(II) guaranty [~~fund~~] funds under Chapter 28, Guaranty Associations, or similar laws of another state.

(c) (i) Within [~~15~~] 45 days of the date of entry of the liquidation order, the liquidator shall report to the court what notice has been given.

(ii) The court may order [~~any additional~~] notice [~~it~~] in addition to the notice required by this Subsection (1) that the court considers appropriate.

(2) (a) Notice to potential claimants under Subsection (1) shall require claimants to file with the liquidator [~~their claims together with proper proofs under Section 31A-27-329,~~] on or before a date the liquidator specifies in the notice[~~, which may not be less than six months nor more than one year after entry of the liquidation order.~~]:

(i) the claimants' claims; and

(ii) proper proofs under Section 31A-27-329.

(b) The liquidator need not require [~~persons~~] the following to file a claim:

(i) a person claiming unearned premium [~~and persons~~]; or

(ii) a person claiming cash surrender values or other investment values in life insurance and annuities [~~to file a claim~~].

(c) The liquidator may specify different dates for filing the different kinds of claims.

(3) If notice is given in accordance with this section, the distribution of the assets of the insurer under this chapter is conclusive with respect to all claimants, whether or not [~~they~~] the claimants received actual notice.

Section 71. Section **31A-27-317** is amended to read:

31A-27-317. Actions by and against liquidator.

(1) (a) The filing of a petition for liquidation of a domestic insurer or of an alien insurer domiciled in this state stays all actions and all proceedings [~~against the insurer in Utah or~~

~~elsewhere and the liquidator may not intervene in them, except as provided in this subsection. Whenever, in the liquidator's judgment, an action in Utah has proceeded to a point where fairness or convenience would be served by its continuation to judgment, the liquidator may apply to the court for leave to defend or to be substituted for the insurer, and if the court grants the application, the action is not stayed. Whenever in the liquidator's judgment, the protection of the estate of the insurer necessitates intervention in an action against the insurer that is pending outside Utah, with approval of the court the liquidator may intervene in the action.~~]:

(i) (A) at law;

(B) in equity; or

(C) in arbitration;

(ii) against the insurer or liquidator; and

(iii) regardless of whether the action is brought in this state or elsewhere.

(b) Any action or proceeding existing at the time the petition for liquidation is filed may not be enforced, perfected, maintained, or further presented after the filing of the petition.

(c) The stay of all actions under this Subsection (1) is automatic.

(d) The liquidator may not intervene or defend in an action or proceeding except as provided in this section.

(2) Except as provided under Section 31A-27-323, filing a petition for liquidation stays the exercise of any right of setoff against the insurer.

(3) (a) If the liquidator determines that protection of the estate of the insurer necessitates intervention in an action pending against the insurer, the liquidator may intervene in the action.

(b) An action described in Subsection (1)(a) is not stayed if:

(i) the liquidator applies to the court for:

(A) leave to intervene or defend; or

(B) ratification by the court of intervention; and

(ii) the court grants the application.

(c) The estate of the insurer may be charged for the expenses incurred by the liquidator in defending any action in which the liquidator intervenes under this section.

[~~(3)~~] (4) (a) The liquidator may[~~, within two years subsequent to an order for liquidation or within any further time as applicable law permits,~~] institute an action or proceeding on behalf of the estate of the insurer upon any cause of action against which the period of limitation fixed

by applicable law had not expired at the time of the filing of the petition.

(b) Where, by any agreement, a period of limitation is fixed for instituting [~~a suit~~] an action or proceeding upon any claim or for filing any claim, proof of claim, proof of loss, demand, notice, or the like, or where in any proceeding, judicial or otherwise, a period of limitation is fixed, either in the proceeding or by applicable law, for taking any action, filing any claim or pleading, or doing any act, and where in any of these sections the period had not expired at the date of the filing of the petition for liquidation, the liquidator may, for the benefit of the estate, take any action or do any act, required of or permitted to the insurer, within a period of 180 days subsequent to the entry of an order for liquidation, or within any further period as is permitted by the agreement, in the proceeding, or by applicable law, or within any further time period as is shown to the satisfaction of the court not to be unfairly prejudicial to the other party.

[~~(4)~~] (5) (a) No statute of limitations runs and no defense of laches is available with respect to any action against an insurer between the filing of a petition for liquidation and the denial of the petition.

(b) Any action against the insurer that might have been commenced when the petition was filed may be commenced for at least 60 days after the petition is denied.

[~~(5)~~] (6) Any guaranty fund or association that may become liable as a result of the liquidation of an insurer may intervene in any court proceeding concerning the liquidation of the insurer.

Section 72. Section **31A-27-332** is amended to read:

31A-27-332. Disputed claims.

(1) (a) When a claim is disallowed in whole or in part by the liquidator, written notice of the determination and of the right to object shall be given promptly to the claimant or the claimant's attorney of record, if any, by first-class mail at the addresses shown in the proof of claim.

(b) (i) Within 60 days from the mailing of the notice required by Subsection (1)(a), the claimant may file objections with the court.

(ii) If objections are not filed within the period provided in Subsection (1)(b)(i), the claimant may not further object to the determination.

(2) (a) Whenever objections are filed with the court and the liquidator does not alter the liquidator's ruling, the liquidator shall ask the court for a hearing as soon as practicable.

(b) [~~The~~] If the liquidator asks for a hearing under Subsection (2)(a), the court shall issue an order setting a date as early as possible.

(c) At the request of the liquidator, the court may establish procedures for the objections hearing.

(d) The liquidator shall give notice of [~~the~~] a hearing under this Subsection (2) by first-class mail to:

(i) the claimant or the claimant's attorney; and

(ii) any other persons directly affected.

(e) A hearing under this Subsection (2):

(i) shall be heard without a jury[~~.~~]; and

[~~(f) The matter~~] (ii) may be heard by:

[~~(i)~~] (A) the court; or

[~~(ii)~~] (B) a court-appointed referee.

[~~(g)~~] (f) [~~If a referee is appointed under Subsection (2)(f), the referee~~] A hearing under this Subsection (2) shall[~~: (i) review and~~] be limited to the evidence upon which the liquidator made the determination of the claims[~~; and~~].

[~~(ii)~~] (g) If a referee is appointed under this Subsection (2), the referee shall submit to the court:

(i) findings of fact [~~together with~~]; and

(ii) recommendations.

(h) Consistent with Subsection 31A-27-336(2), the court may approve, disapprove, or modify:

(i) the liquidator's determination of a claim; or

(ii) a referee's recommendations on a claim.

(3) A court order issued after a hearing and pursuant to this section may be appealed as a final order for purposes of Rule 54 [~~of the~~], Utah Rules of Civil Procedure.

Section 73. Section **31A-27-337** is amended to read:

31A-27-337. Distribution of assets.

(1) (a) Subject to any instructions the court may give, the liquidator shall make distributions in a manner that will assure the proper recognition of priorities and a reasonable balance between the expeditious completion of the liquidation and the protection of unliquidated

and undetermined claims, including third party claims.

(b) Distribution of assets in kind may be made at valuations set by agreement between the liquidator and the creditor and approved by the court in advance of the distribution.

(2) (a) The liquidator shall make distributions to guaranty funds and associations under Subsection (1) to satisfy their claims under Chapter 28, Guaranty Associations, or similar laws of other states, if the claims have been filed pursuant to rules established under Subsections 31A-27-328(1) and (4).

(b) The total distributions to guaranty funds and associations paid under this Subsection (2) may not exceed the total of the claims properly made by the funds and associations under Subsections 31A-27-328(1) and (4).

(c) The liquidator shall pay distributions as frequently as is practicable and in sums as large as possible without sacrificing asset values by untimely disposition or inequitable allocation of available assets.

(d) The liquidator may protect against inequitable allocations by making payments to funds and associations subject to binding agreements by [~~them~~] the funds or associations to repay any portions of the distributions [~~which~~] that are later found to be in excess of an equitable allocation.

(e) If assets are available, the liquidator may [~~also~~] lend to guaranty funds and associations, subject to express advance court approval.

(3) (a) The liquidator shall report to the court within [~~four months~~] 120 days after the [~~issuance of~~] day the liquidation order is issued under Section 31A-27-310, [~~and every three months thereafter~~] on the status of the assets [~~and the payment of distributions and loans under Subsection (2).~~] of the liquidation estate.

(b) (i) After the report required by Subsection (3)(a), the liquidator will report to the court on the status of the liquidation on a calendar quarter basis.

(ii) A report required by this Subsection (3)(b) shall be due within 45 days of the end of the calendar quarter unless the court orders otherwise.

(c) The court may order the liquidator to make distributions to guaranty funds and associations under Subsection (2) more expeditiously to minimize the need for assessments under Chapter 28, Guaranty Associations, or similar laws of other states.

(4) (a) Upon liquidation of a domestic nonlife mutual insurance company, any assets held in excess of [~~its~~] the company's liabilities and of the amounts [~~which~~] that may be paid to [~~its~~] the

company's members as provided under Subsection (4)(b) shall be paid into the state treasury to the credit of the Uniform School Fund.

