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S.B. 122

1 # INSURANCE LAW AMENDMENTS

2 2002 GENERAL SESSION

3 STATE OF UTAH

4 **Sponsor: L. Steven Poulton**

5 **This act modifies the Insurance Code by amending definitions, making technical changes,**
6 **and making the following changes. The act addresses disclosure of examination reports.**
7 **The act addresses fees. The act addresses waiver of retaliatory requirements. The act**
8 **addresses withdrawal from a line of insurance. The act addresses selection and removal of**
9 **directors and officers of mutual insurers. This act addresses required minimum capital of**
10 **certain insurers, deposits, and permanent surplus. This act addresses cancellation,**
11 **termination, nonrenewal, or changes in certain insurance coverage. This act addresses**
12 **reporting requirements for point of service or point of sales products. The act addresses**
13 **computation for minimum standards for annuities. This act addresses the scope of the Utah**
14 **Rate Regulation Act. This act addresses what constitutes an insurable interest. This act**
15 **addresses when information can be incorporated by reference. The act addresses**
16 **requirements for certificates of group insurance policies. The act addresses provisions**
17 **related to the regulation of life, credit life, and accident and health insurance. This act**
18 **addresses insurance marketing and licensing, including requirements for title insurance.**
19 **This act addresses the regulation of third party administrators and insurance adjustors.**
20 **This act addresses rehabilitation and liquidation of insurers. This act modifies requirements**
21 **for the account maintained by the Utah Property and Casualty Health Insurance Guaranty**
22 **Association. This act addresses the Individual and Small Employer Health Insurance Act.**
23 **This act provides an effective date.**
24 This act affects sections of Utah Code Annotated 1953 as follows:
25 AMENDS:
26 **31A-1-103**, as last amended by Chapter 116, Laws of Utah 2001
27 **31A-1-301**, as last amended by Chapter 116, Laws of Utah 2001

28 **31A-2-204**, as last amended by Chapter 316, Laws of Utah 1994
29 **31A-3-103**, as last amended by Chapter 329, Laws of Utah 1998
30 **31A-3-401**, as last amended by Chapter 131, Laws of Utah 1999
31 **31A-4-115**, as last amended by Chapter 114, Laws of Utah 2000
32 **31A-5-405**, as last amended by Chapter 300, Laws of Utah 2000
33 **31A-5-409**, as last amended by Chapter 300, Laws of Utah 2000
34 **31A-5-410**, as last amended by Chapter 300, Laws of Utah 2000
35 **31A-8-101**, as last amended by Chapter 116, Laws of Utah 2001
36 **31A-8-103**, as last amended by Chapter 116, Laws of Utah 2001
37 **31A-8-209**, as last amended by Chapter 116, Laws of Utah 2001
38 **31A-8-211**, as last amended by Chapter 116, Laws of Utah 2001
39 **31A-8-408**, as last amended by Chapter 116, Laws of Utah 2001
40 **31A-17-505**, as last amended by Chapter 116, Laws of Utah 2001
41 **31A-17-506**, as last amended by Chapter 20, Laws of Utah 1995
42 **31A-19a-101**, as last amended by Chapter 116, Laws of Utah 2001
43 **31A-21-104**, as last amended by Chapter 116, Laws of Utah 2001
44 **31A-21-106**, as last amended by Chapter 114, Laws of Utah 2000
45 **31A-21-311**, as enacted by Chapter 242, Laws of Utah 1985
46 **31A-22-400**, as enacted by Chapter 242, Laws of Utah 1985
47 **31A-22-402**, as last amended by Chapter 114, Laws of Utah 2000
48 **31A-22-403**, as last amended by Chapter 116, Laws of Utah 2001
49 **31A-22-404**, as last amended by Chapter 116, Laws of Utah 2001
50 **31A-22-405**, as enacted by Chapter 242, Laws of Utah 1985
51 **31A-22-409**, as last amended by Chapter 204, Laws of Utah 1986
52 **31A-22-522**, as enacted by Chapter 116, Laws of Utah 2001
53 **31A-22-602**, as last amended by Chapter 116, Laws of Utah 2001
54 **31A-22-624**, as last amended by Chapter 116, Laws of Utah 2001
55 **31A-22-625**, as last amended by Chapter 9, Laws of Utah 2001
56 **31A-22-629**, as enacted by Chapter 162, Laws of Utah 2000
57 **31A-22-703**, as last amended by Chapter 116, Laws of Utah 2001
58 **31A-22-705**, as last amended by Chapter 116, Laws of Utah 2001

59 **31A-22-708**, as repealed and reenacted by Chapter 329, Laws of Utah 1998
60 **31A-22-714**, as last amended by Chapter 329, Laws of Utah 1998
61 **31A-22-801**, as last amended by Chapter 116, Laws of Utah 2001
62 **31A-22-804**, as last amended by Chapter 116, Laws of Utah 2001
63 **31A-22-807**, as last amended by Chapter 116, Laws of Utah 2001
64 **31A-22-808**, as last amended by Chapter 116, Laws of Utah 2001
65 **31A-23-102**, as last amended by Chapters 9 and 116, Laws of Utah 2001
66 **31A-23-204**, as last amended by Chapter 116, Laws of Utah 2001
67 **31A-23-206**, as last amended by Chapter 116, Laws of Utah 2001
68 **31A-23-211**, as last amended by Chapter 9, Laws of Utah 1996, Second Special Session
69 **31A-23-216**, as last amended by Chapter 116, Laws of Utah 2001
70 **31A-23-307**, as last amended by Chapter 116, Laws of Utah 2001
71 **31A-23-308**, as enacted by Chapter 242, Laws of Utah 1985
72 **31A-23-503**, as last amended by Chapter 116, Laws of Utah 2001
73 **31A-23-601**, as last amended by Chapter 116, Laws of Utah 2001
74 **31A-25-205**, as last amended by Chapter 116, Laws of Utah 2001
75 **31A-26-202 (Effective 07/01/02)**, as last amended by Chapter 8, Laws of Utah 2001, First
76 Special Session
77 **31A-26-202 (Superseded 07/01/02)**, as last amended by Chapter 116, Laws of Utah 2001
78 **31A-26-206**, as last amended by Chapter 116, Laws of Utah 2001
79 **31A-26-213**, as last amended by Chapter 116, Laws of Utah 2001
80 **31A-26-301.6**, as enacted by Chapter 240, Laws of Utah 2001
81 **31A-27-102**, as last amended by Chapter 131, Laws of Utah 1999
82 **31A-27-103**, as enacted by Chapter 242, Laws of Utah 1985
83 **31A-27-305**, as last amended by Chapter 204, Laws of Utah 1986
84 **31A-27-311.5**, as repealed and reenacted by Chapter 116, Laws of Utah 2001
85 **31A-27-315**, as last amended by Chapter 375, Laws of Utah 1997
86 **31A-27-317**, as enacted by Chapter 242, Laws of Utah 1985
87 **31A-27-332**, as last amended by Chapter 131, Laws of Utah 1999
88 **31A-27-337**, as last amended by Chapter 204, Laws of Utah 1986
89 **31A-27-340**, as enacted by Chapter 242, Laws of Utah 1985

90 **31A-27-341**, as enacted by Chapter 242, Laws of Utah 1985
91 **31A-28-203**, as last amended by Chapter 363, Laws of Utah 2001
92 **31A-28-205**, as last amended by Chapter 363, Laws of Utah 2001
93 **31A-28-207**, as last amended by Chapter 363, Laws of Utah 2001
94 **31A-28-208**, as last amended by Chapter 363, Laws of Utah 2001
95 **31A-28-222**, as enacted by Chapter 363, Laws of Utah 2001
96 **31A-29-113**, as last amended by Chapter 329, Laws of Utah 1998
97 **31A-30-101**, as last amended by Chapter 321, Laws of Utah 1995
98 **31A-30-103**, as last amended by Chapter 116, Laws of Utah 2001
99 **31A-30-104**, as last amended by Chapter 116, Laws of Utah 2001
100 **31A-30-106**, as last amended by Chapter 116, Laws of Utah 2001
101 **31A-30-106.7**, as enacted by Chapter 265, Laws of Utah 1997
102 **31A-30-107**, as last amended by Chapter 116, Laws of Utah 2001
103 **31A-30-108**, as last amended by Chapter 329, Laws of Utah 1998
104 **31A-30-110**, as last amended by Chapter 53, Laws of Utah 2001
105 **31A-30-111**, as enacted by Chapter 321, Laws of Utah 1995
106 **59-9-105**, as last amended by Chapter 131, Laws of Utah 1999
107 **63-55-231**, as last amended by Chapter 116, Laws of Utah 2001
108 ENACTS:
109 **31A-3-104**, Utah Code Annotated 1953
110 **31A-8-402.3**, Utah Code Annotated 1953
111 **31A-8-402.5**, Utah Code Annotated 1953
112 **31A-8-402.7**, Utah Code Annotated 1953
113 **31A-22-721**, Utah Code Annotated 1953
114 **31A-22-803.1**, Utah Code Annotated 1953
115 **31A-30-107.1**, Utah Code Annotated 1953
116 **31A-30-107.3**, Utah Code Annotated 1953
117 **31A-30-107.5**, Utah Code Annotated 1953
118 **31A-30-114**, Utah Code Annotated 1953
119 REPEALS:
120 **31A-8-402**, as last amended by Chapter 116, Laws of Utah 2001

121 **31A-15-206**, as enacted by Chapter 258, Laws of Utah 1992
122 **31A-22-720**, as last amended by Chapter 116, Laws of Utah 2001
123 *Be it enacted by the Legislature of the state of Utah:*
124 Section 1. Section **31A-1-103** is amended to read:
125 **31A-1-103. Scope and applicability of title.**
126 (1) This title does not apply to:
127 (a) a retainer [~~contracts~~] contract made by [~~attorneys-at-law~~] an attorney-at-law:
128 (i) with an individual [~~clients with~~] client; and
129 (ii) under which fees are based on estimates of the nature and amount of services to be
130 provided to the specific client[~~, and similar contracts~~];
131 (b) a contract similar to a contract described in Subsection (1)(a) made with a group of
132 clients involved in the same or closely related legal matters;
133 [~~(b) arrangements~~] (c) an arrangement for providing benefits that do not exceed a limited
134 amount of consultations, advice on simple legal matters, either alone or in combination with
135 referral services, or the promise of fee discounts for handling other legal matters;
136 [~~(c)~~] (d) limited legal assistance on an informal basis involving neither an express
137 contractual obligation nor reasonable expectations, in the context of an employment, membership,
138 educational, or similar relationship; or
139 [~~(d)~~] (e) legal assistance by employee organizations to their members in matters relating
140 to employment.
141 (2) (a) This title restricts otherwise legitimate business activity.
142 (b) What this title does not prohibit is permitted unless contrary to other provisions of Utah
143 law.
144 (3) Except as otherwise expressly provided, this title does not apply to:
145 (a) those activities of an insurer where state jurisdiction is preempted by Section 514 of
146 the federal Employee Retirement Income Security Act of 1974, as amended;
147 (b) ocean marine insurance;
148 (c) death and accident and health benefits provided by an organization [~~where the~~] if the
149 organization:
150 (i) has as its principal purpose [~~is~~] to achieve charitable, educational, social, or religious
151 objectives rather than to provide death and accident and health benefits[~~, if the organization~~];

152 (ii) does not incur a legal obligation to pay a specified amount; and
153 (iii) does not create reasonable expectations of receiving a specified amount on the part
154 of an insured person;
155 (d) other business specified in rules adopted by the commissioner on a finding that:
156 (i) the transaction of [such] the business in this state does not require regulation for the
157 protection of the interests of the residents of this state; or [on a finding that];
158 (ii) it would be impracticable to require compliance with this title;
159 (e) [(i) transactions] except as provided in Subsection (4), a transaction independently
160 procured through negotiations under Section 31A-15-104;
161 [(ii) however, the transactions described in Subsection (3)(e)(i) are subject to taxation
162 under Section 31A-3-301;]
163 (f) self-insurance;
164 (g) reinsurance;
165 (h) subject to Subsection [(4)] (5), employee and labor union group or blanket insurance
166 covering risks in this state if:
167 (i) the policyholder exists primarily for purposes other than to procure insurance;
168 (ii) the policyholder:
169 (A) is not a resident of this state [or];
170 (B) is not a domestic corporation; or
171 (C) does not have its principal office in this state;
172 (iii) no more than 25% of the certificate holders or insureds are residents of this state;
173 (iv) on request of the commissioner, the insurer files with the department a copy of the
174 policy and a copy of each form or certificate; and
175 (v) (A) the insurer agrees to pay premium taxes on the Utah portion of its business, as if
176 it were authorized to do business in this state[,]; and [if]
177 (B) the insurer provides the commissioner with the security the commissioner considers
178 necessary for the payment of premium taxes under Title 59, Chapter 9, Taxation of Admitted
179 Insurers; or
180 (i) to the extent provided in Subsection [(5)] (6):
181 (i) a manufacturer's or seller's warranty; and
182 (ii) a manufacturer's or seller's service contract.