(b) The maximum amount payable upon liquidation to any member for and on account of [~~his~~] that member's membership in a domestic nonlife mutual insurance company, in addition to the insurance benefits promised in the policy, is the total of all premium payments made by the member within the past five years with interest at the legal rate compounded annually.

Section 74. Section **31A-27-340** is amended to read:

31A-27-340. Reopening liquidation.

(1) After the liquidation proceeding has been terminated and the liquidator discharged, [~~the commissioner or other interested party may at any time~~] within a reasonable time any of the following may petition the court to reopen the proceedings for good cause, including the discovery of additional assets[~~.~~]:

(a) the commissioner;

(b) a policyholder;

(c) a creditor; or

(d) a claimant of the closed liquidation estate.

(2) If the court is satisfied that there is justification for reopening, [~~it~~] the court shall order [~~it~~] the reopening.

Section 75. Section **31A-27-341** is amended to read:

31A-27-341. Disposition of records.

[~~Records~~] Upon a motion of the liquidator, the records of any insurer in the process of liquidation or completely liquidated under this chapter may be disposed of in the [~~same~~] manner [~~as records under Section 31A-2-207~~] ordered by the court.

Section 76. Section **31A-28-203** is amended to read:

31A-28-203. Definitions.

As used in this part:

(1) "Affiliate" is as defined in Section 31A-1-301.

(2) "Association account" means the Utah Property and Casualty Insurance Guaranty Association Account created by Section 31A-28-205.

[~~(2)~~] (3) (a) "Claimant" means:

(i) an insured making a first-party claim; or

(ii) a person instituting a liability claim.

(b) A person who is an affiliate of the insolvent insurer may not be a claimant.

[~~(3)~~] (4) (a) "Covered claim" means an unpaid claim, including an unpaid claim under a personal lines policy for unearned premiums submitted by a claimant, if:

(i) the claim arises out of the coverage;

(ii) the claim is within the coverage;

(iii) the claim is not in excess of the applicable limits of an insurance policy to which this part applies;

(iv) the insurer who issued the policy becomes an insolvent insurer; and

(v) (A) the claimant or insured is a resident of this state at the time of the insured event; or

(B) the claim is a first-party claim for damage to property that is permanently located in this state.

(b) "Covered claim" does not include:

(i) any amount awarded as punitive or exemplary damages or any amount due any reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise, nor does it include any supplementary payment obligation, including adjustment fees and expenses, attorneys' fees and expenses, court costs, interest, and bond premiums, prior to the appointment of a liquidator;

(ii) any amount sought as a return of premium under a retrospective rating plan;

(iii) any first-party claim by an insured if:

(A) the insured's net worth exceeds $25,000,000 on December 31 of the year preceding the date the insurer becomes an insolvent insurer; and

(B) the insured's net worth includes the aggregate net worth of the insured and all of its subsidiaries as calculated on a consolidated basis; or

(iv) any first-party claims by an insured that is an affiliate of the insolvent insurer.

[~~(4)~~] (5) "Insolvent insurer" means a member insurer that is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

[~~(5)~~] (6) "Member insurer" means any person who:

(a) writes any kind of insurance to which this part applies under Section 31A-28-202, including the exchange of reciprocal or inter-insurance contracts; and

(b) is licensed to transact insurance in this state.

[~~(6)~~] (7) (a) "Net direct written premiums" means direct gross premiums written in this state on insurance policies that this part applies to, less return premiums and dividends paid or credited to policyholders on the direct business.

(b) "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers.

[~~(7)~~] (8) "Personal lines policy" means an insurance policy issued to an individual that:

(a) insures a motor vehicle used for personal purposes and not used in trade or business; or

(b) insures a residential dwelling.

[~~(8)~~] (9) "Residence" means, for entities other than a natural person, the state where the principal place of business of a claimant, insured, or policyholder is located at the time of the insured event.

Section 77. Section **31A-28-205** is amended to read:

31A-28-205. Creation of the association.

(1) (a) The Utah Property and Casualty Insurance Guaranty Association shall continue as a nonprofit legal entity.

(b) All member insurers of the association are, and remain, members of the association as a condition of their authority to transact insurance business in this state.

(c) The association shall:

(i) perform its functions under the plan of operation established and approved under Section 31A-28-209; and

(ii) exercise its powers through a board of directors established under Section 31A-28-206.

(d) For the purposes of administration and assessment, the association shall maintain[~~: (i) a workers' compensation insurance~~] an account[~~;~~] known as the Property and Casualty Insurance Guaranty Association Account.

[~~(ii) an automobile insurance account; and~~]

[~~(iii) a miscellaneous account for all other insurance to which this part applies.~~]

(e) (i) If as of May 6, 2002, the association has more than one account, the association shall consolidate all accounts into the Property and Casualty Insurance Guaranty Association Account.

(ii) The Property and Casualty Insurance Guaranty Association Account:

(A) succeeds to all funds held by the association in an account existing on May 6, 2002; and

(B) is subject to any liability or obligation attributable to an account of the association existing on May 6, 2002.

(2) (a) An insurer shall cease to be a member insurer on the day following the termination or expiration of the insurer's license to transact the kinds of insurance to which this part applies.

(b) Notwithstanding Subsection (2)(a), the insurer shall remain liable as a member insurer for all obligations, including assessments levied:

(i) before the termination or expiration of the insurer's license; and

(ii) after the termination or expiration of the insurer's license but that relate to an insurer that became an insolvent insurer before the termination or expiration of the insurer's license.

(3) Meetings or records of the association shall be open to the public upon a majority vote of the board of directors of the association.

(4) The association is not an agency of the state.

Section 78. Section **31A-28-207** is amended to read:

31A-28-207. Powers and duties of the association.

(1) (a) The association is obligated on the amount of the covered claims:

(i) existing prior to the order of liquidation; and

(ii) arising:

(A) within 30 days after the order of liquidation; or

(B) (I) before the policy expiration date if it is less than 30 days after the order of liquidation; or

(II) before the insured replaces the policy or causes its cancellation, if the insured does so within 30 days of the order of liquidation.

(b) The obligation under Subsection (1)(a) includes only that amount of each covered claim that is less than $300,000.

(c) A claim under a personal lines policy for unearned premiums shall include only those claims that exceed $100 in amount, subject to a maximum of $10,000 per policy.

(d) The association shall pay the full amount of any covered claim arising out of a workers' compensation policy. The association is not obligated to a policyholder or claimant in an amount

in excess of the obligation of the insolvent insurer under the policy from which the claim arises.

(e) Any obligation of the association to defend an insured on a covered claim shall cease:

(i) upon payment by the association, as part of a settlement releasing the insured; or

(ii) on a judgment, of the lesser of:

(A) the association's covered claim obligation limit; or

(B) the applicable policy limit.

(f) The association:

(i) is considered as the insurer only to the extent of its obligation on the covered claims, subject to the limitations provided in this part;

(ii) has all the rights, duties, and obligations of the insolvent insurer as if the insurer had not yet become insolvent, including the right to pursue and retain salvage and subrogation recoverable on paid covered claim obligations; and

(iii) may not be considered the insolvent insurer for any purpose relating to whether the association is subject to personal jurisdiction in the courts of any state.

(g) (i) Notwithstanding any other provisions of this part, except in the case of a claim for benefits under workers' compensation coverage, any obligation of the association to or on behalf of a particular insured and its affiliates on covered claims shall cease when:

(A) a total amount of $10,000,000 has been paid to or on behalf of the insured and its affiliates on covered claims by the association or a similar association; and

(B) all payments on covered claims arise under one or more policies of a single insolvent insurer.

(ii) The association may establish a plan to allocate the amounts payable by the association in a manner the association considers equitable if the association determines that:

(A) there is more than one claimant asserting a covered claim against:

(I) the association;

(II) a similar association; or

(III) a property or casualty insurance security fund in another state; and

(B) all claims arise under the policy or policies of a single insolvent insurer.

(h) The association shall [~~allocate claims paid and expenses incurred among the accounts established under Section 31A-28-205 separately, and~~] assess member insurers [~~separately for each account~~] amounts necessary to pay:

(i) the obligations of the association under Subsection (1)(a), as limited by Subsections (1)(e) through (g), subsequent to the liquidation of an insolvent insurer;

(ii) the expenses of handling covered claims subsequent to the liquidation of an insolvent insurer;

(iii) the cost of examinations under Section 31A-28-214; and

(iv) other expenses authorized by this part.

(i) (i) The association shall:

(A) investigate claims brought against the association; and

(B) adjust, compromise, settle, and pay covered claims to the extent of the association's obligation and deny all other claims.

(ii) The association is not bound by a settlement, release, compromise, waiver, or judgment executed or entered into by the insolvent insurer:

(A) less than 12 months before the entry of an order of liquidation; or

(B) more than 12 months before the entry of an order of liquidation if the settlement, release, compromise, waiver, or judgment is:

(I) based on a claim that is not a covered claim; or

(II) the result of fraud, collusion, default, or failure to defend.

(iii) The association may assert all defenses available including defenses applicable to determining and enforcing the association's statutory rights and obligations to a claim.

(iv) The association may appoint and direct legal counsel retained under a liability insurance policy for the defense of a covered claim.