183 (4) A transaction described in Subsection (3)(e) is subject to taxation under Section
184 31A-3-301.
185 [(4)] (5) (a) After a hearing, the commissioner may order an insurer of certain group or
186 blanket contracts to transfer the Utah portion of the business otherwise exempted under Subsection
187 (3)(h) to an authorized insurer if the contracts have been written by an unauthorized insurer.
188 (b) If the commissioner finds that the conditions required for the exemption of a group or
189 blanket insurer are not satisfied or that adequate protection to residents of this state is not provided,
190 the commissioner may require:
191 (i) the insurer to be authorized to do business in this state; or
192 (ii) that any of the insurer's transactions be subject to this title.
193 [(5)] (6) (a) As used in Subsection (3)(i) and this Subsection [(5)] (6):
194 (i) "manufacturer's or seller's service contract" means a service contract:
195 (A) made available by:
196 (I) a manufacturer of a product[:];
197 (II) a seller of a product; or
198 (III) an affiliate of a manufacturer or seller of a product;
199 (B) made available:
200 (I) on one or more specific [product] products; or
201 (II) on products that are components of a system; and
202 [(B)] (C) under which the [manufacturer] person described in Subsection (6)(a)(i)(A) is
203 liable for services to be provided under the service contract including, if the manufacturer's or
204 seller's service contract designates, providing parts and labor;
205 (ii) "manufacturer's or seller's warranty" means the guaranty of:
206 (A) (I) the manufacturer of a product[:];
207 (II) a seller of a product; or
208 (III) an affiliate of a manufacturer or seller of a product;
209 [(A)] (B) (I) on one or more specific [product] products; or
210 (II) on products that are components of a system; and
211 [(B)] (C) under which the [manufacturer] person described in Subsection (6)(a)(ii)(A) is
212 liable for services to be provided under the warranty, including, if the manufacturer's or seller's
213 warranty designates, providing parts and labor; and

214 (iii) "service contract" is as defined in Section 31A-6a-101.
215 (b) A manufacturer's or seller's warranty may be designated as:
216 (i) a warranty;
217 (ii) a guaranty; or
218 (iii) a term similar to a term described in Subsection [~~(5)~~] (6)(b)(i) or (ii).
219 (c) This title does not apply to:
220 (i) a manufacturer's or seller's warranty;
221 (ii) a manufacturer's or seller's service contract paid for with consideration that is in
222 addition to the consideration paid for the product itself; and
223 (iii) a service contract that is not a manufacturer's or seller's warranty or manufacturer's
224 or seller's service contract if:
225 (A) the service contract is paid for with consideration that is in addition to the
226 consideration paid for the product itself; [~~and~~]
227 (B) the service contract is for the repair or maintenance of goods;
228 (C) the cost of the product is equal to an amount determined in accordance with
229 Subsection [~~(5)~~] (6)(e); and
230 (D) the product is not a motor vehicle.
231 (d) This title does not apply to a manufacturer's or seller's warranty or service contract paid
232 for with consideration that is in addition to the consideration paid for [~~for~~] the product itself
233 regardless of whether the manufacturer's or seller's warranty or service contract is sold:
234 (i) at the time of the purchase of the product; or
235 (ii) at a time other than the time of the purchase of the product.
236 (e) (i) For fiscal year 2001-02, the amount described in Subsection [~~(5)~~] (6)(c)(iii)(C) shall
237 be equal to $3,700 or less.
238 (ii) For each fiscal year after fiscal year 2001-02, the commissioner shall annually
239 determine whether the amount described in Subsection [~~(5)~~] (6)(c)(iii)(C) should be adjusted in
240 accordance with changes in the Consumer Price Index published by the United States Bureau of
241 Labor Statistics selected by the commissioner by rule, between:
242 (A) the Consumer Price Index for the February immediately preceding the adjustment; and
243 (B) the Consumer Price Index for February 2001.
244 (iii) If under Subsection [~~(5)~~] (6)(e)(ii) the commissioner determines that an adjustment

245 should be made, the commissioner shall make the adjustment by rule.

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

247 **31A-1-301. Definitions.**

248 As used in this title, unless otherwise specified:

249 (1) (a) "Accident and health insurance" means insurance to provide protection against

250 economic losses resulting from:

251 (i) a medical condition including:

252 (A) medical care expenses; or

253 (B) the risk of disability;

254 (ii) accident; or

255 (iii) sickness.

256 (b) "Accident and health insurance":

257 (i) includes a contract with disability contingencies including:

258 (A) an income replacement contract;

259 (B) a health care contract;

260 (C) an expense reimbursement contract;

261 (D) a credit accident and health contract;

262 (E) a continuing care contract; and

263 (F) long-term care contracts; and

264 (ii) may provide:

265 (A) hospital coverage;

266 (B) surgical coverage;

267 (C) medical coverage; or

268 (D) loss of income coverage.

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

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

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

272 (4) "Affiliate" means any person who controls, is controlled by, or is under common

273 control with, another person. A corporation is an affiliate of another corporation, regardless of

274 ownership, if substantially the same group of natural persons manages the corporations.

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

276 (6) "Amendment" means an endorsement to an insurance policy or certificate.
277 (7) "Annuity" means an agreement to make periodical payments for a period certain or over
278 the lifetime of one or more natural persons if the making or continuance of all or some of the series
279 of the payments, or the amount of the payment, is dependent upon the continuance of human life.
280 (8) "Application" means a document:
281 (a) completed by an applicant to provide information about the risk to be insured; and
282 (b) that contains information that is used by the insurer to:
283 (i) evaluate risk; and
284 (ii) decide whether to:
285 (A) insure the risk under:
286 (I) the coverages as originally offered; or
287 (II) a modification of the coverage as originally offered; or
288 (B) decline to insure the risk.
289 (9) "Articles" or "articles of incorporation" means the original articles, special laws,
290 charters, amendments, restated articles, articles of merger or consolidation, trust instruments, and
291 other constitutive documents for trusts and other entities that are not corporations, and
292 amendments to any of these.
293 (10) "Bail bond insurance" means a guarantee that a person will attend court when
294 required, or will obey the orders or judgment of the court, as a condition to the release of that
295 person from confinement.
296 (11) "Binder" is defined in Section 31A-21-102.
297 (12) "Board," "board of trustees," or "board of directors" means the group of persons with
298 responsibility over, or management of, a corporation, however designated.
299 (13) "Business of insurance" is defined in Subsection [~~(64)~~] (68).
300 (14) "Business plan" means the information required to be supplied to the commissioner
301 under Subsections 31A-5-204(2)(i) and (j), including the information required when these
302 subsections are applicable by reference under:
303 (a) Section 31A-7-201;
304 (b) Section 31A-8-205; or
305 (c) Subsection 31A-9-205(2).
306 (15) "Bylaws" means the rules adopted for the regulation or management of a corporation's

307 affairs, however designated and includes comparable rules for trusts and other entities that are not
308 corporations.
309 (16) "Casualty insurance" means liability insurance as defined in Subsection [~~(70)~~] (75).
310 (17) "Certificate" means evidence of insurance given to:
311 (a) an insured under a group insurance policy; or
312 (b) a third party.
313 (18) "Certificate of authority" is included within the term "license."
314 (19) "Claim," unless the context otherwise requires, means a request or demand on an
315 insurer for payment of benefits according to the terms of an insurance policy.
316 (20) "Claims-made coverage" means an insurance contract or provision limiting coverage
317 under a policy insuring against legal liability to claims that are first made against the insured while
318 the policy is in force.
319 (21) (a) "Commissioner" or "commissioner of insurance" means Utah's insurance
320 commissioner.
321 (b) When appropriate, the terms listed in Subsection (21)(a) apply to the equivalent
322 supervisory official of another jurisdiction.
323 (22) (a) "Continuing care insurance" means insurance that:
324 (i) provides board and lodging;
325 (ii) provides one or more of the following services:
326 (A) personal services;
327 (B) nursing services;
328 (C) medical services; or
329 (D) other health-related services; and
330 (iii) provides the coverage described in Subsection (22)(a)(i) under an agreement effective:
331 (A) for the life of the insured; or
332 (B) for a period in excess of one year.
333 (b) Insurance is continuing care insurance regardless of whether or not the board and
334 lodging are provided at the same location as the services described in Subsection (22)(a)(ii).
335 (23) (a) "Control," "controlling," "controlled," or "under common control" means the direct
336 or indirect possession of the power to direct or cause the direction of the management and policies
337 of a person. This control may be:

338 (i) by contract;
339 (ii) by common management;
340 (iii) through the ownership of voting securities; or
341 (iv) by a means other than those described in Subsections (23)(a)(i) through (iii).
342 (b) There is no presumption that an individual holding an official position with another
343 person controls that person solely by reason of the position.
344 (c) A person having a contract or arrangement giving control is considered to have control
345 despite the illegality or invalidity of the contract or arrangement.
346 (d) There is a rebuttable presumption of control in a person who directly or indirectly
347 owns, controls, holds with the power to vote, or holds proxies to vote 10% or more of the voting
348 securities of another person.
349 (24) (a) "Corporation" means insurance corporation, except when referring to:
350 (i) a corporation doing business as an insurance broker, consultant, or adjuster under:
351 (A) Chapter 23, Insurance Marketing - Licensing Agents, Brokers, Consultants, and
352 Reinsurance Intermediaries; and
353 (B) Chapter 26, Insurance Adjusters; or
354 (ii) a noninsurer that is part of a holding company system under Chapter 16, Insurance
355 Holding Companies.
356 (b) "Stock corporation" means stock insurance corporation.
357 (c) "Mutual" or "mutual corporation" means a mutual insurance corporation.
358 (25) "Credit accident and health insurance" means insurance on a debtor to provide
359 indemnity for payments coming due on a specific loan or other credit transaction while the debtor
360 is disabled.
361 (26) "Credit insurance" means surety insurance under which mortgagees and other
362 creditors are indemnified against losses caused by the default of debtors.
363 (27) "Credit life insurance" means insurance on the life of a debtor in connection with a
364 loan or other credit transaction.
365 (28) "Creditor" means a person, including an insured, having any claim, whether:
366 (a) matured;
367 (b) unmatured;
368 (c) liquidated;

369 (d) unliquidated;
370 (e) secured;
371 (f) unsecured;
372 (g) absolute;
373 (h) fixed; or
374 (i) contingent.
375 (29) (a) "Customer service representative" means a person that provides insurance services
376 and insurance product information:
377 (i) for its agent, broker, or consultant employer; and
378 (ii) to its employer's customer, client, or organization.
379 (b) A customer service representative may only operate within the scope of authority of
380 its agent, broker, or consultant employer.
381 (30) "Deadline" means the final date or time:
382 (a) imposed by:
383 (i) statute;
384 (ii) rule; or
385 (iii) order; and
386 (b) by which a required filing or payment must be received by the department.
387 (31) "Deemer clause" means a provision under this title under which upon the occurrence
388 of a condition precedent, the commissioner is deemed to have taken a specific action. If the statute
389 so provides, the condition precedent may be the commissioner's failure to take a specific action.
390 (32) "Degree of relationship" means the number of steps between two persons determined
391 by counting the generations separating one person from a common ancestor and then counting the
392 generations to the other person.
393 (33) "Department" means the Insurance Department.
394 (34) "Director" means a member of the board of directors of a corporation.
395 (35) "Disability" means a physiological or psychological condition that partially or totally
396 limits an individual's ability to:
397 (a) perform the duties of:
398 (i) that individual's occupation; or
399 (ii) any occupation for which the individual is reasonably suited by education, training, or

400 experience; or
401 (b) perform two or more of the following basic activities of daily living:
402 (i) eating;
403 (ii) toileting;
404 (iii) transferring;
405 (iv) bathing; or
406 (v) dressing.
407 (36) "Domestic insurer" means an insurer organized under the laws of this state.
408 (37) "Domiciliary state" means the state in which an insurer:
409 (a) is incorporated;
410 (b) is organized; or
411 (c) in the case of an alien insurer, enters into the United States.
412 (38) (a) "Eligible employee" means:
413 (i) an employee who:
414 (A) works on a full-time basis; and
415 (B) has a normal work week of 30 or more hours; or
416 (ii) a person described in Subsection (38)(b).
417 (b) "Eligible employee" includes, if the individual is included under a health benefit plan
418 of a small employer:
419 (i) a sole proprietor;
420 (ii) a partner in a partnership; or
421 (iii) an independent contractor.
422 (c) "Eligible employee" does not include, unless eligible under Subsection (38)(b):
423 (i) an individual who works on a temporary or substitute basis for a small employer;
424 (ii) an employer's spouse; or
425 (iii) a dependent of an employer.
426 (39) "Employee" means any individual employed by an employer.
427 [~~(38)~~] (40) "Employee benefits" means one or more benefits or services provided to:
428 (a) employees; or [~~their~~]
429 (b) dependents of employees.
430 [~~(39)~~] (41) (a) "Employee welfare fund" means a fund:

431 (i) established or maintained, whether directly or through trustees, by:
432 (A) one or more employers;
433 (B) one or more labor organizations; or
434 (C) a combination of employers and labor organizations; and
435 (ii) that provides employee benefits paid or contracted to be paid, other than income from
436 investments of the fund, by or on behalf of an employer doing business in this state or for the
437 benefit of any person employed in this state.
438 (b) "Employee welfare fund" includes a plan funded or subsidized by user fees or tax
439 revenues.
440 [~~(40)~~] (42) "Endorsement" means a written agreement attached to a policy or certificate
441 to modify one or more of the provisions of the policy or certificate.
442 [~~(41)~~] (43) "Excludes" is not exhaustive and does not mean that other things are not also
443 excluded. The items listed are representative examples for use in interpretation of this title.
444 [~~(42)~~] (44) "Expense reimbursement insurance" means insurance:
445 (a) written to provide payments for expenses relating to hospital confinements resulting
446 from illness or injury; and
447 (b) written:
448 (i) as a daily limit for a specific number of days in a hospital; and
449 (ii) to have a one or two day waiting period following a hospitalization.
450 [~~(43)~~] (45) "Fidelity insurance" means insurance guaranteeing the fidelity of persons
451 holding positions of public or private trust.
452 [~~(44)~~] (46) (a) "Filed" means that a filing is:
453 (i) submitted to the department in accordance with any applicable statute, rule, or filing
454 order;
455 (ii) received by the department within the time period provided in the applicable statute,
456 rule, or filing order; and
457 (iii) accompanied with the applicable one or more filing fees required by:
458 (A) Section 31A-3-103; or
459 (B) rule.
460 (b) "Filed" does not include a filing that is rejected by the department because it is not
461 submitted in accordance with Subsection [~~(44)~~] (46)(a).

462 [~~(45)~~] (47) "Filing," when used as a noun, means an item required to be filed with the
463 department including:
464 (a) a policy;
465 (b) a rate;
466 (c) a form;
467 (d) a document;
468 (e) a plan;
469 (f) a manual;
470 (g) an application;
471 (h) a report;
472 (i) a certificate;
473 (j) an endorsement;
474 (k) an actuarial certification;
475 (l) a licensee annual statement;
476 (m) a licensee renewal application; or
477 (n) an advertisement.
478 [~~(46)~~] (48) "First party insurance" means an insurance policy or contract in which the
479 insurer agrees to pay claims submitted to it by the insured for the insured's losses.
480 [~~(47)~~] (49) "Foreign insurer" means an insurer domiciled outside of this state, including
481 an alien insurer.
482 [~~(48)~~] (50) (a) "Form" means [~~a policy, certificate, or application~~] one of the following
483 prepared for general use[~~.~~]:
484 (i) a policy;
485 (ii) a certificate;
486 (iii) an application; or
487 (iv) an outline of coverage.
488 (b) "Form" does not include a document specially prepared for use in an individual case.
489 [~~(49)~~] (51) "Franchise insurance" means individual insurance policies provided through
490 a mass marketing arrangement involving a defined class of persons related in some way other than
491 through the purchase of insurance.
492 (52) "Group health plan" means an employee welfare benefit plan to the extent that the

493 plan provides medical care:
494 (a) (i) to employees; or
495 (ii) to a dependent of an employee; and
496 (b) (i) directly;
497 (ii) through insurance reimbursement; or
498 (iii) through any other method.
499 (53) "Health benefit plan" means a policy or certificate for health care insurance, except
500 that health benefit plan does not include coverage:
501 (a) solely for:
502 (i) accident;
503 (ii) dental;
504 (iii) vision;
505 (iv) Medicare supplement;
506 (v) long-term care; or
507 (vi) income replacement; or
508 (b) that is:
509 (i) offered and marketed as supplemental health insurance;
510 (ii) not offered or marketed as a substitute for:
511 (A) hospital or medical expense insurance; or
512 (B) major medical expense insurance; and
513 (iii) solely for:
514 (A) a specified disease;
515 (B) hospital confinement indemnity; or
516 (C) limited benefit plan.
517 [~~(50)~~] (54) "Health care" means any of the following intended for use in the diagnosis,
518 treatment, mitigation, or prevention of a human ailment or impairment:
519 (a) professional services;
520 (b) personal services;
521 (c) facilities;
522 (d) equipment;
523 (e) devices;

524 (f) supplies; or
525 (g) medicine.
526 [~~(51)~~] (55) (a) "Health care insurance" or "health insurance" means insurance providing:
527 (i) health care benefits; or
528 (ii) payment of incurred health care expenses.
529 (b) "Health care insurance" or "health insurance" does not include accident and health
530 insurance providing benefits for:
531 (i) replacement of income;
532 (ii) short-term accident;
533 (iii) fixed indemnity;
534 (iv) credit accident and health;
535 (v) supplements to liability;
536 (vi) workers' compensation;
537 (vii) automobile medical payment;
538 (viii) no-fault automobile;
539 (ix) equivalent self-insurance; or
540 (x) any type of accident and health insurance coverage that is a part of or attached to
541 another type of policy.
542 [~~(52)~~] (56) "Income replacement insurance" or "disability income insurance" means
543 insurance written to provide payments to replace income lost from accident or sickness.
544 [~~(53)~~] (57) "Indemnity" means the payment of an amount to offset all or part of an insured
545 loss.
546 [~~(54)~~] (58) "Independent adjuster" means an insurance adjuster required to be licensed
547 under Section 31A-26-201 who engages in insurance adjusting as a representative of insurers.
548 [~~(55)~~] (59) "Independently procured insurance" means insurance procured under Section
549 31A-15-104.
550 [~~(56)~~] (60) "Individual" means a natural person.
551 [~~(57)~~] (61) "Inland marine insurance" includes insurance covering:
552 (a) property in transit on or over land;
553 (b) property in transit over water by means other than boat or ship;
554 (c) bailee liability;

555 (d) fixed transportation property such as bridges, electric transmission systems, radio and
556 television transmission towers and tunnels; and
557 (e) personal and commercial property floaters.
558 [(58)] (62) "Insolvency" means that:
559 (a) an insurer is unable to pay its debts or meet its obligations as they mature;
560 (b) an insurer's total adjusted capital is less than the insurer's mandatory control level RBC
561 under Subsection 31A-17-601(8)(c); or
562 (c) an insurer is determined to be hazardous under this title.
563 [(59)] (63) (a) "Insurance" means:
564 (i) an arrangement, contract, or plan for the transfer of a risk or risks from one or more
565 persons to one or more other persons; or
566 (ii) an arrangement, contract, or plan for the distribution of a risk or risks among a group
567 of persons that includes the person seeking to distribute that person's risk.
568 (b) "Insurance" includes:
569 (i) risk distributing arrangements providing for compensation or replacement for damages
570 or loss through the provision of services or benefits in kind;
571 (ii) contracts of guaranty or suretyship entered into by the guarantor or surety as a business
572 and not as merely incidental to a business transaction; and
573 (iii) plans in which the risk does not rest upon the person who makes the arrangements,
574 but with a class of persons who have agreed to share it.
575 [(60)] (64) "Insurance adjuster" means a person who directs the investigation, negotiation,
576 or settlement of a claim under an insurance policy other than life insurance or an annuity, on behalf
577 of an insurer, policyholder, or a claimant under an insurance policy.
578 [(61)] (65) "Interinsurance exchange" is defined in Subsection [(100)] (110).
579 [(62)] (66) Except as provided in Subsection 31A-23-201.5(1), "insurance agent" or
580 "agent" means a person who represents insurers in soliciting, negotiating, or placing insurance.
581 [(63)] (67) Except as provided in Subsection 31A-23-201.5(1), "insurance broker" or
582 "broker" means a person who:
583 (a) acts in procuring insurance on behalf of an applicant for insurance or an insured; and
584 (b) does not act on behalf of the insurer except by collecting premiums or performing other
585 ministerial acts.

586 [~~(64)~~] (68) "Insurance business" or "business of insurance" includes:
587 (a) providing health care insurance, as defined in Subsection [~~(51)~~] (55), by organizations
588 that are or should be licensed under this title;
589 (b) providing benefits to employees in the event of contingencies not within the control
590 of the employees, in which the employees are entitled to the benefits as a right, which benefits may
591 be provided either:
592 (i) by single employers or by multiple employer groups; or
593 (ii) through trusts, associations, or other entities;
594 (c) providing annuities, including those issued in return for gifts, except those provided
595 by persons specified in Subsections 31A-22-1305(2) and (3);
596 (d) providing the characteristic services of motor clubs as outlined in Subsection [~~(77)~~]
597 (82);
598 (e) providing other persons with insurance as defined in Subsection [~~(59)~~] (63);
599 (f) making as insurer, guarantor, or surety, or proposing to make as insurer, guarantor, or
600 surety, any contract or policy of title insurance;
601 (g) transacting or proposing to transact any phase of title insurance, including solicitation,
602 negotiation preliminary to execution, execution of a contract of title insurance, insuring, and
603 transacting matters subsequent to the execution of the contract and arising out of it, including
604 reinsurance; and
605 (h) doing, or proposing to do, any business in substance equivalent to Subsections [~~(64)~~]
606 (68)(a) through (g) in a manner designed to evade the provisions of this title.
607 [~~(65)~~] (69) Except as provided in Subsection 31A-23-201.5(1), "insurance consultant" or
608 "consultant" means a person who:
609 (a) advises other persons about insurance needs and coverages;
610 (b) is compensated by the person advised on a basis not directly related to the insurance
611 placed; and
612 (c) is not compensated directly or indirectly by an insurer, agent, or broker for advice
613 given.
614 [~~(66)~~] (70) "Insurance holding company system" means a group of two or more affiliated
615 persons, at least one of whom is an insurer.
616 [~~(67)~~] (71) (a) "Insured" means a person to whom or for whose benefit an insurer makes

617 a promise in an insurance policy and includes:
618 (i) policyholders;
619 (ii) subscribers;
620 (iii) members; and
621 (iv) beneficiaries.
622 (b) The definition in Subsection [~~(67)~~] (71)(a):
623 (i) applies only to this title; and
624 (ii) does not define the meaning of this word as used in insurance policies or certificates.
625 [~~(68)~~] (72) (a) (i) "Insurer" means any person doing an insurance business as a principal
626 including:
627 (A) fraternal benefit societies;
628 (B) issuers of gift annuities other than those specified in Subsections 31A-22-1305(2) and
629 (3);
630 (C) motor clubs;
631 (D) employee welfare plans; and
632 (E) any person purporting or intending to do an insurance business as a principal on that
633 person's own account.
634 (ii) "Insurer" does not include a governmental entity, as defined in Section 63-30-2, to the
635 extent it is engaged in the activities described in Section 31A-12-107.
636 (b) "Admitted insurer" is defined in Subsection [~~(115)~~] (126)(b).
637 (c) "Alien insurer" is defined in Subsection (5).
638 (d) "Authorized insurer" is defined in Subsection [~~(115)~~] (126)(b).
639 (e) "Domestic insurer" is defined in Subsection (36).
640 (f) "Foreign insurer" is defined in Subsection [~~(47)~~] (49).
641 (g) "Nonadmitted insurer" is defined in Subsection [~~(115)~~] (126)(a).
642 (h) "Unauthorized insurer" is defined in Subsection [~~(115)~~] (126)(a).
643 (73) "Large employer," in connection with a health benefit plan, means an employer who,
644 with respect to a calendar year and to a plan year:
645 (a) employed an average of at least 51 eligible employees on each business day during the
646 preceding calendar year; and
647 (b) employs at least two employees on the first day of the plan year.