(j) (i) The association shall handle claims through:

(A) its employees;

(B) one or more insurers; or

(C) other persons designated as servicing facilities.

(ii) Designation of a servicing facility is subject to the approval of the commissioner, but this designation may be declined by a member insurer.

(k) The association shall:

(i) reimburse each servicing facility for:

(A) obligations of the association paid by the facility; and

(B) expenses incurred by the facility while handling claims on behalf of the association;

and

(ii) pay the other expenses of the association as authorized by this title.

(2) The association may:

(a) employ or retain the persons, including private legal counsel, necessary to handle claims and perform other duties of the association;

(b) borrow funds necessary to implement the purposes of this part in accord with the plan of operation;

(c) sue or be sued;

(d) negotiate and become a party to the contracts necessary to carry out the purpose of this part;

(e) perform any other acts necessary or proper to accomplish the purposes of this chapter; or

(f) refund to the member insurers, in proportion to the contribution of each member insurer to [~~that~~] the association account, the amount that the assets of the account exceed the liabilities, if, at the end of any calendar year, the board of directors finds that:

(i) the assets of the association in [~~any~~] the association account exceed the liabilities [~~of that account~~] as estimated by the board of directors for the coming year; and

(ii) the excess assets are not needed for other purposes of this part.

(3) For a refund due to a member insurer for an assessment that has been offset against premium taxes, the association may pay the amount of the refund directly to the State Tax Commission.

(4) The courts of the state shall have exclusive jurisdiction over all actions brought against the association that relate to or arise out of this part.

(5) (a) Any person recovering under this part is considered to have assigned that person's rights under the policy to the association to the extent of that person's recovery from the association.

(b) Every insured or claimant seeking the protection of this chapter shall cooperate with the association to the same extent the person would have been required to cooperate with the insolvent insurer.

(c) Except as provided in Subsection (5)(e), the association has no cause of action against the insured of the insolvent insurer for any sums the association has paid out except those causes

of action the insolvent insurer would have had if the sums had been paid by the insolvent insurer.

(d) When an insolvent insurer operates on a plan with assessment liability, payments of claims of the association do not reduce the liability for unpaid assessments of the insurer to:

(i) the receiver;

(ii) liquidator; or

(iii) statutory successor.

(e) The association may recover from the following persons the amount of any "covered claim" paid on behalf of that person pursuant to this part:

(i) any insured whose:

(A) net worth on December 31 of the year next preceding the date the insurer becomes insolvent, exceeds $25,000,000; and

(B) liability obligations to other persons are satisfied in whole or in part by payments made under this part; and

(ii) any person:

(A) who is an affiliate of the insolvent insurer; and

(B) whose liability obligations to other persons are satisfied in whole or in part by payments made under this part.

(f) (i) The receiver, liquidator, or statutory successor of an insolvent insurer is bound by:

(A) a determination of a covered claim eligibility under this part; and

(B) a settlement of a covered claim by the association or a similar organization in another state.

(ii) The court having jurisdiction shall grant settled claims a priority equal to that which the claimant would have been entitled to in the absence of this part, against the assets of the insolvent insurer.

(g) The association or any similar organization in another state shall:

(i) be recognized as a claimant in the liquidation of an insolvent insurer for any amounts paid on a covered claim obligation as determined under this part or a similar law in another state; and

(ii) receive dividends or distributions at the priority set forth in Section 31A-27-335.

(h) (i) The association shall periodically file with the receiver or liquidator of the insolvent insurer:

(A) statements of the covered claims paid by the association; and

(B) estimates of anticipated claims on the association.

(ii) The filing under this Subsection (5)(h) preserves the rights of the association for claims against the assets of the insolvent insurer.

(i) The association need not pay any claim filed after the final date under Sections 31A-27-315 and 31A-27-328, or similar statutes of other states, for filing the same type of claim with the liquidator of the insolvent insurer.

Section 79. Section **31A-28-208** is amended to read:

31A-28-208. Assessments.

(1) (a) To provide the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers[~~, separately for each account established under Section 31A-28-205,~~] at the time and in the amount the board finds necessary.

(b) An assessment under this section:

(i) is due not less than 30 days after written notice to the member insurers; and

(ii) accrues interest to the extent unpaid after the due date at the greater of:

(A) 10% per annum; or

(B) the then legal rate of interest provided in Section 15-1-1.

[~~(c) The association shall allocate claims and incurred expenses among the accounts.~~]

(2) An assessment [~~for each account~~] is to be made in the amount necessary to carry out the powers and duties of the association under Section 31A-28-207 for an insolvent insurer.

(3) An assessment against a member insurer [~~for each account~~] is in the proportion that the net direct written premiums of the member insurer for the preceding calendar year on the kinds of insurance [~~in the account~~] for which this part applies bears to the net direct written premiums of all member insurers for the preceding calendar year on [~~all~~] the kinds of insurance [~~in the account~~] for which this part applies.

(4) A member insurer may not be assessed in any year [~~on any account~~] for an amount greater than 2% of that member insurer's net direct written premiums for the preceding calendar year on the kinds of insurance [~~in the account~~] for which this part applies.

(5) If the maximum assessment, together with the other assets of the association in [~~any~~] the association account, do not provide in any one year [~~in any account~~] an amount sufficient to make all necessary payments [~~from that account~~], the funds available shall be prorated and the

unpaid portion shall be paid as soon as funds become available.

(6) The association may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance.

(7) Each member insurer may set off against any assessment authorized payments made on covered claims and expenses incurred in the payment of the claims by the member insurer, if they are chargeable to the association account [~~for which the assessment is made~~].

Section 80. Section **31A-28-222** is amended to read:

31A-28-222. Application of amendments.

(1) The amendments in [~~this act~~] Chapter 363, Laws of Utah 2001, shall become effective on April 30, 2001 and apply to the association's obligations under policies of insolvent insurers as they exist on or after April [~~20~~] 30, 2001.

(2) Notwithstanding Subsection (1), the amendments to Subsections 31A-28-203(3) and 31A-28-207(1)(a) in Chapter 363, Laws of Utah 2001, that add coverage for unearned premium claims shall apply only to insurers that become insolvent after [~~the effective date~~] April 30, 2001.

Section 81. Section **31A-29-113** is amended to read:

31A-29-113. Benefits -- Additional types of pool insurance -- Preexisting conditions -- Waiver -- Maximum benefits.

(1) (a) The pool policy shall pay for eligible expenses rendered or furnished for the diagnoses or treatment of illness or injury [~~which~~] that:

(i) exceed the deductible and copayment amounts applicable under Section 31A-29-114; and [~~which~~]

(ii) are not otherwise limited or excluded.

(b) Eligible expenses are the charges for the health care services and items rendered during times for which benefits are extended under the pool policy.

(2) The coverage to be issued by the pool, its schedule of benefits, exclusions, and other limitations shall be established by the board.

(3) The commissioner shall approve the benefit package developed by the board to ensure its compliance with this chapter.

(4) The pool shall offer at least one benefit plan through a managed care program as

authorized under Section 31A-29-106.

(5) This chapter [~~shall~~] may not be construed to prohibit the pool from issuing additional types of health insurance policies with different types of benefits which in the opinion of the board may be of benefit to the citizens of Utah.

(6) The board shall design and require an administrator to employ cost containment measures and requirements including preadmission certification and concurrent inpatient review for the purpose of making the pool more cost effective. The provisions of Sections 31A-22-617 and 31A-22-618 of this title do not apply to coverage issued under this chapter.

(7) A pool policy may contain provisions under which coverage is excluded during a six-month period following the effective date of plan coverage as to a given individual for a preexisting condition, as long as either of the following exists:

(a) the condition has manifested itself within a period of six months before the effective date of coverage in such a manner as would cause an ordinary, prudent person to seek diagnosis or treatment; or

(b) medical advice or treatment was recommended or received for the condition within a period of six months before the effective date of coverage.

(8) A pool policy may exclude coverage for pregnancies for ten months following the effective date of coverage[~~.~~], unless the individual is eligible to receive credit for previous coverage under the Health Insurance Portability and Accountability Act, P. L. 104-91, 110 Stat. 1962.

(9) (a) [~~The~~] For individuals changing from individual health insurance, as defined in Subsection 31A-29-103(5), to the health insurance pool, the preexisting condition exclusion described in Subsection (7) shall be waived to the extent to which similar exclusions have been satisfied under any prior health insurance coverage:

(i) which was involuntarily terminated, other than for nonpayment of premium, if the application for pool coverage is made not later than [~~31~~] 63 days following the involuntary termination; or

(ii) whose premium rate exceeds the rate of the pool for equal or lesser benefits.

(b) If Subsection (9)(a) applies, coverage in the pool shall be effective from the date on which the prior coverage was terminated.

(10) (a) The pool may not apply any preexisting condition exclusion to an individual that

is changing group health coverage to the health insurance pool if:

(i) the individual applies not later than 63 days following the date of involuntary termination from group health coverage;

(ii) the individual has at least 18 months of creditable coverage as of the date the individual seeks coverage from:

(A) the health insurance pool; or

(B) an individual health plan;

(iii) the individual's most recent prior creditable coverage was under:

(A) a group health plan;

(B) government plan; or

(C) a church plan;

(iv) the individual is not eligible for coverage under:

(A) a group health plan;

(B) Part A or Part B of Title XVIII of the Social Security Act; or

(C) a state plan under Title XIX of the Social Security Act;

(v) the individual does not have other health insurance coverage;

(vi) the individual's most recent coverage was not terminated because of:

(A) nonpayment of premiums; or

(B) fraud;

(vii) the individual has been offered the option of continuing coverage under:

(A) a continuation provision; or

(B) a similar state extension program; and

(viii) the individual's premium rate exceeds the rate of the pool for equal or lesser coverage.

(b) If Subsection (10)(a) applies, coverage in the pool shall be effective from the date on which the prior coverage was terminated.

[~~(10)~~] (11) The board shall establish a policy allowing for the waiver of the preexisting condition exclusion set forth in Subsection (7) for coverage of medically necessary outpatient medical care.

[~~(11)~~] (12) Benefits available under the pool may not exceed $1,000,000 paid to or on behalf of any person.

Section 82. Section **31A-30-101** is amended to read:

CHAPTER 30. INDIVIDUAL, SMALL, AND GROUP EMPLOYER HEALTH INSURANCE ACT

31A-30-101. Title.

This chapter [~~shall be~~] is known as the "Individual [~~and~~], Small, and Group Employer Health Insurance Act."

Section 83. Section **31A-30-103** is amended to read:

31A-30-103. Definitions.

As used in this [~~part~~] chapter:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual approved by the commissioner that a covered carrier is in compliance with [~~the provisions of~~] Section 31A-30-106, based upon the examination of the covered carrier, including review of the appropriate records and of the actuarial assumptions and methods [~~utilized~~] used by the covered carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

(3) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the covered carrier to covered insureds with similar case characteristics for health benefit plans with the same or similar coverage.

(4) "Basic coverage" means the coverage provided in the Basic Health Care Plan established by the Health Benefit Plan Committee under Subsection 31A-22-613.5(6).

(5) "Carrier" means any person or entity that provides health insurance in this state including:

(a) an insurance company[~~,~~];

(b) a prepaid hospital or medical care plan[~~,~~];

(c) a health maintenance organization[~~,~~];

(d) a multiple employer welfare arrangement[~~,~~]; and

(e) any other person or entity providing a health insurance plan under this title.

(6) (a) Except as provided in Subsection (6)(b), "case characteristics" means demographic or other objective characteristics of a covered insured that are considered by the carrier in determining premium rates for the covered insured. [~~However,~~]

(b) "Case characteristics" does not include:

(i) duration of coverage since the policy was issued[~~,~~];

(ii) claim experience[~~,~~]; and

(iii) health status[~~, are not case characteristics for the purposes of this chapter~~].

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

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

(9) "Covered carrier" means any individual carrier or small employer carrier subject to this [~~act~~] chapter.

(10) "Covered individual" means any individual who is covered under a health benefit plan subject to this [~~act~~] chapter.

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

(12) "Dependent" means [~~individuals~~] an individual to the extent [~~they are~~] that the individual is defined to be a dependent by:

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

(b) [~~the provisions of~~] Chapter 22, Part VI, [~~Disability~~] Accident and Health Insurance.

[~~(13) (a) "Eligible employee" means:~~]

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

[~~(ii) an independent contractor if the independent contractor is included under a health benefit plan of a small employer.~~]

[~~(b) "Eligible employee" does not include:~~]

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

[~~(ii) the spouse or dependents of the employer.~~]

[~~(14)~~] (13) "Established geographic service area" means a geographical area approved by

the commissioner within which the carrier is authorized to provide coverage.

[~~(15) "Health benefit plan" means any certificate under a group health insurance policy, or any health insurance policy, except that health benefit plan does not include coverage only for:~~]

[~~(a) accident;~~]

[~~(b) dental;~~]

[~~(c) vision;~~]

[~~(d) Medicare supplement;~~]

[~~(e) long-term care; or~~]

[~~(f) the following when offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance:~~]

[~~(i) specified disease;~~]

[~~(ii) hospital confinement indemnity; or~~]

[~~(iii) limited benefit plan.~~]

[~~(16)~~] (14) "Index rate" means, for each class of business as to a rating period for covered insureds with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

[~~(17)~~] (15) "Individual carrier" means a carrier that [~~offers~~] provides coverage on an individual basis through a health benefit [~~plans covering insureds in this state under individual policies.~~] plan regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar groups; or

(b) the policy or contract is situated out-of-state.

[~~(18)~~] (16) "Individual conversion policy" means a conversion policy issued [~~by a health benefit plan as defined in Subsection (15)~~] to:

(a) an individual; or

(b) an individual with a family.

[~~(19)~~] (17) "Individual coverage count" means the number of natural persons covered under a carrier's health benefit [~~plans~~] products that are individual policies.

[~~(20)~~] (18) "Individual enrollment cap" means the percentage set by the commissioner in accordance with Section 31A-30-110.

[~~(21)~~] (19) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or that could have been charged or offered, by the carrier to covered insureds with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(20) "Preexisting condition" is as defined in Section 31A-1-301.

[~~(22)~~] (21) "Premium" means all monies paid by covered insureds and covered individuals as a condition of receiving coverage from a covered carrier, including any fees or other contributions associated with the health benefit plan.

[~~(23)~~] (22) (a) "Rating period" means the calendar period for which premium rates established by a covered carrier are assumed to be in effect, as determined by the carrier. [~~However, a~~]

(b) A covered carrier may not have:

(i) more than one rating period in any calendar month[~~.~~]; and

(ii) no more than 12 rating periods in any calendar year.

[~~(24)~~] (23) "Resident" means an individual who has resided in this state for at least 12 consecutive months immediately preceding the date of application.

[~~(25) "Small employer" means any person, firm, corporation, partnership, or association actively engaged in business that, on at least 50% of its working days during the preceding calendar quarter, employed at least two and no more than 50 eligible employees, the majority of whom were employed within this state. In determining the number of eligible employees, companies that are affiliated or that are eligible to file a combined tax return for purposes of state taxation are considered one employer.~~]

(24) "Short-term limited duration insurance" means a health benefit product that:

(a) is not renewable; and

(b) has an expiration date specified in the contract that is less than 364 days after the date the plan became effective.

[~~(26)~~] (25) "Small employer carrier" means a carrier that [~~offers~~] provides health benefit plans covering eligible employees of one or more small employers in this state[~~.~~], regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) trust;

(iii) discretionary group; or

(iv) other similar grouping; or

(b) the policy or contract is situated out-of-state.

[~~(27)~~] (26) "Uninsurable" means an individual who:

(a) is eligible for the Comprehensive Health Insurance Pool coverage under the underwriting criteria established in Subsection 31A-29-111(4); or

(b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and

(ii) has a condition of health that does not meet consistently applied underwriting criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)[~~(k)~~](i) and [~~(l)~~] (j) for which coverage the applicant is applying.

[~~(28)~~] (27) "Uninsurable percentage" for a given calendar year equals UC/CI where, for purposes of this formula:

(a) "UC" means the number of uninsurable individuals who were issued an individual policy on or after July 1, 1997; and

(b) "CI" means the carrier's individual coverage count as of December 31 of the preceding year.

Section 84. Section **31A-30-104** is amended to read:

31A-30-104. Applicability and scope.

(1) This chapter applies to any:

(a) health benefit plan that provides coverage to:

(i) individuals;

(ii) small [~~employer groups~~] employers; or

(iii) both Subsections (1)(a)(i) and (ii); or

(b) individual conversion policy for purposes of Sections 31A-30-106.5 and [~~31A-30-107~~] 31A-30-107.5.

(2) This chapter applies to a health benefit plan that provides coverage to small employers or individuals regardless of:

(a) whether the contract is issued to:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar grouping; or

(b) the situs of delivery of the policy or contract.

(3) This chapter does not apply to:

(a) a large employer health benefit plan; or

(b) short-term limited duration health insurance.

[~~(2)~~] (4) (a) Except as provided in Subsection [~~(2)~~] (4)(b), for the purposes of this chapter[~~,~~]:

(i) carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier; and

(ii) any restrictions or limitations imposed by this chapter shall apply as if all health benefit plans delivered or issued for delivery to covered insureds in this state by the affiliated carriers were issued by one carrier.

(b) [~~An~~] Upon a finding of the commissioner, an affiliated carrier that is a health maintenance organization having a certificate of authority under this title may be considered to be a separate carrier for the purposes of this chapter.

(c) Unless otherwise authorized by the commissioner, a covered carrier may not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to covered insureds in this state if [~~such~~] the ceding arrangements would result in less than 50% of the insurance obligation or risk for [~~such~~] the health benefit plans being retained by the ceding carrier.

(d) [~~The provisions of~~] Section 31A-22-1201 [~~apply~~] applies if a covered carrier cedes or assumes all of the insurance obligation or risk with respect to one or more health benefit plans delivered or issued for delivery to covered insureds in this state.