648 [~~(69)~~] (74) (a) Except [~~as provided~~] for a retainer contract or legal assistance described in
649 Section 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for
650 specified legal expenses.
651 (b) "Legal expense insurance" includes arrangements that create reasonable expectations
652 of enforceable rights[~~, but it~~].
653 (c) "Legal expense insurance" does not include the provision of, or reimbursement for,
654 legal services incidental to other insurance coverages.
655 [~~(70)~~] (75) (a) "Liability insurance" means insurance against liability:
656 (i) for death, injury, or disability of any human being, or for damage to property, exclusive
657 of the coverages under:
658 (A) Subsection [~~(74)~~] (79) for medical malpractice insurance;
659 (B) Subsection [~~(92)~~] (102) for professional liability insurance; and
660 (C) Subsection [~~(118)~~] (129) for workers' compensation insurance;
661 (ii) for medical, hospital, surgical, and funeral benefits to persons other than the insured
662 who are injured, irrespective of legal liability of the insured, when issued with or supplemental to
663 insurance against legal liability for the death, injury, or disability of human beings, exclusive of
664 the coverages under:
665 (A) Subsection [~~(74)~~] (79) for medical malpractice insurance;
666 (B) Subsection [~~(92)~~] (102) for professional liability insurance; and
667 (C) Subsection [~~(118)~~] (129) for workers' compensation insurance;
668 (iii) for loss or damage to property resulting from accidents to or explosions of boilers,
669 pipes, pressure containers, machinery, or apparatus;
670 (iv) for loss or damage to any property caused by the breakage or leakage of sprinklers,
671 water pipes and containers, or by water entering through leaks or openings in buildings; or
672 (v) for other loss or damage properly the subject of insurance not within any other kind
673 or kinds of insurance as defined in this chapter, if such insurance is not contrary to law or public
674 policy.
675 (b) "Liability insurance" includes:
676 (i) vehicle liability insurance as defined in Subsection [~~(116)~~] (127);
677 (ii) residential dwelling liability insurance as defined in Subsection [~~(102)~~] (112); and
678 (iii) making inspection of, and issuing certificates of inspection upon, elevators, boilers,

679 machinery, and apparatus of any kind when done in connection with insurance on them.
680 [~~(71)~~] (76) (a) "License" means the authorization issued by the insurance commissioner
681 under this title to engage in some activity that is part of or related to the insurance business. [~~It~~]
682 (b) "License" includes certificates of authority issued to insurers.
683 [~~(72)~~] (77) (a) "Life insurance" means insurance on human lives and insurances pertaining
684 to or connected with human life.
685 (b) The business of life insurance includes:
686 (i) granting death benefits;
687 (ii) granting annuity benefits;
688 (iii) granting endowment benefits;
689 (iv) granting additional benefits in the event of death by accident;
690 (v) granting additional benefits to safeguard the policy against lapse in the event of
691 disability; and
692 (vi) providing optional methods of settlement of proceeds.
693 [~~(73)~~] (78) (a) "Long-term care insurance" means an insurance policy or rider advertised,
694 marketed, offered, or designated to provide coverage:
695 (i) in a setting other than an acute care unit of a hospital;
696 (ii) for not less than 12 consecutive months for each covered person on the basis of:
697 (A) expenses incurred;
698 (B) indemnity;
699 (C) prepayment; or
700 (D) another method;
701 (iii) for one or more necessary or medically necessary services that are:
702 (A) diagnostic;
703 (B) preventative;
704 (C) therapeutic;
705 (D) rehabilitative;
706 (E) maintenance; or
707 (F) personal care; and
708 (iv) that may be issued by:
709 (A) an insurer;

710 (B) a fraternal benefit society;

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

712 (II) a medical service corporation;

713 (D) a prepaid health plan;

714 (E) a health maintenance organization; or

715 (F) an entity similar to the entities described in Subsections [~~(73)~~] (78)(a)(iv)(A) through

716 (E) to the extent that the entity is otherwise authorized to issue life or health care insurance.

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

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

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

720 (B) a life insurance policy or rider;

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

722 (A) cognitive impairment; or

723 (B) functional capacity; or

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

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

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

727 (ii) basic hospital expense coverage;

728 (iii) basic medical/surgical expense coverage;

729 (iv) hospital confinement indemnity coverage;

730 (v) major medical expense coverage;

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

732 (vii) accident only coverage;

733 (viii) coverage for a specified:

734 (A) disease; or

735 (B) accident;

736 (ix) limited benefit health coverage; or

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

738 sum payment:

739 (A) if [~~neither the benefits nor eligibility is~~] the following are not conditioned on the

740 receipt of long-term care:

741 (I) benefits; or
742 (II) eligibility; and
743 (B) the coverage is for one or more the following qualifying events:
744 (I) terminal illness;
745 (II) medical conditions requiring extraordinary medical intervention; or
746 (III) permanent institutional confinement.
747 [~~(74)~~] (79) "Medical malpractice insurance" means insurance against legal liability
748 incident to the practice and provision of medical services other than the practice and provision of
749 dental services.
750 [~~(75)~~] (80) "Member" means a person having membership rights in an insurance
751 corporation.
752 [~~(76)~~] (81) "Minimum capital" or "minimum required capital" means the capital that must
753 be constantly maintained by a stock insurance corporation as required by statute.
754 [~~(77)~~] (82) "Motor club" means a person:
755 (a) licensed under:
756 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
757 (ii) Chapter 11, Motor Clubs; or
758 (iii) Chapter 14, Foreign Insurers; and
759 (b) that promises for an advance consideration to provide for a stated period of time:
760 (i) legal services under Subsection 31A-11-102(1)(b);
761 (ii) bail services under Subsection 31A-11-102(1)(c); or
762 (iii) trip reimbursement, towing services, emergency road services, stolen automobile
763 services, a combination of these services, or any other services given in Subsections
764 31A-11-102(1)(b) through (f).
765 [~~(78)~~] (83) "Mutual" means mutual insurance corporation.
766 (84) "Network plan" means health care insurance that:
767 (a) is issued by an insurer; and
768 (b) under which the financing and delivery of medical care is provided, in whole or in part,
769 through a defined set of providers under contract with the insurer, including the financing and
770 delivery of items paid for as medial care.
771 [~~(79)~~] (85) "Nonparticipating" means a plan of insurance under which the insured is not

772 entitled to receive dividends representing shares of the surplus of the insurer.
773 [~~(80)~~] (86) "Ocean marine insurance" means insurance against loss of or damage to:
774 (a) ships or hulls of ships;
775 (b) goods, freight, cargoes, merchandise, effects, disbursements, profits, moneys,
776 securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia interests,
777 or other cargoes in or awaiting transit over the oceans or inland waterways;
778 (c) earnings such as freight, passage money, commissions, or profits derived from
779 transporting goods or people upon or across the oceans or inland waterways; or
780 (d) a vessel owner or operator as a result of liability to employees, passengers, bailors,
781 owners of other vessels, owners of fixed objects, customs or other authorities, or other persons in
782 connection with maritime activity.
783 [~~(81)~~] (87) "Order" means an order of the commissioner.
784 [~~(82)~~] (88) "Outline of coverage" means a summary that explains an accident and health
785 insurance policy.
786 [~~(83)~~] (89) "Participating" means a plan of insurance under which the insured is entitled
787 to receive dividends representing shares of the surplus of the insurer.
788 (90) "Participation," as used in a health benefit plan, means a requirement relating to the
789 minimum percentage of eligible employees that must be enrolled in relation to the total number
790 of eligible employees of an employer reduced by each eligible employee who voluntarily declines
791 coverage under the plan because the employee has other health care insurance coverage.
792 [~~(84)~~] (91) "Person" includes an individual, partnership, corporation, incorporated or
793 unincorporated association, joint stock company, trust, reciprocal, syndicate, or any similar entity
794 or combination of entities acting in concert.
795 (92) "Plan sponsor" is as defined in 29 U.S.C. 1002.
796 (93) "Plan year" means:
797 (a) the year that is designated as the plan year in:
798 (i) the plan document of a group health plan; or
799 (ii) a summary plan description of a group health plan;
800 (b) if the plan document or summary plan description does not designate a plan year or
801 there is no plan document or summary plan description:
802 (i) the year used to determine deductibles or limits;

803 (ii) the policy year, if the plan does not impose deductibles or limits on a yearly basis; or
804 (iii) the employer's taxable year if:
805 (A) the plan does not impose deductibles or limits on a yearly basis; and
806 (B) (I) the plan is not insured; or
807 (II) the insurance policy is not renewed on an annual basis; or
808 (c) in a case not described in Subsection (93)(a) or (b), the calendar year.
809 [(85)] (94) (a) (i) "Policy" means any document, including attached endorsements and
810 riders, purporting to be an enforceable contract, which memorializes in writing some or all of the
811 terms of an insurance contract.
812 (ii) "Policy" includes a service contract issued by:
813 (A) a motor club under Chapter 11, Motor Clubs;
814 (B) a service contract provided under Chapter 6a, Service Contracts; and
815 (C) a corporation licensed under:
816 (I) Chapter 7, Nonprofit Health Service Insurance Corporations; or
817 (II) Chapter 8, Health Maintenance Organizations and Limited Health Plans.
818 (iii) "Policy" does not include:
819 (A) a certificate under a group insurance contract; or
820 (B) a document that does not purport to have legal effect.
821 (b) (i) "Group insurance policy" means a policy covering a group of persons that is issued
822 to a policyholder on behalf of the group, for the benefit of group members who are selected under
823 procedures defined in the policy or in agreements which are collateral to the policy. [This type of]
824 (ii) A group insurance policy may include members of the policyholder's family or
825 dependents.
826 (c) "Blanket insurance policy" means a group policy covering classes of persons without
827 individual underwriting, where the persons insured are determined by definition of the class with
828 or without designating the persons covered.
829 [(86)] (95) "Policyholder" means the person who controls a policy, binder, or oral contract
830 by ownership, premium payment, or otherwise.
831 [(87)] (96) "Policy illustration" means a presentation or depiction that includes
832 nonguaranteed elements of a policy of life insurance over a period of years.
833 [(88)] (97) "Policy summary" means a synopsis describing the elements of a life insurance

834 policy.

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

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

838 (i) the enrollment date; or

839 (ii) the effective date of coverage; or

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

842 [~~(89)~~] (99) (a) "Premium" means the monetary consideration for an insurance policy, and
843 includes assessments, membership fees, required contributions, or monetary consideration,
844 however designated.

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

848 [~~(90)~~] (100) "Principal officers" of a corporation means the officers designated under
849 Subsection 31A-5-203(3).

850 [~~(91)~~] (101) "Proceedings" includes actions and special statutory proceedings.

851 [~~(92)~~] (102) "Professional liability insurance" means insurance against legal liability
852 incident to the practice of a profession and provision of any professional services.

853 [~~(93)~~] (103) "Property insurance" means insurance against loss or damage to real or
854 personal property of every kind and any interest in that property, from all hazards or causes, and
855 against loss consequential upon the loss or damage including vehicle comprehensive and vehicle
856 physical damage coverages, but excluding inland marine insurance and ocean marine insurance
857 as defined under Subsections [~~(57)~~] (61) and [~~(80)~~] (86).

858 [~~(94)~~] (104) (a) "Public agency insurance mutual" means any entity formed by joint
859 venture or interlocal cooperation agreement by two or more political subdivisions or public
860 agencies of the state for the purpose of providing insurance coverage for the political subdivisions
861 or public agencies.

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

865 subdivision of the state.
866 [~~(95)~~] (105) "Qualified long-term care insurance contract" or "federally tax qualified
867 long-term care insurance contract" means:
868 (a) an individual or group insurance contract that meets the requirements of Section
869 7702B(b), Internal Revenue Code; or
870 (b) the portion of a life insurance contract that provides long-term care insurance:
871 (i) (A) by rider; or
872 (B) as a part of the contract; and
873 (ii) that satisfies the requirements of Section 7702B(b) and (e), Internal Revenue Code.
874 [~~(96)~~] (106) (a) "Rate" means:
875 (i) the cost of a given unit of insurance; or
876 (ii) for property-casualty insurance, that cost of insurance per exposure unit either
877 expressed as:
878 (A) a single number; or
879 (B) a pure premium rate, adjusted before any application of individual risk variations based
880 on loss or expense considerations to account for the treatment of:
881 (I) expenses;
882 (II) profit; and
883 (III) individual insurer variation in loss experience.
884 (b) "Rate" does not include a minimum premium.
885 [~~(97)~~] (107) (a) Except as provided in Subsection [~~(97)~~] (107)(b), "rate service
886 organization" means any person who assists insurers in rate making or filing by:
887 (i) collecting, compiling, and furnishing loss or expense statistics;
888 (ii) recommending, making, or filing rates or supplementary rate information; or
889 (iii) advising about rate questions, except as an attorney giving legal advice.
890 (b) "Rate service organization" does not mean:
891 (i) an employee of an insurer;
892 (ii) a single insurer or group of insurers under common control;
893 (iii) a joint underwriting group; or
894 (iv) a natural person serving as an actuarial or legal consultant.
895 [~~(98)~~] (108) "Rating manual" means any of the following used to determine initial and

896 renewal policy premiums:
897 (a) a manual of rates;
898 (b) classifications;
899 (c) rate-related underwriting rules; and
900 (d) rating formulas that describe steps, policies, and procedures for determining initial and
901 renewal policy premiums.
902 [~~(99)~~] (109) "Received by the department" means:
903 (a) except as provided in Subsection [~~(99)~~] (109)(b), the date delivered to and stamped
904 received by the department, whether delivered:
905 (i) in person;
906 (ii) by a delivery service; or
907 (iii) electronically; and
908 (b) if an item with a department imposed deadline is delivered to the department by a
909 delivery service, the delivery service's postmark date or pick-up date unless otherwise stated in:
910 (i) statute;
911 (ii) rule; or
912 (iii) a specific filing order.
913 [~~(100)~~] (110) "Reciprocal" or "interinsurance exchange" means any unincorporated
914 association of persons:
915 (a) operating through an attorney-in-fact common to all of them; and
916 (b) exchanging insurance contracts with one another that provide insurance coverage on
917 each other.
918 [~~(101)~~] (111) "Reinsurance" means an insurance transaction where an insurer, for
919 consideration, transfers any portion of the risk it has assumed to another insurer. In referring to
920 reinsurance transactions, this title sometimes refers to:
921 (a) the insurer transferring the risk as the "ceding insurer"; and
922 (b) the insurer assuming the risk as the:
923 (i) "assuming insurer"; or
924 (ii) "assuming reinsurer."
925 [~~(102)~~] (112) "Residential dwelling liability insurance" means insurance against liability
926 resulting from or incident to the ownership, maintenance, or use of a residential dwelling that is

927 a detached single family residence or multifamily residence up to four units.