[~~(3)~~] (5) (a) A Taft Hartley trust created in accordance with Section 302(c)(5) of the Federal Labor Management Relations Act, or a carrier with the written authorization of such a trust, may make a written request to the commissioner for a waiver from the application of any of the provisions of Subsection 31A-30-106(1) with respect to a health benefit plan provided to the trust.

(b) The commissioner may grant [~~such~~] a trust or carrier described in Subsection (5)(a) a waiver if the commissioner finds that application with respect to the trust would:

(i) have a substantial adverse effect on the participants and beneficiaries of the trust; and

(ii) require significant modifications to one or more collective bargaining arrangements under which the trust is established or maintained.

(c) A waiver granted under this Subsection [~~(3)~~] (5) may not apply to an individual if the person participates in [~~such~~] a Taft Hartley trust as an associate member of any employee organization.

[~~(4) A carrier who offers individual and small employer health benefit plans may use the small employer index rates to establish the rate limitations for individual policies, even if some individual policies are rated below the small employer base rate.~~]

[~~(5)~~] (6) Sections 31A-30-106, 31A-30-106.5, 31A-30-106.7, 31A-30-107, 31A-30-108, and 31A-30-111 apply to:

(a) any insurer engaging in the business of insurance related to the risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of [~~its~~] the small employer's employees provided as an employee benefit; and

(b) any contract of an insurer, other than a workers' compensation policy, related to the risk of a small employer for medical, surgical, hospital, or ancillary health care expenses of [~~its~~] the small employer's employees provided as an employee benefit.

[~~(6)~~] (7) The commissioner may make rules requiring that the marketing practices be consistent with this chapter for:

(a) [~~an insurer and its~~] a small employer carrier;

(b) a small employer carrier's agent;

[~~(b)~~] (c) an insurance broker; and

[~~(c)~~] (d) an insurance consultant.

Section 85. Section **31A-30-106** is amended to read:

31A-30-106. Premiums -- Rating restrictions -- Disclosure.

(1) Premium rates for health benefit plans under this chapter are subject to the [~~following~~] provisions[~~:~~] of this Subsection (1).

(a) The index rate for a rating period for any class of business [~~shall~~] may not exceed the index rate for any other class of business by more than 20%.

(b) (i) For a class of business, the premium rates charged during a rating period to covered insureds with similar case characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system for that class of business, may not vary from the index rate by more than 30% of the index rate, except as provided in Section 31A-22-625.

(ii) A covered carrier that offers individual and small employer health benefit plans may use the small employer index rates to establish the rate limitations for individual policies, even if some individual policies are rated below the small employer base rate.

(c) The percentage increase in the premium rate charged to a covered insured for a new rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period[~~. In the case of a health benefit plan into which the covered carrier is no longer enrolling new covered insureds, the covered carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the covered carrier is actively enrolling new covered insureds~~];

(ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the covered individuals as determined from the covered carrier's rate manual for the class of business, except as provided in Section 31A-22-625; and

(iii) any adjustment due to change in coverage or change in the case characteristics of the covered insured as determined from the covered carrier's rate manual for the class of business.

(d) (i) Adjustments in rates for claims experience, health status, and duration from issue may not be charged to individual employees or dependents.

(ii) Any [~~such~~] adjustment described in Subsection (1)(d)(i) shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

(e) A covered carrier may [~~utilize~~] use industry as a case characteristic in establishing premium rates, provided that the highest rate factor associated with any industry classification does not exceed the lowest rate factor associated with any industry classification by more than 15%.

[~~(f) In the case of health benefit plans issued prior to July 1, 1994, a premium rate for a rating period, adjusted pro rata for rating period of less than a year, may exceed the ranges under~~

~~Subsections (1)(a) and (b) until July 1, 1996. In that case, the percentage increase in the premium rate charged to a covered insured for a new rating period may not exceed the sum of the following:~~]

[~~(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case where a covered carrier is not issuing any new policies the covered carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the covered carrier is actively enrolling new covered insureds; and~~]

[~~(ii) any adjustment due to change in coverage or change in the case characteristics of the covered insured as determined from the carrier's rate manual for the class of business.~~]

[~~(g) The commissioner may grant a one-year extension of the July 1, 1996, deadline specified in Subsection (1)(f) if the commissioner determines that an extension is needed to avoid significant disruption of the health insurance market subject to this chapter or to insure the financial stability of carriers in the market.~~]

[~~(h)~~] (f) (i) Covered carriers shall apply rating factors, including case characteristics, consistently with respect to all covered insureds in a class of business.

(ii) Rating factors shall produce premiums for identical groups [~~which~~] that:

(A) differ only by the amounts attributable to plan design; and

(B) do not reflect differences due to the nature of the groups assumed to select particular health benefit [~~plans~~] products.

[~~(ii)~~] (iii) A covered carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

[~~(i)~~] (g) For the purposes of this Subsection (1), a health benefit plan that [~~utilizes~~] uses a restricted network provision [~~shall~~] may not be considered similar coverage to a health benefit plan that does not [~~utilize~~] use such a network, provided that [~~utilization~~] use of the restricted network provision results in substantial difference in claims costs.

[~~(j)~~] (h) The covered carrier [~~shall~~] may not, without prior approval of the commissioner, use case characteristics other than:

(i) age[~~,~~];

(ii) gender[~~,~~];

(iii) industry[~~,~~];

(iv) geographic area[~~,~~];

(v) family composition[~~,~~]; and

(vi) group size.

[~~(k)~~] (i) (i) The commissioner may establish [~~regulations~~] rules in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, to:

(A) implement [~~the provisions of~~] this chapter; and

(B) to assure that rating practices used by covered carriers are consistent with the purposes of this chapter[~~, including regulations~~].

(ii) The rules described in Subsection (1)(i)(i) may include rules that:

[~~(i)~~] (A) assure that differences in rates charged for health benefit [~~plans~~] products by covered carriers are reasonable and reflect objective differences in plan design, [~~(~~]not including differences due to the nature of the groups assumed to select particular health benefit [~~plans)~~] products;

[~~(ii)~~] (B) prescribe the manner in which case characteristics may be used by covered carriers;

[~~(iii) require insurers, as a condition of transacting business with regard to health care insurance policies after January 1, 1995, to reissue a health care insurance policy to any policyholder whose health care insurance policy has, after January 1, 1994, been terminated by the insurer for reasons other than those listed in Subsections 31A-30-107(1)(a) through (1)(e) or not renewed by the insurer after January 1, 1994. The commissioner may prescribe terms for the reissue of coverage that the commissioner determines are reasonable and necessary to provide continuity of coverage to insured individuals;~~]

[~~(iv)~~] (C) implement the individual enrollment cap under Section 31A-30-110, including specifying:

(I) the contents for certification[~~,~~];

(II) auditing standards[~~,~~];

(III) underwriting criteria for uninsurable classification[~~,~~]; and

(IV) limitations on high risk enrollees under Section 31A-30-111; and

[~~(v)~~] (D) establish the individual enrollment cap under Subsection 31A-30-110(1).

[~~(l)~~] (j) Before implementing regulations for underwriting criteria for uninsurable

classification, the commissioner shall contract with an independent consulting organization to develop industry-wide underwriting criteria for uninsurability based on an individual's expected claims under open enrollment coverage exceeding 200% of that expected for a standard insurable individual with the same case characteristics.

[~~(m)~~] (k) The commissioner shall revise rules issued for Sections 31A-22-602 and 31A-22-605 regarding individual accident and health policy rates to allow rating in accordance with this section.

(2) For purposes of Subsection (1)(c)(i), if a health benefit product into which the covered carrier is no longer enrolling new covered insureds, the covered carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit product into which the covered carrier is actively enrolling new covered insureds.

[~~(2)~~] (3) (a) A covered carrier [~~shall~~] may not transfer a covered insured involuntarily into or out of a class of business.

(b) A covered carrier [~~shall~~] may not offer to transfer a covered insured into or out of a class of business unless [~~such~~] the offer is made to transfer all covered insureds in the class of business without regard:

(i) to case characteristics[~~,~~];

(ii) claim experience[~~,~~];

(iii) health status[~~,~~]; or

(iv) duration of coverage since issue.

[~~(3) Upon offering for sale any health benefit plan to a small employer, or individual, the covered carrier shall, as part of its solicitation and sales materials, disclose or make available all of the following:~~]

[~~(a) the extent to which premium rates for a specified covered insured are established or adjusted in part based on the actual or expected variation in claims costs or actual or expected variation in health status of covered individuals;~~]

[~~(b) provisions concerning the covered carrier's right to change premium rates and the factors other than claim experience which affect changes in premium rates;~~]

[~~(c) provisions relating to renewability of policies and contracts; and~~]

[~~(d) provisions relating to any preexisting condition provision.~~]

(4) (a) Each covered carrier shall maintain at [~~its~~] the covered carrier's principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that [~~its~~] the covered carrier's rating methods and practices are:

(i) based upon commonly accepted actuarial assumptions; and [~~are~~]

(ii) in accordance with sound actuarial principles.

(b) (i) Each covered carrier shall file with the commissioner, on or before March 15 of each year, in a form, manner, and containing such information as prescribed by the commissioner, an actuarial certification certifying that:

(A) the covered carrier is in compliance with this chapter; and [~~that~~]

(B) the rating methods of the covered carrier are actuarially sound.