928 [~~(103)~~] (113) "Retrocession" means reinsurance with another insurer of a liability assumed
929 under a reinsurance contract. A reinsurer "retrocedes" when it reinsures with another insurer part
930 of a liability assumed under a reinsurance contract.

931 [~~(104)~~] (114) "Rider" means an endorsement to:

932 (a) an insurance policy; or

933 (b) an insurance certificate.

934 [~~(105)~~] (115) (a) "Security" means any:

935 (i) note;

936 (ii) stock;

937 (iii) bond;

938 (iv) debenture;

939 (v) evidence of indebtedness;

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

941 (vii) collateral-trust certificate;

942 (viii) preorganization certificate or subscription;

943 (ix) transferable share;

944 (x) investment contract;

945 (xi) voting trust certificate;

946 (xii) certificate of deposit for a security;

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

949 (xiv) commodity contract or commodity option;

950 (xv) any certificate of interest or participation in, temporary or interim certificate for,
951 receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed in
952 Subsections [~~(105)~~] (115)(a)(i) through (xiv); or

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

954 (b) "Security" does not include:

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

958 (ii) a burial certificate or burial contract.

959 [(106)] (116) "Self-insurance" means any arrangement under which a person provides for
960 spreading its own risks by a systematic plan.

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

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

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

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

971 [(107)] (117) "Short-term care insurance" means any insurance policy or rider advertised,
972 marketed, offered, or designed to provide coverage that is similar to long-term care insurance but
973 that provides coverage for less than 12 consecutive months for each covered person.

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

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

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

979 [(108)] (119) (a) "Subsidiary" of a person means an affiliate controlled by that person
980 either directly or indirectly through one or more affiliates or intermediaries.

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

984 [(109)] (120) Subject to Subsection [(59)] (63)(b), "surety insurance" includes:

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

987 (b) bail bond insurance; and

988 (c) fidelity insurance.

989 [~~(110)~~] (121) (a) "Surplus" means the excess of assets over the sum of paid-in capital and
990 liabilities.
991 (b) (i) "Permanent surplus" means the surplus of a mutual insurer that has been designated
992 by the insurer as permanent.
993 (ii) Sections 31A-5-211, 31A-7-201, 31A-8-209, 31A-9-209, and 31A-14-209 require that
994 mutuals doing business in this state maintain specified minimum levels of permanent surplus.
995 (iii) Except for assessable mutuals, the minimum permanent surplus requirement is
996 essentially the same as the minimum required capital requirement that applies to stock insurers.
997 (c) "Excess surplus" means:
998 (i) for life or accident and health insurers, health organizations, and property and casualty
999 insurers as defined in Section 31A-17-601, the lesser of:
1000 (A) that amount of an insurer's or health organization's total adjusted capital, as defined
1001 in Subsection [~~(113)~~] (124), that exceeds the product of:
1002 (I) 2.5; and
1003 (II) the sum of the insurer's or health organization's minimum capital or permanent surplus
1004 required under Section 31A-5-211, 31A-9-209, or 31A-14-205; or
1005 (B) that amount of an insurer's or health organization's total adjusted capital, as defined
1006 in Subsection [~~(113)~~] (124), that exceeds the product of:
1007 (I) 3.0; and
1008 (II) the authorized control level RBC as defined in Subsection 31A-17-601(8)(a); and
1009 (ii) for monoline mortgage guaranty insurers, financial guaranty insurers, and title insurers,
1010 that amount of an insurer's paid-in-capital and surplus that exceeds the product of:
1011 (A) 1.5; and
1012 (B) the insurer's total adjusted capital required by Subsection 31A-17-609(1).
1013 [~~(111)~~] (122) "Third party administrator" or "administrator" means any person who
1014 collects charges or premiums from, or who, for consideration, adjusts or settles claims of residents
1015 of the state in connection with insurance coverage, annuities, or service insurance coverage,
1016 except:
1017 (a) a union on behalf of its members;
1018 (b) a person administering any:
1019 (i) pension plan subject to the federal Employee Retirement Income Security Act of 1974;

1020 (ii) governmental plan as defined in Section 414(d), Internal Revenue Code; or
1021 (iii) nonelecting church plan as described in Section 410(d), Internal Revenue Code;
1022 (c) an employer on behalf of the employer's employees or the employees of one or more
1023 of the subsidiary or affiliated corporations of the employer;
1024 (d) an insurer licensed under Chapter 5, 7, 8, 9, or 14, but only for a line of insurance for
1025 which the insurer holds a license in this state; or
1026 (e) a person licensed or exempt from licensing under Chapter 23 or 26 whose activities are
1027 limited to those authorized under the license the person holds or for which the person is exempt.
1028 [~~(112)~~] (123) "Title insurance" means the insuring, guaranteeing, or indemnifying of
1029 owners of real or personal property or the holders of liens or encumbrances on that property, or
1030 others interested in the property against loss or damage suffered by reason of liens or
1031 encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity or
1032 unenforceability of any liens or encumbrances on the property.
1033 [~~(113)~~] (124) "Total adjusted capital" means the sum of an insurer's or health
1034 organization's statutory capital and surplus as determined in accordance with:
1035 (a) the statutory accounting applicable to the annual financial statements required to be
1036 filed under Section 31A-4-113; and
1037 (b) any other items provided by the RBC instructions, as RBC instructions is defined in
1038 Section 31A-17-601.
1039 [~~(114)~~] (125) (a) "Trustee" means "director" when referring to the board of directors of a
1040 corporation.
1041 (b) "Trustee," when used in reference to an employee welfare fund, means an individual,
1042 firm, association, organization, joint stock company, or corporation, whether acting individually
1043 or jointly and whether designated by that name or any other, that is charged with or has the overall
1044 management of an employee welfare fund.
1045 [~~(115)~~] (126) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted insurer"
1046 means an insurer:
1047 (i) not holding a valid certificate of authority to do an insurance business in this state; or
1048 (ii) transacting business not authorized by a valid certificate.
1049 (b) "Admitted insurer" or "authorized insurer" means an insurer:
1050 (i) holding a valid certificate of authority to do an insurance business in this state; and

1051 (ii) transacting business as authorized by a valid certificate.
1052 [(116)] (127) "Vehicle liability insurance" means insurance against liability resulting from
1053 or incident to ownership, maintenance, or use of any land vehicle or aircraft, exclusive of vehicle
1054 comprehensive and vehicle physical damage coverages under Subsection [(93)] (103).
1055 [(117)] (128) "Voting security" means a security with voting rights, and includes any
1056 security convertible into a security with a voting right associated with it.
1057 [(118)] (129) "Workers' compensation insurance" means:
1058 (a) insurance for indemnification of employers against liability for compensation based
1059 on:
1060 (i) compensable accidental injuries; and
1061 (ii) occupational disease disability;
1062 (b) employer's liability insurance incidental to workers compensation insurance and written
1063 in connection with it; and
1064 (c) insurance assuring to the persons entitled to workers compensation benefits the
1065 compensation provided by law.
1066 Section 3. Section **31A-2-204** is amended to read:
1067 **31A-2-204. Conducting examinations.**
1068 (1) (a) For each examination under Section 31A-2-203, the commissioner shall issue an
1069 order:
1070 (i) stating the scope of the examination; and
1071 (ii) designating the examiner in charge.
1072 (b) The commissioner need not give advance notice of an examination to an examinee.
1073 (c) The examiner in charge shall give the examinee a copy of the order issued under this
1074 Subsection (1).
1075 (d) (i) The commissioner may alter the scope or nature of [the] an examination at any time
1076 without advance notice to the examinee [but].
1077 (ii) If the commissioner amends an order described in this Subsection (1), the
1078 commissioner shall provide a copy of any amended order to the examinee.
1079 (e) Statements in the commissioner's examination order concerning examination scope are
1080 for the examiner's guidance only.
1081 (f) Examining relevant matters not mentioned in [the] an order issued under this

1082 Subsection (1) is not a violation of this title.
1083 (2) The commissioner shall, whenever practicable, cooperate with the insurance regulators
1084 of other states by conducting joint examinations of multistate insurers doing business in this state.
1085 (3) An examiner authorized by the commissioner shall, when necessary to the purposes
1086 of the examination, have access at all reasonable hours to the premises and to any books, records,
1087 files, securities, documents, or property of:
1088 (a) the examinee; and [to those of]
1089 (b) any of the following if the premises, books, records, files, securities, documents, or
1090 property relate to the affairs of the examinee:
1091 (i) an officer [or] of the examinee;
1092 (ii) any other person who:
1093 (A) has executive authority over the examinee; or
1094 (B) is in charge of any segment of the examinee's affairs[,]; or [of]
1095 (iii) any affiliate of the examinee under Subsection 31A-2-203 (1)(b)[, if they relate to the
1096 affairs of the examinee].
1097 (4) (a) The officers, employees, and agents of the examinee and of persons under
1098 Subsection 31A-2-203(1)(b) shall comply with every reasonable request of the examiners for
1099 assistance in any matter relating to the examination. [No]
1100 (b) A person may not obstruct or interfere with the examination except by legal process.
1101 (5) If the commissioner finds the accounts or records to be inadequate for proper
1102 examination of the condition and affairs of the examinee or improperly kept or posted, the
1103 commissioner may employ experts to rewrite, post, or balance the accounts or records at the
1104 expense of the examinee.
1105 (6) (a) The examiner in charge of an examination shall make a report of the examination
1106 no later than 60 days after the completion of the examination that shall include:
1107 (i) the information and analysis ordered under Subsection (1)[, together with]; and
1108 (ii) the examiner's recommendations.
1109 (b) At the option of the examiner in charge, preparation of the report may include
1110 conferences with the examinee or [its] representatives of the examinee.
1111 (c) The report is confidential until [it] the report becomes a public document under
1112 Subsection (7), [but] except the commissioner may use information from the report as a basis for

1113 action under Chapter 27, Insurers Rehabilitation and Liquidation.
1114 (7) (a) The commissioner shall serve a copy of the examination report described in
1115 Subsection (6) upon the examinee.
1116 (b) Within 20 days after service, the examinee shall [either]:
1117 (i) accept the examination report as written; or
1118 (ii) request agency action to modify the examination report.
1119 (c) The report is considered accepted under this Subsection (7) if the examinee does not
1120 file a request for agency action to modify the report within 20 days after service of the report.
1121 (d) If the examination report is accepted[, it]:
1122 (i) the examination report immediately becomes a public document; and
1123 (ii) the commissioner shall distribute [it] the examination report to all jurisdictions in
1124 which the examinee is authorized to do business.
1125 (e) (i) Any adjudicative proceeding held as a result of the examinee's request for agency
1126 action shall, upon the examinee's demand, be closed to the public, [but] except that the
1127 commissioner need not exclude any participating examiner from this closed hearing.
1128 (ii) Within 20 days after the hearing held under this Subsection (7)(e), the commissioner
1129 shall:
1130 (A) adopt the examination report with any necessary modifications; and
1131 (B) serve a copy of the adopted report upon the examinee. [The]
1132 (iii) Unless the examinee seeks judicial relief, the adopted examination report:
1133 (A) shall become a public document ten days after service[,]; and
1134 (B) may be distributed as described in this section[, unless the examinee seeks judicial
1135 relief].
1136 (8) The examinee shall promptly furnish copies of the adopted examination report
1137 described in Subsection (7) to each member of [its] the examinee's board.
1138 (9) [The] After an examination report becomes a public document under Subsection (7),
1139 the commissioner may furnish, without cost or at a reasonable price set under Section 31A-3-103,
1140 a copy of the examination report to interested persons, including:
1141 (a) a member of the board of the examinee; or
1142 (b) one or more newspapers in this state[, after the report becomes a public document
1143 under Subsection (7)].