(ii) A copy of [~~that~~] the certification required by Subsection (4)(b)(i) shall be retained by the covered carrier at [~~its~~] the covered carrier's principal place of business.

(c) A covered carrier shall make the information and documentation described in this Subsection (4) available to the commissioner upon request.

(d) Records submitted to the commissioner under [~~the provisions of~~] this section shall be maintained by the commissioner as protected records under Title 63, Chapter 2, Government Records Access and Management Act.

Section 86. Section **31A-30-106.7** is amended to read:

31A-30-106.7. Surcharge for groups changing carriers.

[~~If~~] (1) (a) Except as provided in Subsection (1)(b), if prior notice is given, a covered carrier may impose upon a small group that changes coverage to that carrier from another carrier a one-time surcharge of up to 25% of the annualized premium that the carrier could otherwise charge under Section 31A-30-106[~~, unless the change in carriers occurs on the annual policy renewal date of the coverage being replaced~~].

(b) A covered carrier may not impose the surcharge described in Subsection (1)(a) if:

(i) the change in carriers occurs on the anniversary of the plan year, as defined in Section 31A-1-301;

(ii) the previous coverage was terminated under Subsection 31A-30-107(3)(e); or

(iii) employees from an existing group form a new business.

(2) A covered carrier may not impose the surcharge described in Subsection (1) if the offer

to cover the group occurs at a time other than the anniversary of the plan year because:

(a) (i) the application for coverage is made prior to the anniversary date in accordance with the covered carrier's published policies; and

(ii) the offer to cover the group is not issued until after the anniversary date; or

(b) (i) the application for coverage is made prior to the anniversary date in accordance with the covered carrier's published policies; and

(ii) additional underwriting or rating information requested by the covered carrier is not received until after the anniversary date.

(3) If a covered carrier chooses to apply a surcharge under Subsection (1), the application of the surcharge and the criteria for incurring or avoiding the surcharge shall be clearly stated in the:

(a) written application materials provided to the applicant at the time of application; and

(b) written producer guidelines.

(4) The commissioner shall adopt rules in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, to ensure compliance with this section.

Section 87. Section **31A-30-107** is amended to read:

31A-30-107. Renewal -- Limitations -- Exclusions.

(1) [~~A~~] Except as otherwise provided in this section, a small employer health benefit plan [~~subject to this chapter~~] is renewable and continues in force:

(a) with respect to all [~~covered individuals~~] eligible employees and dependents; and

(b) at the option of the [~~covered insured except in any of the following cases:~~] plan sponsor.

[~~(a) nonpayment of the required premiums;~~]

[~~(b) fraud or misrepresentation of:~~]

[~~(i) the employer; or~~]

[~~(ii) with respect to coverage of individual insureds, the insureds or their representatives;~~]

[~~(c) noncompliance with the covered carrier's minimum participation requirements;~~]

[~~(d) noncompliance with the covered carrier's employer contribution requirements;~~]

[~~(e) repeated misuse of a provider network provision; or~~]

[~~(f) an election by the covered carrier to nonrenew all of its health benefit plans issued to covered insureds in this state, in which case the covered carrier shall:~~]

[~~(i) provide advanced notice of its decision under this Subsection (1) to the commissioner in each state in which it is licensed;~~]

[~~(ii) provide notice of the decision not to renew coverage to all affected covered insureds and to the commissioner in each state in which an affected insured individual is known to reside; and~~]

[~~(iii) provide a plan of orderly withdrawal as required by Section 31A-4-115.~~]

[~~(2) Notice under Subsection (1) shall be provided:~~]

[~~(a) to affected covered insureds at least 180 days prior to nonrenewal of any health benefit plans by the covered carrier; and~~]

[~~(b) to the commissioner at least three working days prior to the notice to the affected covered insureds.~~]

[~~(3) A covered carrier that elects not to renew a health benefit plan under Subsection (1)(f) is prohibited from writing new business subject to this chapter in this state for a period of five years from the date of notice to the commissioner.~~]

[~~(4) When a covered carrier is doing business subject to this chapter in one service area of this state, Subsections (1) through (3) apply only to the covered carrier's operations in that service area.~~]

[~~(5) Health benefit plans covering covered insureds shall comply with Subsections (5)(a) and (b).~~]

[~~(a) (i) A health benefit plan may not deny, exclude, or limit benefits for a covered individual for losses incurred more than 12 months, or 18 months in the case of a late enrollee, as defined in P.L. 104-191, 110 Stat. 1940, Sec. 101, following the effective date of the individual's coverage due to a preexisting condition.~~]

[~~(ii) A health benefit plan may not define a preexisting condition more restrictively than:~~]

[~~(A) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the earlier of:~~]

[~~(I) the enrollment date; or~~]

[~~(II) the effective date of coverage; or~~]

[~~(B) for an individual insurance policy, a pregnancy existing on the effective date of coverage.~~]

[~~(iii) An individual insurer shall offer a health benefit plan in compliance with Subsections~~

~~(5)(a)(i) and (ii), and may, when the insurer and the insured mutually agree in writing to a condition-specific exclusion rider, offer to issue an individual policy that excludes a specific physical condition consistent with Subsections (5)(a)(iv) and (v).~~]

[~~(iv) The commissioner shall establish, in rule, a list of nonlife threatening physical conditions that may be the subject of a condition-specific exclusion rider.~~]

[~~(v) A condition-specific exclusion rider shall be limited to the excluded condition and may not extend to any secondary medical condition that may or may not be directly related to the excluded condition.~~]

[~~(b) (i) A covered carrier shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in a health benefit plan for the period of time the individual was previously covered by public or private health insurance or by any other health benefit arrangement that provided benefits with respect to such services, provided that:~~]

[~~(A) the previous coverage was continuous to a date not more than 63 full days prior to the effective date of the new coverage; and~~]

[~~(B) the insured provides notification of previous coverage to the covered carrier within 36 months of the coverage effective date if the insurer has previously requested such notification.~~]

[~~(ii) The period of continuous coverage under Subsection (5)(b)(i)(A) may not include any waiting period for the effective date of the new coverage applied by the employer or the carrier. This Subsection (5)(b)(ii) does not preclude application of any waiting period applicable to all new enrollees under the plan.~~]

[~~(iii) Credit for previous coverage as provided under Subsection (5)(b)(i)(A) need not be given for any condition which was previously excluded under a condition-specific exclusion rider. A new preexisting waiting period may be applied to any condition that was excluded by a rider under the terms of previous individual coverage.~~]

(2) A small employer health benefit plan may be discontinued or nonrenewed:

(a) for a network plan, if:

(i) there is no longer any enrollee under the group health plan who lives, resides, or works in:

(A) the service area of the covered carrier; or

(B) the area for which the covered carrier is authorized to do business; and

(ii) in the case of the small employer market, the small employer carrier applies the same criteria the small employer carrier would apply in denying enrollment in the plan under Subsection 31A-30-108(6); or

(b) for coverage made available in the small or large employer market only through an association, if:

(i) the employer's membership in the association ceases; and

(ii) the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

(3) A small employer health benefit plan may be discontinued if:

(a) a condition described in Subsection (2) exists;

(b) the plan sponsor fails to pay premiums or contributions in accordance with the terms of the contract;

(c) the plan sponsor:

(i) performs an act or practice that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact under the terms of the coverage;

(d) the covered carrier:

(i) elects to discontinue offering a particular small employer health benefit product delivered or issued for delivery in this state; and

(ii) (A) provides notice of the discontinuation in writing:

(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

(II) at least 90 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner; and

(II) at least three working days prior to the date the notice is sent to the affected plan sponsors, employees, and dependents of the plan sponsors or employees;

(C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all other small employer health benefit products currently being offered by the small employer carrier in the market; and

(D) in exercising the option to discontinue that product and in offering the option of coverage in this section, acts uniformly without regard to:

(I) the claims experience of a plan sponsor;

(II) any health status-related factor relating to any covered participant or beneficiary; or

(III) any health status-related factor relating to any new participant or beneficiary who may become eligible for the coverage; or

(e) the covered carrier:

(i) elects to discontinue all of the covered carrier's small employer health benefit plans in:

(A) the small employer market;

(B) the large employer market; or

(C) both the small employer and large employer markets; and

(ii) (A) provides notice of the discontinuation in writing:

(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

(II) at least 180 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner in each state in which an affected insured individual is known to reside; and

(II) at least 30 working days prior to the date the notice is sent to the affected plan sponsors, employees, and the dependents of the plan sponsors or employees;

(C) discontinues and nonrenews all plans issued or delivered for issuance in the market; and

(D) provides a plan of orderly withdrawal as required by Section 31A-4-115.

(4) A small employer health benefit plan may be nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) for noncompliance with the covered carrier's:

(i) minimum participation requirements; or

(ii) employer contribution requirements.

(5) (a) Except as provided in Subsection (5)(d), an eligible employee may be discontinued if after issuance of coverage the eligible employee:

(i) engages in an act or practice that constitutes fraud in connection with the coverage; or

(ii) makes an intentional misrepresentation of material fact in connection with the coverage.

(b) An eligible employee that is discontinued under Subsection (5)(a) may reenroll:

(i) 12 months after the date of discontinuance; and

(ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies to reenroll.

(c) At the time the eligible employee's coverage is discontinued under Subsection (5)(a), the covered carrier shall notify the eligible employee of the right to reenroll when coverage is discontinued.

(d) An eligible employee may not be discontinued under this Subsection (5) because of a fraud or misrepresentation that relates to health status.

(6) For purposes of this section, a reference to "plan sponsor" includes a reference to the employer:

(a) with respect to coverage provided to an employer member of the association; and

(b) if the small employer health benefit plan is made available by a covered carrier in the employer market only through:

(i) an association;

(ii) a trust; or

(iii) a discretionary group.

(7) A covered carrier may modify a small employer health benefit plan only:

(a) at the time of coverage renewal; and

(b) if the modification is effective uniformly among all plans with that product.

Section 88. Section **31A-30-107.1** is enacted to read:

31A-30-107.1. Individual discontinuance and nonrenewal.

(1) (a) Except as otherwise provided in this section, a health benefit plan offered on an individual basis is renewable and continues in force:

(i) with respect to all individuals or dependents; and

(ii) at the option of the individual.

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

(i) whether the contract is issued through:

(A) a trust;

(B) an association;

(C) a discretionary group; or

(D) other similar grouping; or

(ii) the situs of delivery of the policy or contract.

(2) A health benefit plan may be discontinued or nonrenewed:

(a) for a network plan, if:

(i) the individual no longer lives, resides, or works in:

(A) the service area of the covered carrier; or

(B) the area for which the covered carrier is authorized to do business; and

(ii) coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual; or

(b) for coverage made available through an association, if:

(i) the individual's membership in the association ceases; and

(ii) the coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

(3) A health benefit plan may be discontinued if:

(a) a condition described in Subsection (2) exists;

(b) the individual fails to pay premiums or contributions in accordance with the terms of the health benefit plan, including any timeliness requirements;

(c) the individual:

(i) performs an act or practice that constitutes fraud in connection with the coverage; or

(ii) makes an intentional misrepresentation of material fact under the terms of the coverage;

(d) the covered carrier:

(i) elects to discontinue offering a particular health benefit product delivered or issued for delivery in this state; and

(ii) (A) provides notice of the discontinuance in writing:

(I) to each individual provided coverage; and

(II) at least 90 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner; and

(II) at least three working days prior to the date the notice is sent to the affected individuals;

(C) offers to each covered individual on a guaranteed issue basis, the option to purchase

all other individual health benefit products currently being offered by the covered carrier for individuals in that market; and

(D) acts uniformly without regard to any health status-related factor of a covered individual or dependent of a covered individual who may become eligible for coverage; or

(e) the covered carrier:

(i) elects to discontinue all of the covered carrier's health benefit plans in the individual market; and

(ii) (A) provides notice of the discontinuation in writing:

(I) to each covered individual; and

(II) at least 180 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner in each state in which an affected insured individual is known to reside; and

(II) at least 30 working days prior to the date the notice is sent to the affected individuals;

(C) discontinues and nonrenews all health benefit plans the covered carrier issues or delivers for insurance in the individual market; and

(D) acts uniformly without regard to any health status-related factor of a covered individual or a dependent of a covered individual who may become eligible for coverage.

Section 89. Section **31A-30-107.3** is enacted to read:

31A-30-107.3. Discontinuance and nonrenewal limitations.

(1) (a) A carrier that elects to discontinue offering a health benefit plan under Subsection 31A-30-107(3)(e) or 31A-30-107.1(3)(e) is prohibited from writing new business:

(i) in the small employer and individual market in this state; and

(ii) for a period of five years beginning on the date of discontinuation of the last coverage that is discontinued.

(b) The prohibition described in Subsection (1)(a) may be waived if the commissioner finds that waiver is in the public interest:

(i) to promote competition; or

(ii) to resolve inequity in the marketplace.

(2) If a carrier is doing business in one established geographic service area of the state, Sections 31A-30-107 and 31A-30-107.1 apply only to the carrier's operations in that geographic

service area.

(3) If a small employer employs less than two employees, a carrier may not discontinue or not renew the health benefit plan until the first renewal date following the beginning of a new plan year, even if the carrier knows as of the beginning of the plan year that the employer no longer has at least two current employees.

Section 90. Section **31A-30-107.5** is enacted to read:

31A-30-107.5. Limitations and exclusions.

(1) A health benefit plan may impose a preexisting condition exclusion only if:

(a) the exclusion relates to a condition, regardless of the cause of the condition, for which medical advise, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date;

(b) the exclusion extends for a period of:

(i) not more than 12 months after the enrollment date; or

(ii) in the case of a late enrollee, 18 months after the enrollment date; and

(c) the period of the preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date.

(2) (a) The period of continuous coverage under Subsection (1)(c) may not include any waiting period for the effective date of the new coverage applied by the employer or the carrier.

(b) This Subsection (2) does not preclude application of any waiting period applicable to all new enrollees under the plan.

(3) (a) Credit for previous coverage as provided under Subsection (1)(c) need not be given for any condition that was previously excluded under a condition-specific exclusion rider issued pursuant to Subsection (5).

(b) A new preexisting waiting period may be applied to any condition that was excluded by a rider under the terms of previous individual coverage.

(4) (a) For purposes of Subsection (1)(c), a period of creditable coverage may not be counted with respect to enrollment of an individual under a health benefit plan, if:

(i) after the period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage; or

(ii) the insured fails to provide notification of previous coverage to the covered carrier within 36 months of the coverage effective date if the covered carrier has previously requested the

notification.

(b) (i) Credit for previous coverage as provided under Subsection (1)(c) need not be given for any condition that was previously excluded in compliance with Subsection (5).

(ii) A new preexisting waiting period may be applied to any condition that was excluded under the terms of previous individual coverage.

(5) (a) An individual carrier:

(i) shall offer a health benefit plan in compliance with Subsection (1); and

(ii) may, when the individual carrier and the insured mutually agree in writing to a condition-specific exclusion rider, offer to issue an individual policy that excludes a specific physical condition consistent with Subsection (5)(b).

(b) (i) The commissioner shall establish by rule a list of life threatening physical conditions that may not be the subject of a condition-specific exclusion rider.

(ii) A condition-specific exclusion rider:

(A) shall be limited to the excluded condition; and

(B) may not extend to any secondary medical condition that may or may not be directly related to the excluded condition.

Section 91. Section **31A-30-108** is amended to read:

31A-30-108. Eligibility for small employer and individual market.

(1) (a) Small employer carriers shall accept residents for small group coverage as set forth in the Health Insurance Portability and Accountability Act, P.L. 104-191, 110 Stat. 1962, Sec. 1701(f) and 2711(a).

(b) Individual carriers shall accept residents for individual coverage pursuant:

(i) to P.L. 104-191, 110 Stat. 1979, Sec. 2741(a)-(b); and

(ii) Subsection (3).

(2) (a) Small employer carriers shall offer to accept all eligible employees and their dependents at the same level of benefits under any health benefit plan provided to a small employer.

(b) Small employer carriers may:

(i) request a small employer to submit a copy of [~~its~~] the small employer's quarterly income tax withholdings to determine whether the employees for whom coverage is provided or requested are bona fide employees of the small employer; and

(ii) deny or terminate coverage if the small employer refuses to provide documentation requested under Subsection (2)(b)(i).

(3) Except as provided in Subsection (5) and Section 31A-30-110, individual carriers shall accept for coverage individuals to whom all of the following conditions apply:

(a) the individual is not covered or eligible for coverage[~~,~~]:

(i) (A) as an employee of an employer[~~,~~];

(B) as a member of an association[~~,~~]; or

(C) as a member of any other group; and

(ii) under:

[~~(i)~~] (A) a health benefit plan; or

[~~(ii)~~] (B) a self-insured arrangement that provides coverage similar to that provided by a health benefit plan as defined in Section [~~31A-30-103~~] 31A-1-301;

(b) the individual is not covered and is not eligible for coverage under any public health benefits arrangement including:

(i) the Medicare program established under Title XVIII [~~or~~];

(ii) the Medicaid program established under Title XIX of the Social Security Act[~~, or~~];

(iii) any [~~other~~] act of Congress or law of this or any other state that provides benefits comparable to the benefits provided under this [~~part, including~~] chapter; or

(iv) coverage under the Comprehensive Health Insurance Pool Act created in Chapter 29, Comprehensive Health Insurance Pool Act;

(c) unless the maximum benefit has been reached the individual is not covered or eligible for coverage under any:

(i) Medicare supplement policy[~~,~~];

(ii) conversion option[~~,~~];

(iii) continuation or extension under COBRA[~~,~~]; or

(iv) state extension [~~unless the maximum benefit has been reached~~];

(d) the individual has not terminated or declined coverage described in Subsection (3)(a), (b), or (c) within 93 days of application for coverage, unless the individual is eligible for individual coverage under P.L. 104-191, 110 Stat. 1979, Sec. 2741(b), in which case, the requirement of this Subsection (3)(d) does not apply; and

(e) the individual is certified as ineligible for the Health Insurance Pool if:

(i) the individual applies for coverage with the Comprehensive Health Insurance Pool within 30 days after being rejected or refused coverage by the covered carrier and reapplies for coverage with that covered carrier within 30 days after the date of issuance of a certificate under Subsection 31A-29-111(4)(c); or

(ii) the individual applies for coverage with any individual carrier within 45 days after:

(A) notice of cancellation of coverage under Subsection 31A-29-115(1); or

(B) the date of issuance of a certificate under Subsection 31A-29-111(4)(c) if the individual applied first for coverage with the Comprehensive Health Insurance Pool.