1144 (10) (a) In a proceeding by or against the examinee, or any officer or agent of the
1145 examinee, the examination report as adopted by the commissioner is admissible as evidence of the
1146 facts stated in the report.
1147 (b) In any proceeding commenced under Chapter 27, Insurers Rehabilitation and
1148 Liquidation, the examination report, whether adopted by the commissioner or not, is admissible
1149 as evidence of the facts stated in [it] the examination report.
1150 Section 4. Section **31A-3-103** is amended to read:
1151 **31A-3-103. Fees.**
1152 (1) [The fees] For purposes of this section:
1153 (a) "Regulatory fee" is as defined in Section 63-38-3.2.
1154 (b) "Services" means functions that are reasonable and necessary to enable the
1155 commissioner to perform the duties imposed by this title including:
1156 (i) issuing and renewing licenses and certificates of authority;
1157 (ii) filing policy forms;
1158 (iii) reporting agent appointments and terminations; and
1159 (iv) filing annual statements.
1160 (c) Fees related to the renewal of licenses may be imposed no more frequently than once
1161 each year.
1162 (2) (a) A regulatory fee charged by the department shall be set in accordance with Section
1163 63-38-3.2.
1164 (b) Fees shall be set and collected for services provided by the department.
1165 (3) (a) For a fee authorized by this chapter that is not a regulatory fee, the department may
1166 adopt a schedule of fees provided that each fee in the schedule of fees is:
1167 (i) reasonable and fair; and
1168 (ii) submitted to the Legislature as part of the department's annual appropriations request.
1169 (b) If a fee schedule described in Subsection (3)(a) is submitted as part of the department's
1170 annual appropriations request, the Legislature may, in a manner substantially similar to Section
1171 63-38-3.2:
1172 (i) approve any fee in the fee schedule;
1173 (ii) (A) increase or decrease any fee in the fee schedule; and
1174 (B) approve any fee in the fee schedule as changed by the Legislature; or

1175 (iii) reject any fee in the fee schedule.
1176 (c) A fee approved by the Legislature pursuant to this Subsection (3) shall be deposited
1177 into the General Fund as a dedicated credit to be used by the department to provide services
1178 through use of electronic commerce or other similar technology.
1179 [(2)] (4) The commissioner shall separately publish the schedule of fees approved by the
1180 Legislature and make it available upon request for $1 per copy. This fee schedule shall also be
1181 included in any compilation of rules promulgated by the commissioner.
1182 [~~(3) (a) Fees shall be set and collected for services provided by the department. "Services"~~
1183 ~~include issuing and renewing licenses and certificates of authority, filing policy forms, reporting~~
1184 ~~agent appointments and terminations, filing annual statements, and other functions that are~~
1185 ~~reasonable and necessary to enable the commissioner to perform the duties imposed by the~~
1186 ~~Insurance Code.~~]
1187 [~~(b) Fees related to the renewal of licenses may be imposed no more frequently than once~~
1188 ~~each year.~~]
1189 [~~(4)~~] (5) The commissioner shall, by rule, establish the deadlines for payment of [~~each of~~
1190 ~~the various fees~~] any fee established by the department in accordance with this section.
1191 Section 5. Section **31A-3-104** is enacted to read:
1192 **31A-3-104. Electronic commerce dedicated fees.**
1193 (1) The department may charge a fee for requests for information:
1194 (a) that is obtained from an electronic database of the department; or
1195 (b) derived from data that is generated by electronic means.
1196 (2) In addition to any fee authorized in this title, the department shall impose a
1197 supplemental fee on the issuance or renewal of any of the following issued by the department:
1198 (a) a license;
1199 (b) a registration; or
1200 (c) a certificate of authority.
1201 (3) A fee imposed under this section shall be:
1202 (a) established in accordance with Subsection 31A-3-103(3); and
1203 (b) deposited into the General Fund as a dedicated credit in accordance with Subsection
1204 31A-3-103(3).
1205 (4) In accordance with Section 63-55-231, this section is repealed on July 1, 2006.

1206 Section 6. Section **31A-3-401** is amended to read:

1207 **31A-3-401. Retaliation against insurers of foreign state or country.**

1208 (1) Except as provided in Section 31A-3-402, when, under the laws of another state or
1209 foreign country any taxes, licenses, other fees, deposit requirements, or other material obligations,
1210 prohibitions, or restrictions are or would be imposed on Utah insurers, or on the agents or
1211 representatives of Utah insurers, [~~which~~] that are in excess of the taxes, licenses, other fees, deposit
1212 requirements, or other obligations, prohibitions, or restrictions directly imposed upon similar
1213 insurers, or upon the agents or representatives of those insurers, of that other state or country under
1214 the statutes of this state, as long as the laws of that other state or country continue in force or are
1215 so applied, the same taxes, licenses, other fees, deposit requirements, or other material obligations,
1216 prohibitions, or restrictions of any kind shall be imposed, collected, and enforced by the State Tax
1217 Commission, with the assistance of the commissioner, upon the insurers, or upon the agents or
1218 representatives of those insurers, of that other state or country doing business or seeking to do
1219 business in this state.

1220 (2) Any tax, license, or other obligation imposed by any city, county, or other political
1221 subdivision or agency of another state or country on Utah insurers, their agents, or representatives
1222 is considered as being imposed by that state or country within the meaning of this section.

1223 (3) The commissioner may by rule waive the retaliatory requirements for [~~an individual~~
1224 ~~or agency licensee~~] a person that is:

1225 (a) doing business in this state; or

1226 (b) seeking to do business in this state.

1227 Section 7. Section **31A-4-115** is amended to read:

1228 **31A-4-115. Plan of orderly withdrawal.**

1229 (1) (a) When an insurer intends to withdraw from writing a line of insurance in this state
1230 or to reduce its total annual premium volume by 75% or more, [~~it~~] the insurer shall file with the
1231 commissioner a plan of orderly withdrawal.

1232 (b) For purposes of this section, a nonrenewal pursuant to one of the following provisions
1233 is a withdrawal from a line of insurance:

1234 (i) Subsection 31A-30-107(3)(e); or

1235 (ii) Subsection 31A-30-107.1(3)(e).

1236 (2) An insurer's plan of orderly withdrawal shall:

1237 (a) indicate the date the insurer intends to begin and complete its withdrawal plan; and
1238 (b) include provisions for:
1239 (i) meeting the insurer's contractual obligations;
1240 (ii) providing services to its Utah policyholders and claimants; [~~and~~]
1241 (iii) meeting any applicable statutory obligations[~~.~~]; and
1242 (iv) (A) the payment of a withdrawal fee of $50,000 to the Utah Comprehensive Health
1243 Insurance Pool if:
1244 (I) the insurer is an accident and health insurer; and
1245 (II) the insurer's line of business is not assumed or placed with another insurer approved
1246 by the commissioner; or
1247 (B) the payment of a withdrawal fee of $50,000 to the department if:
1248 (I) the insurer is not an accident and health insurer; and
1249 (II) the insurer's line of business is not assumed or placed with another insurer approved
1250 by the commissioner.
1251 (3) The commissioner shall approve a plan of orderly withdrawal if [~~it~~] the plan adequately
1252 demonstrates that the insurer will:
1253 (a) protect the interests of the people of the state;
1254 (b) meet [~~its~~] the insurer's contractual obligations;
1255 (c) provide service to [~~its~~] the insurer's Utah policyholders and claimants; and
1256 (d) meet any applicable statutory obligations.
1257 (4) Section 31A-2-302 governs the commissioner's approval or disapproval of a plan for
1258 orderly withdrawal.
1259 (5) The commissioner may require an insurer to increase the deposit maintained in
1260 accordance with Section 31A-4-105 or Section 31A-4-105.5 and place the deposit in trust in the
1261 name of the commissioner upon finding, after an adjudicative proceeding that:
1262 (a) there is reasonable cause to conclude that the interests of the people of the state are best
1263 served by such action; and
1264 (b) the insurer:
1265 (i) has filed a plan of orderly withdrawal; or
1266 (ii) intends to:
1267 (A) withdraw from writing a line of insurance in this state; or

1268 (B) reduce [its] the insurer's total annual premium volume by 75% or more.
1269 (6) An insurer [that] is subject to the civil penalties under Section 31A-2-308, if the
1270 insurer:
1271 (a) (i) withdraws from writing insurance in this state; or [that]
1272 (ii) reduces its total annual premium volume by 75% or more in any year without having
1273 submitted a plan or receiving the commissioner's approval [is subject to the civil penalties under
1274 Section 31A-2-308].
1275 (7) An insurer that withdraws from writing all lines of insurance in this state may not
1276 resume writing insurance in this state for five years [without] unless:
1277 (a) [the approval of] the commissioner finds that the prohibition should be waived because
1278 the waiver is:
1279 (i) in the public interest to promote competition; or
1280 (ii) to resolve inequity in the marketplace; and
1281 (b) [complying] the insurer complies with Subsection 31A-30-108(5), if applicable.
1282 (8) The commissioner shall adopt rules necessary to implement [the provisions of] this
1283 section.
1284 Section 8. Section **31A-5-405** is amended to read:
1285 **31A-5-405. Meetings of mutuals and mutual policyholders' and members' voting**
1286 **rights.**
1287 (1) (a) Subject to this section, Sections 16-6a-701, 16-6a-702, 16-6a-704, and 16-6a-714
1288 apply to the meetings of members, the notice, and the voting in mutuals.
1289 (b) Subject to this section and Section 31A-5-409, Section 16-6a-711 applies to the voting
1290 of members of mutuals.
1291 (2) (a) Policyholders or voting members in all mutuals have the right to vote on:
1292 (i) conversion[,];
1293 (ii) voluntary dissolution[,];
1294 (iii) amendment of the articles[,]; and
1295 (iv) the election of directors except public directors appointed [under Subsection] in
1296 accordance with Subsections 31A-5-409(1) and (2).
1297 (b) The mutual may adopt reasonable provisions in its bylaws to determine:
1298 (i) which individual among joint policyholders may exercise a voting right; and

1299 (ii) how to deal with cases where the same individual is one of several joint policyholders
1300 in various policies.
1301 [~~(b)~~] (c) The articles of any mutual may give the policyholders or voting members
1302 additional voting rights. These articles may require a greater percentage of affirmative votes to
1303 approve an action than the statutes require.
1304 (3) (a) The articles or bylaws shall contain rules governing voting procedures and voting
1305 eligibility consistent with Subsection (1). [~~No~~]
1306 (b) An amendment to [~~these rules~~] a rule described in this Subsection (3) is not effective
1307 until at least 30 days after [~~it~~] the rule has been filed with the commissioner.
1308 (4) (a) The articles or bylaws may provide for regular or special meetings of the
1309 policyholders or voting members, and, if meetings are not provided for, then mail elections shall
1310 be provided for in lieu of elections at meetings.
1311 (b) Notice of the time and place of regular meetings or elections shall be given to each
1312 policyholder or voting member in a reasonable manner as the commissioner approves or requires.
1313 Changes may be made by written notice mailed, properly addressed, and stamped, to the
1314 last-known address of all policyholders or voting members.
1315 (5) (a) The articles may provide that representatives or delegates selected by the
1316 policyholders or voting members shall be from specific geographical districts or defined classes
1317 of policyholders or voting members, as determined on a reasonable basis.
1318 (b) After the representative assembly has been selected by the policyholder or voting
1319 members, the assembly or the respective classes of policyholders or voting members may choose
1320 replacements for members unable to complete their terms, if the articles provide for their
1321 replacement.
1322 (c) The vote of a person holding a valid proxy is treated as the vote of the policyholders
1323 or voting members who gave the proxy.
1324 Section 9. Section **31A-5-409** is amended to read:
1325 **31A-5-409. Selection and removal of directors and officers of mutuals.**
1326 (1) The articles or bylaws of a mutual [~~may provide that any~~] shall state:
1327 (a) the number of directors of the mutual including the directors that are:
1328 (i) appointed as public directors under this Subsection (1) and Subsection (2); or
1329 (ii) elected under Subsection (3);

1330 (b) the number of [the] directors [are] of the mutual that may be appointed as public
1331 directors [chosen under a plan proposed by the corporation and approved by the commissioner.];
1332 and
1333 (c) the plan specifying the manner in which:
1334 (i) a public director is to be appointed; and
1335 (ii) a director who is not a public director is to be elected.
1336 (2) (a) The plan for the appointment of public directors specified in Subsection (1) shall
1337 assure true public representation on the board. [The persons nominated as directors]
1338 (b) A person appointed as a public director shall have insurance business or [general] other
1339 business or professional experience that qualifies [them] that person to serve responsibly and
1340 impartially as a director.
1341 (c) A public director may be an uncompensated member of the board of directors.
1342 (d) Notwithstanding Subsection (2)(c), a public director shall meet the qualifications of
1343 Subsection (2)(b).
1344 [(2)] (3) (a) [Directors not chosen under Subsection (1) are] A director who is not a public
1345 director shall be elected by:
1346 (i) the policyholders; or
1347 (ii) voting members.
1348 (b) If the directors who are not public directors are divided into classes, one class shall be
1349 elected:
1350 (i) at least every four years[,]; and
1351 (ii) for a term not exceeding six years.
1352 [(3)] (4) A director may be removed from office for cause by an affirmative vote of a
1353 majority of the full board at a meeting of the board called for that purpose.
1354 [(4)] (5) Subject to Subsections (1)[, (2), and (3)] through (4), Section 16-6a-810 applies
1355 to vacancies on the governing board.
1356 Section 10. Section **31A-5-410** is amended to read:
1357 **31A-5-410. Supervision of management changes.**
1358 (1) (a) [The] Immediately after the selection of a person as a director or principal officer,
1359 the insurer shall report to the commissioner:
1360 (i) the name of [a] the person selected as a director or principal officer of a corporation[,