(4) (a) If coverage is obtained under Subsection (3)(e)(i) and the required premium is paid, the effective date of coverage shall be the first day of the month following the individual's submission of a completed insurance application to that covered carrier.

(b) If coverage is obtained under Subsection (3)(e)(ii) and the required premium is paid, the effective date of coverage shall be the day following the:

(i) cancellation of coverage under Subsection 31A-29-115(1); or

(ii) submission of a completed insurance application to the Comprehensive Health Insurance Pool.

(5) (a) An individual carrier is not required to accept individuals for coverage under Subsection (3) if the carrier issues no new individual policies in the state after July 1, 1997.

(b) A carrier described in Subsection (5)(a) may not issue new individual policies in the state for five years from July 1, 1997.

(c) Notwithstanding Subsection (5)(b), a carrier may request permission to issue new policies after July 1, 1999, which may only be granted if:

(i) the carrier accepts uninsurables as is required of a carrier entering the market under Subsection 31A-30-110; and

(ii) the commissioner finds that the carrier's issuance of new individual policies:

(A) is in the best interests of the state; and

(B) does not provide an unfair advantage to the carrier.

(6) (a) If a small employer carrier offers health benefit plans to small employers through a network plan, the small employer carrier may:

(i) limit the employers that may apply for the coverage to those employers with eligible employees who live, reside, or work in the service area for the network plan; and

(ii) within the service area of the network plan, deny coverage to an employer if the small employer carrier has demonstrated to the commissioner that the small employer carrier:

(A) will not have the capacity to deliver services adequately to enrollees of any additional groups because of the small employer carrier's obligations to existing group contract holders and enrollees; and

(B) applies this section uniformly to all employers without regard to:

(I) the claims experience of an employer, an employer's employee, or a dependent of an employee; or

(II) any health status-related factor relating to an employee or dependent of an employee.

(b) (i) A small employer carrier that denies a health benefit product to an employer in any service area in accordance with this section may not offer coverage in the small employer market within the service area to any employer for a period of 180 days after the date the coverage is denied.

(ii) This Subsection (6)(b) does not:

(A) limit the small employer carrier's ability to renew coverage that is in force; or

(B) relieve the small employer carrier of the responsibility to renew coverage that is in force.

(c) Coverage offered within a service area after the 180-day period specified in Subsection (6)(b) is subject to the requirements of this section.

Section 92. Section **31A-30-110** is amended to read:

31A-30-110. Individual enrollment cap.

(1) The commissioner shall set the individual enrollment cap at .5% on July 1, 1997.

(2) The commissioner shall raise the individual enrollment cap by .5% at the later of the following dates:

(a) six months from the last increase in the individual enrollment cap; or

(b) the date when CCI/TI is greater than .90, where:

(i) "CCI" is the total individual coverage count for all carriers certifying that their uninsurable percentage has reached the individual enrollment cap; and

(ii) "TI" is the total individual coverage count for all carriers.

(3) The commissioner may establish a minimum number of uninsurable individuals that a carrier entering the market who is subject to this chapter must accept under the individual

enrollment provisions of this chapter.

(4) Beginning July 1, 1997, an individual carrier may decline to accept individuals applying for individual enrollment under Subsection 31A-30-108(3), other than individuals applying for coverage as set forth in P.L. 104-191, 110 Stat. 1979, Sec. 2741 (a)-(b), if:

(a) the uninsurable percentage for that carrier equals or exceeds the cap established in Subsection (1); and

(b) the covered carrier has certified on forms provided by the commissioner that its uninsurable percentage equals or exceeds the individual enrollment cap.

(5) The department may audit a carrier's records to verify whether the carrier's uninsurable classification meets industry standards for underwriting criteria as established by the commissioner in accordance with Subsection 31A-30-106(1)[~~(k)~~](i).

(6) (a) If the commissioner determines that individual enrollment is causing a substantial adverse effect on premiums, enrollment, or experience, the commissioner may suspend, limit, or delay further individual enrollment for up to 12 months.

(b) The commissioner shall adopt rules to establish a uniform methodology for calculating and reporting loss ratios for individual policies for determining whether the individual enrollment provisions of Section 31A-30-108 should be waived for an individual carrier experiencing significant and adverse financial impact as a result of complying with those provisions.

Section 93. Section **31A-30-111** is amended to read:

31A-30-111. Limitations on high risk enrollees.

(1) (a) The requirements of this chapter do not apply to any carrier that is currently in a state of supervision, insolvency, or liquidation.

(b) If a carrier demonstrates to the satisfaction of the commissioner that the requirements of this chapter would place the carrier in a state of supervision, insolvency, or liquidation the commissioner may waive or modify the requirements of Sections 31A-30-108 and 31A-30-110.

(2) (a) A modification or waiver by the commissioner under [~~this section~~] Subsection (1)(b) shall be effective for period of not more than one year.

(b) At the end of the [~~year~~] period described in Subsection (2)(a), a carrier [~~must demonstrate new~~] is subject to Sections 31A-30-108 and 31A-30-110 unless the carrier demonstrates to the satisfaction of the commissioner the need for [~~the~~] a modification or waiver in accordance with Subsection (1)(b).

(3) Notwithstanding the requirements of this chapter, a carrier may deny health benefit plan coverage in the small employer and individual market if the carrier demonstrates to the satisfaction of the commissioner that the carrier:

(a) does not have the financial reserves necessary to underwrite additional coverage;

(b) is applying this section uniformly to all small employers and individuals without regard to:

(i) any health status-related factor of the individuals; or

(ii) whether the individuals are eligible individuals.

Section 94. Section **31A-30-114** is enacted to read:

31A-30-114. Disclosure.

(1) A covered carrier shall make the information described in Subsection (2) available:

(a) to:

(i) a small employer; or

(ii) an individual; and

(b) (i) at the time of solicitation; or

(ii) upon the request of:

(A) a small employer; or

(B) an individual;

(c) as part of the covered carrier's solicitation and sales materials.

(2) The following information is required to be disclosed or made available under Subsection (1):

(a) the provisions of the coverage concerning the covered carrier's right to change premium rates; and

(b) the factors that may effect changes in premium rates;

(c) the provisions of the coverage relating to renewability of coverage; and

(d) the provisions of the coverage relating to any preexisting condition exclusion.

Section 95. Section **59-9-105** is amended to read:

59-9-105. Tax on certain insurers to pay for relative value study and other publications or services.

(1) Each insurer providing coverage for motor vehicle liability, uninsured motorist, and personal injury protection shall pay to the State Tax Commission on or before March 31 of each

year, a tax of .01% on the total premiums received for these coverages during the preceding calendar year from policies covering motor vehicle risks in this state.

(2) The taxable premium under this section shall be reduced by all premiums returned or credited to policyholders on direct business subject to tax in this state.

(3) All money received by the state under this section shall be deposited in the General Fund as a dedicated credit for the purpose of providing funds to pay for any costs and expenses incurred by the Insurance Department:

(a) in conducting, maintaining, and administering the relative value study referred to in Section 31A-22-307; [~~and~~]

(b) to prepare, publish, and distribute publications relating to insurance and consumers of insurance as provided in Section 31A-2-208[~~.~~]; and

(c) in providing the services of the Insurance Department through the use of:

(i) electronic commerce; and

(ii) other information technology.

Section 96. Section **63-55-231** is amended to read:

63-55-231. Repeal dates, Title 31A.

(1) Section 31A-3-104, Electronic Commerce Dedicated Fees, is repealed July 1, 2006.

[~~(1)~~] (2) Section 31A-2-208.5, Comparison tables, is repealed July 1, 2005.

[~~(2)~~] (3) Section 31A-2-217, Coordination with other states, is repealed July 1, 2003.

[~~(3)~~] (4) Section 31A-22-315, Motor Vehicle Insurance Reporting, is repealed July 1, 2010.

[~~(4)~~] (5) Section 31A-22-625, Catastrophic Coverage of Mental Health Conditions, is repealed July 1, 2011.

[~~(5)~~] (6) Title 31A, Chapter 31, Insurance Fraud Act, is repealed July 1, 2007.

Section 97. **Repealer.**

This act repeals:

Section **31A-8-402, Contract cancellation or nonrenewal.**

Section **31A-15-206, Countersignatures not required.**

Section **31A-22-720, Mental health parity.**

Section 98. **Effective date.**

This act takes effect on May 6, 2002, except that the amendments to Section 31A-26-202

(Effective 07/01/02) take effect on July 1, 2002.