1361 together with]; and
1362 (ii) pertinent biographical and other data that the commissioner requires by rule[, shall be
1363 reported to the commissioner immediately after the selection].
1364 (b) For five years after the initial issuance of a certificate of authority to a corporation, the
1365 commissioner may, within 30 days after receipt of a report under Subsection (1)(a), disapprove any
1366 person selected who fails to satisfy the commissioner that [he] the person:
1367 (i) is trustworthy; and
1368 (ii) has the competence and experience necessary to discharge [his] that person's
1369 responsibilities.
1370 (2) (a) Whenever a director or principal officer of a corporation is removed under [Section
1371 16-10a-808 or 16-10a-832, Subsections 16-6a-820(4) and 31A-5-409(3),] a provision listed in
1372 Subsection (2)(b), the insurer shall immediately report to the commissioner:
1373 (i) the removal [shall be reported to the commissioner immediately, together with]; and
1374 (ii) a statement of the reasons for the removal.
1375 (b) Subsection (2)(a) applies to a removal under:
1376 (i) Subsection 16-6a-820(4);
1377 (ii) Section 16-10a-808;
1378 (iii) Section 16-10a-832; and
1379 (iv) Subsection 31A-5-409(4).
1380 (3) [If] The commission may order the removal of a director or officer if the commissioner
1381 finds, after a hearing, that:
1382 (a) a director or officer:
1383 (i) is incompetent [or];
1384 (ii) untrustworthy[, or];
1385 (iii) is not qualified under Section 31A-5-409; or
1386 (iv) has wilfully violated:
1387 (A) this [code,] title;
1388 (B) a rule adopted under Subsection 31A-2-201(3)[,]; or
1389 (C) an order issued under Subsection 31A-2-201(4)[,]; and [that the incompetence,
1390 untrustworthiness, or the violation]
1391 (b) the circumstances described in Subsection (3)(a) endangers the interests of:

1392 (i) insureds; or
1393 (ii) the public[, he may order the removal of the director or officer].
1394 Section 11. Section **31A-8-101** is amended to read:
1395 **31A-8-101. Definitions.**
1396 For purposes of this chapter:
1397 (1) "Basic health care services" means:
1398 (a) emergency care;
1399 (b) inpatient hospital and physician care;
1400 (c) outpatient medical services; and
1401 (d) out-of-area coverage.
1402 (2) "Director of health" means:
1403 (a) the executive director of the Department of Health; or [his]
1404 (b) the authorized representative of the executive director of the Department of Health.
1405 (3) "Enrollee" means an individual:
1406 (a) who has entered into a contract with an organization for health care; or
1407 (b) in whose behalf an arrangement for health care has been made.
1408 (4) "Health care" is as defined in Section 31A-1-301.
1409 (5) "Health maintenance organization" means any person:
1410 (a) other than:
1411 (i) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance Corporations;
1412 or
1413 (ii) an individual who contracts to render professional or personal services that the
1414 individual directly performs; and
1415 (b) that:
1416 (i) furnishes at a minimum, either directly or through arrangements with others, basic
1417 health care services to an enrollee in return for prepaid periodic payments agreed to in amount
1418 prior to the time during which the health care may be furnished; and
1419 (ii) is obligated to the enrollee to arrange for or to directly provide available and accessible
1420 health care.
1421 (6) (a) "Limited health plan" means, except as limited under Subsection (6)(b), any person
1422 who furnishes, either directly or through arrangements with others, services:

1423 (i) of:
1424 (A) dentists;
1425 (B) optometrists;
1426 (C) physical therapists;
1427 (D) podiatrists;
1428 (E) psychologists;
1429 (F) physicians;
1430 (G) chiropractic physicians;
1431 (H) naturopathic physicians;
1432 (I) osteopathic physicians;
1433 (J) social workers;
1434 (K) family counselors;
1435 (L) other health care providers; or
1436 (M) reasonable combinations of the services described in this Subsection [~~(1)~~] (6)(a)(i);
1437 (ii) to an enrollee;
1438 (iii) in return for prepaid periodic payments agreed to in amount prior to the time during
1439 which the services may be furnished; and
1440 (iv) for which the person is obligated to the enrollee to arrange for or directly provide the
1441 available and accessible [~~the~~] services described in this Subsection (6)(a).
1442 (b) "Limited health plan" does not include:
1443 (i) a health maintenance organization;
1444 (ii) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance Corporations;
1445 or
1446 (iii) an individual who contracts to render professional or personal services that [~~he~~] the
1447 individual performs [~~himself~~].
1448 (7) (a) "Nonprofit organization" or "nonprofit corporation" means an organization no part
1449 of the income of which is distributable to its members, trustees, or officers, or a nonprofit
1450 cooperative association, except in a manner allowed under Section 31A-8-406.
1451 (b) "Nonprofit health maintenance organization" and "nonprofit limited health plan" are
1452 used when referring specifically to one of the types of organizations with "nonprofit" status.
1453 (8) "Organization" means a health maintenance organization and limited health plan,

1454 unless used in the context of:
1455 (a) "organization permit," [in] which [case see] is described in Sections 31A-8-204 and
1456 31A-8-206; or
1457 (b) "organization expenses," [in] which [case see] is described in Section 31A-8-208.
1458 (9) "Participating provider" means a provider as defined in Subsection (10) who, under a
1459 contract with the health maintenance organization, [has agreed] agrees to provide health care
1460 services to enrollees with an expectation of receiving payment, directly or indirectly, from the
1461 health maintenance organization, other than copayment.
1462 (10) "Provider" means any person who:
1463 (a) furnishes health care directly to the enrollee; and [who]
1464 (b) is licensed or otherwise authorized to furnish [this] the health care in this state.
1465 (11) "Uncovered expenditures" means the costs of health care services that are covered by
1466 an organization for which an enrollee is liable in the event of the organization's insolvency.
1467 (12) "Unusual or infrequently used health services" means those health services [which]
1468 that are projected to involve fewer than 10% of the organization's enrollees' encounters with
1469 providers, measured on an annual basis over the organization's entire enrollment.
1470 Section 12. Section **31A-8-103** is amended to read:
1471 **31A-8-103. Applicability to other provisions of law.**
1472 (1) (a) Except for exemptions specifically granted under this title, an organization is
1473 subject to regulation under all of the provisions of this title.
1474 (b) Notwithstanding any provision of this title, an organization licensed under this chapter:
1475 (i) is wholly exempt from [Chapters]:
1476 (A) Chapter 7,[9, 10, 11, 12, 13, 19, and 28] Nonprofit Health Service Insurance
1477 Corporations;
1478 (B) Chapter 9, Insurance Fraternals;
1479 (C) Chapter 10, Annuities;
1480 (D) Chapter 11, Motor Clubs;
1481 (E) Chapter 12, State Risk Management Fund;
1482 (F) Chapter 13, Employee Welfare Funds and Plans;
1483 (G) Chapter 19a, Utah Rate Regulation Act; and
1484 (H) Chapter 28, Guaranty Associations; and

1485 (ii) not subject to:
1486 [(i)] (A) Chapter 3, Department Funding, Fees, and Taxes, except for Part I;
1487 [(ii)] (B) Section 31A-4-107;
1488 [(iii)] (C) Chapter 5, Domestic Stock and Mutual Insurance Corporations, except for
1489 provisions specifically made applicable by this chapter;
1490 [(iv)] (D) Chapter 14, Foreign Insurers, except for provisions specifically made applicable
1491 by this chapter;
1492 [(v)] (E) Chapter 17, Determination of Financial Condition, except:
1493 [(A) Part] (I) Parts II and VI; or
1494 [(B)] (II) as made applicable by the commissioner by rule consistent with this chapter;
1495 (vi) Chapter 18, Investments, except as made applicable by the commissioner by rule
1496 consistent with this chapter; and
1497 (vii) Chapter 22, Contracts in Specific Lines, except for Parts VI, VII, and XII.
1498 (2) The commissioner may by rule waive other specific provisions of this title that the
1499 commissioner considers inapplicable to health maintenance organizations or limited health plans,
1500 upon a finding that the waiver will not endanger the interests of:
1501 (a) enrollees;
1502 (b) investors; or
1503 (c) the public.
1504 (3) Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, and Title 16, Chapter
1505 10a, Utah Revised Business Corporation Act, do not apply to an organization except as specifically
1506 made applicable by:
1507 (a) this chapter;
1508 (b) a provision referenced under this chapter; or
1509 (c) a rule adopted by the commissioner to deal with corporate law issues of health
1510 maintenance organizations that are not settled under this chapter.
1511 (4) (a) Whenever in this chapter, Chapter 5, or Chapter 14 is made applicable to an
1512 organization, the application is:
1513 (i) of those provisions that apply to a mutual corporation if the organization is nonprofit;
1514 and
1515 (ii) of those that apply to a stock corporation if the organization is for profit.

1516 (b) When Chapter 5 or 14 is made applicable to an organization under this chapter,
1517 "mutual" means nonprofit organization.
1518 (5) Solicitation of enrollees by an organization is not a violation of any provision of law
1519 relating to solicitation or advertising by health professionals if that solicitation is made in
1520 accordance with:
1521 (a) this chapter; and
1522 (b) Chapter 23, Insurance Marketing - Licensing Agents, Brokers, Consultants, and
1523 Reinsurance Intermediaries.
1524 (6) [~~Nothing in this title prohibits~~] This title does not prohibit any health maintenance
1525 organization from meeting the requirements of any federal law that enables the health maintenance
1526 organization to:
1527 (a) receive federal funds; or
1528 (b) obtain or maintain federal qualification status.
1529 (7) Except as provided in Section 31A-8-501, an organization is exempt from statutes in
1530 this title or department rules that restrict or limit [~~its~~] the organization's freedom of choice in
1531 contracting with or selecting health care providers, including Section 31A-22-618.
1532 (8) An organization is exempt from the assessment or payment of premium taxes imposed
1533 by Sections 59-9-101 through 59-9-104.
1534 Section 13. Section **31A-8-209** is amended to read:
1535 **31A-8-209. Minimum capital or minimum permanent surplus.**
1536 (1) (a) A health maintenance organization being organized or operating under this chapter
1537 shall have and maintain a minimum capital or minimum permanent surplus of $100,000.
1538 (b) Each health maintenance organization authorized to do business in this state shall have
1539 and maintain qualified assets as defined in Subsection 31A-17-201(2)(b) in an amount not less
1540 than the total of:
1541 (i) the health maintenance organization's liabilities;
1542 (ii) the health maintenance organization's minimum capital or minimum permanent surplus
1543 required by Subsection (1)(a); and
1544 (iii) the greater of:
1545 (A) the company action level RBC as defined in Subsection 31A-17-601(8)(b); or
1546 (B) $1,300,000.

1547 (2) (a) The minimum required capital or minimum permanent surplus for a limited health
1548 plan may not:
1549 (i) [~~is at least~~] be less than $10,000; [~~and~~] or
1550 (ii) [~~may not~~] exceed $100,000.
1551 (b) The initial minimum required capital or minimum permanent surplus for a limited
1552 health plan required by Subsection (2)(a) shall be set by the commissioner, after:
1553 (i) a hearing; and
1554 (ii) consideration of:
1555 (A) the services to be provided by the limited health plan;
1556 (B) the size and geographical distribution of the population the limited health plan
1557 anticipates serving;
1558 (C) the nature of the limited health plan's arrangements with providers; and
1559 (D) the arrangements, agreements, and relationships of the limited health plan in place or
1560 reasonably anticipated with respect to:
1561 (I) insolvency insurance;
1562 (II) reinsurance;
1563 (III) lenders subordinating to the interests of enrollees and trade creditors;
1564 (IV) personal and corporate financial guarantees;
1565 (V) provider withholds and assessments;
1566 (VI) surety bonds;
1567 (VII) hold harmless agreements in provider contracts; and
1568 (VIII) other arrangements, agreements, and relationships impacting the security of
1569 enrollees.
1570 (c) Upon a material change in the scope or nature of a limited health plan's operations, the
1571 commissioner may, after a hearing, alter the limited health plan's minimum required capital or
1572 minimum permanent surplus.
1573 [~~(3) Before beginning operations, a health maintenance organization licensed under this~~
1574 ~~chapter shall have total adjusted capital in excess of the company action level RBC as defined in~~
1575 ~~Subsection 31A-17-601(8)(b).~~]
1576 [~~(4) Each health maintenance organization authorized to do business in this state shall~~
1577 ~~maintain assets in an amount equal to the total of the health maintenance organization's:~~]

1578 [~~(a) liabilities;~~]
1579 [~~(b) minimum capital or minimum permanent surplus required by Subsection (1) or (2);~~
1580 ~~and~~]
1581 [~~(c) the company action level RBC as defined in Subsection 31A-17-601(8)(b).~~]
1582 [~~(5) As a prerequisite to receiving an original certificate of authority to do business in this~~
1583 ~~state, a health maintenance organization shall have initial surplus at least $400,000 in excess of~~
1584 ~~the capital and surplus required by Subsection (4).~~]
1585 [~~(6)~~] (3) The commissioner may allow the minimum capital or permanent surplus account
1586 of an organization to be designated by some other name.
1587 [~~(7)~~] (4) A pattern of persistent deviation from the accounting and investment standards
1588 under this section may be grounds for the commissioner to find that the one or more persons with
1589 authority to make the organization's accounting or investment decisions are incompetent for
1590 purposes of Subsection 31A-5-410(3).
1591 Section 14. Section **31A-8-211** is amended to read:
1592 **31A-8-211. Deposit.**
1593 (1) Except as provided in Subsection (2), each health maintenance organization authorized
1594 in this state shall maintain a deposit with the commissioner under Section 31A-2-206 in an amount
1595 equal to the sum of:
1596 (a) [~~the health maintenance organization's minimum capital or minimum permanent~~
1597 ~~surplus requirement of Subsection 31A-8-209(1) or (2)~~] $100,000; and
1598 (b) 50% of the greater of:
1599 (i) $900,000;
1600 (ii) 2% of the annual premium revenues as reported on the most recent annual financial
1601 statement filed with the commissioner; or
1602 (iii) an amount equal to the sum of three months uncovered health care expenditures as
1603 reported on the most recent financial statement filed with the commissioner.
1604 (2) (a) After a hearing the commissioner may exempt a health maintenance organization
1605 from the deposit requirement of Subsection (1) if:
1606 (i) the commissioner determines that the enrollees' interests are adequately protected;
1607 (ii) the health maintenance organization has been continuously authorized to do business
1608 in this state for at least five years; and

1609 (iii) the health maintenance organization has $5,000,000 surplus in excess of [~~its~~] the
1610 health maintenance organization's company action level RBC as defined in Subsection
1611 31A-17-601(8)(b).
1612 (b) The commissioner may rescind an exemption given under Subsection (2)(a).
1613 (3) (a) Each limited health plan authorized in this state shall maintain a deposit with the
1614 commissioner under Section 31A-2-206 in an amount equal to the minimum capital or permanent
1615 surplus plus 50% of the greater of:
1616 (i) .5 times minimum required capital or minimum permanent surplus; or
1617 (ii) (A) during the first year of operation, 10% of the limited health plan's projected
1618 uncovered expenditures for the first year of operation;
1619 (B) during the second year of operation, 12% of the limited health plan's projected
1620 uncovered expenditures for the second year of operation;
1621 (C) during the third year of operation, 14% of the limited health plan's projected uncovered
1622 expenditures for the third year of operation;
1623 (D) during the fourth year of operation, 18% of the limited health plan's projected
1624 uncovered expenditures during the fourth year of operation; or
1625 (E) during the fifth year of operation, and during all subsequent years, 20% of the limited
1626 health plan's projected uncovered expenditures for the previous 12 months.
1627 (b) Projections of future uncovered expenditures shall be established in a manner that is
1628 approved by the commissioner.
1629 (4) A deposit required by this section may be counted toward the minimum capital or
1630 minimum permanent surplus required under Section 31A-8-209.
1631 Section 15. Section **31A-8-402.3** is enacted to read:
1632 **31A-8-402.3. Discontinuance, nonrenewal, or changes to group health benefit plans.**
1633 (1) Except as otherwise provided in this section, a group health benefit plan is renewable
1634 and continues in force:
1635 (a) with respect to all eligible employees and dependents; and
1636 (b) at the option of the plan sponsor.
1637 (2) A health benefit plan may be discontinued or nonrenewed:
1638 (a) for a network plan, if:
1639 (i) there is no longer any enrollee under the group health plan who lives, resides, or works

1640 in:
1641 (A) the service area of the insurer; or
1642 (B) the area for which the insurer is authorized to do business; and
1643 (ii) in the case of the small employer market, the insurer applies the same criteria the
1644 insurer would apply in denying enrollment in the plan under Subsection 31A-30-108(6); or
1645 (b) for coverage made available in the small or large employer market only through an
1646 association, if:
1647 (i) the employer's membership in the association ceases; and
1648 (ii) the coverage is terminated uniformly without regard to any health status-related factor
1649 relating to any covered individual.
1650 (3) A health benefit plan may be discontinued if:
1651 (a) a condition described in Subsection (2) exists;
1652 (b) the plan sponsor fails to pay premiums or contributions in accordance with the terms
1653 of the contract;
1654 (c) the plan sponsor:
1655 (i) performs an act or practice that constitutes fraud; or
1656 (ii) makes an intentional misrepresentation of material fact under the terms of the
1657 coverage; or
1658 (d) the insurer:
1659 (i) elects to discontinue offering a particular health benefit plan delivered or issued for
1660 delivery in this state; and
1661 (ii) (A) provides notice of the discontinuation in writing:
1662 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
1663 (II) at least 90 days before the date the coverage will be discontinued;
1664 (B) provides notice of the discontinuation in writing:
1665 (I) to the commissioner in each state in which an affected insured individual is known to
1666 reside; and
1667 (II) at least three working days prior to the date the notice is sent to the affected plan
1668 sponsors, employees, and dependents of the plan sponsors or employees;
1669 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase:
1670 (I) all other health benefit plans currently being offered by the insurer in the market; or

1671 (II) in the case of a large employer, any other health benefit plan currently being offered
1672 in that market; and
1673 (D) in exercising the option to discontinue that product and in offering the option of
1674 coverage in this section, acts uniformly without regard to:
1675 (I) the claims experience of a plan sponsor;
1676 (II) any health status-related factor relating to any covered participant or beneficiary; or
1677 (III) any health status-related factor relating to any new participant or beneficiary who may
1678 become eligible for the coverage; or
1679 (e) the insurer:
1680 (i) elects to discontinue all of the insurer's health benefit plans in:
1681 (A) the small employer market;
1682 (B) the large employer market; or
1683 (C) both the small employer and large employer markets; and
1684 (ii) (A) provides notice of the discontinuation in writing:
1685 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
1686 (II) at least 180 days before the date the coverage will be discontinued;
1687 (B) provides notice of the discontinuation in writing:
1688 (I) to the commissioner in each state in which an affected insured individual is known to
1689 reside; and
1690 (II) at least 30 working days prior to the date the notice is sent to the affected plan
1691 sponsors, employees, and their dependents of the plan sponsors or employees;
1692 (C) discontinues and nonrenews all plans issued or delivered for issuance in the market;
1693 and
1694 (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.
1695 (4) A health benefit plan may be nonrenewed:
1696 (a) if a condition described in Subsection (2) exists; or
1697 (b) for noncompliance with the insurer's:
1698 (i) minimum participation requirements; or
1699 (ii) employer contribution requirements.
1700 (5) (a) Except as provided in Subsection (5)(d), an eligible employee may be discontinued
1701 if, after issuance, the eligible employee:

1702 (i) engages in an act or practice in connection with the coverage that constitutes fraud; or

1703 (ii) makes an intentional misrepresentation of material fact in connection with the

1704 coverage.

1705 (b) An eligible employee that is discontinued under Subsection (5)(a) may reenroll:

1706 (i) 12 months after the date of discontinuance; and

1707 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies to

1708 reenroll.

1709 (c) At the time the eligible employee's coverage is discontinued under Subsection (5)(a),

1710 the insurer shall notify the eligible employee of the right to reenroll when coverage is discontinued.

1711 (d) An eligible employee may not be discontinued under this Subsection (5) because of

1712 a fraud or misrepresentation that relates to health status.

1713 (6) For purposes of this section, a reference to "plan sponsor" includes a reference to the

1714 employer:

1715 (a) with respect to coverage provided to an employer member of the association; and

1716 (b) if the health benefit plan is made available by an insurer in the employer market only

1717 through:

1718 (i) an association;

1719 (ii) a trust; or

1720 (iii) a discretionary group.

1721 (7) An insurer may modify a health benefit plan only:

1722 (a) at the time of coverage renewal; and

1723 (b) if the modification is effective uniformly among all plans with that product.

1724 Section 16. Section **31A-8-402.5** is enacted to read:

1725 **31A-8-402.5. Individual discontinuance and nonrenewal.**

1726 (1) (a) Except as otherwise provided in this section, a health benefit plan offered on an

1727 individual basis is renewable and continues in force:

1728 (i) with respect to all individuals or dependents; and

1729 (ii) at the option of the individual.

1730 (b) Subsection (1)(a) applies regardless of:

1731 (i) whether the contract is issued through:

1732 (A) a trust;

1733 (B) an association;
1734 (C) a discretionary group; or
1735 (D) other similar grouping; or
1736 (ii) the situs of delivery of the policy or contract.
1737 (2) A health benefit plan may be discontinued or nonrenewed:
1738 (a) for a network plan, if:
1739 (i) the individual no longer lives, resides, or works in:
1740 (A) the service area of the insurer; or
1741 (B) the area for which the insurer is authorized to do business; and
1742 (ii) coverage is terminated uniformly without regard to any health status-related factor
1743 relating to any covered individual; or
1744 (b) for coverage made available through an association, if:
1745 (i) the individual's membership in the association ceases; and
1746 (ii) the coverage is terminated uniformly without regard to any health status-related factor
1747 relating to any covered individual.
1748 (3) A health benefit plan may be discontinued if:
1749 (a) a condition described in Subsection (2) exists;
1750 (b) the individual fails to pay premiums or contributions in accordance with the terms of
1751 the health benefit plan, including any timeliness requirements;
1752 (c) the individual:
1753 (i) performs an act or practice in connection with the coverage that constitutes fraud; or
1754 (ii) makes an intentional misrepresentation of material fact under the terms of the
1755 coverage;
1756 (d) the insurer:
1757 (i) elects to discontinue offering a particular health benefit plan delivered or issued for
1758 delivery in this state; and
1759 (ii) (A) provides notice of the discontinuation in writing:
1760 (I) to each individual provided coverage; and
1761 (II) at least 180 days before the date the coverage will be discontinued;
1762 (B) provides notice of the discontinuation in writing:
1763 (I) to the commissioner in each state in which an affected insured individual is known to

1764 reside; and
1765 (II) at least three working days prior to the date the notice is sent to the affected
1766 individuals;
1767 (C) offers to each covered individual on a guaranteed issue basis, the option to purchase
1768 all other individual health insurance coverage currently being offered by the insurer for individuals
1769 in that market; and
1770 (D) acts uniformly without regard to any health status-related factor of covered individuals
1771 or dependents of covered individuals who may become eligible for coverage; or
1772 (e) the insurer:
1773 (i) elects to discontinue all of the insurer's health benefit plans in the individual market;
1774 and
1775 (ii) (A) provides notice of the discontinuation in writing:
1776 (I) to each individual provided coverage; and
1777 (II) at least 180 days before the date the coverage will be discontinued;
1778 (B) provides notice of the discontinuation in writing:
1779 (I) to the commissioner in each state in which an affected insured individual is known to
1780 reside; and
1781 (II) at least 30 working days prior to the date the notice is sent to the affected individuals;
1782 (C) discontinues and nonrenews all health benefit plans the insurer issues or delivers for
1783 insurance in the individual market; and
1784 (D) acts uniformly without regard to any health status-related factor of covered individuals
1785 or dependents of covered individuals who may become eligible for coverage.
1786 Section 17. Section **31A-8-402.7** is enacted to read:
1787 **31A-8-402.7. Discontinuance and nonrenewal limitations.**
1788 (1) Subject to Section 31A-4-115, an insurer that elects to discontinue offering or to not
1789 renew a health benefit plan under Subsections 31A-8-402.3(3)(e) and 31A-8-402.5(3)(e) is
1790 prohibited from writing new business:
1791 (a) in the market in this state for which the insurer discontinues or does not renew; and
1792 (b) for a period of five years beginning on the date of:
1793 (i) discontinuation; or
1794 (ii) the last date that the coverage that is not renewed is provided.

1795 (2) If an insurer is doing business in one established geographic service area of the state,
1796 Sections 31A-8-402.3 and 31A-8-402.5 apply only to the insurer's operations in that service area.
1797 (3) Notwithstanding whether Chapter 22, Part VII, Group Accident and Health Insurance,
1798 requires a conversion policy be available for certain persons who are no longer entitled to group
1799 coverage, an organization may not be required to provide a conversion policy to a person residing
1800 outside of the organization's service area.
1801 (4) The commissioner may, by rule or order, define the scope of an organization's service
1802 area.
1803 Section 18. Section **31A-8-408** is amended to read:
1804 **31A-8-408. Organizations offering point of service or point of sales products.**
1805 Effective July 1, 1991, a health maintenance organization offering products that permit
1806 members the option of obtaining covered services from a noncontracted provider, which is a point
1807 of service or point of sale product, shall comply with the requirements of Subsections (1) through
1808 (7).
1809 (1) The cost of an encounter with a noncontracted provider is considered an uncovered
1810 expenditure as defined in Section 31A-8-101.
1811 (2) [Any] (a) An organization [offering to sell point of service products] shall report to the
1812 commissioner on a monthly basis the number of encounters with contracted and noncontracted
1813 providers [to the commissioner on a monthly basis] if the organization offers to sell a:
1814 (i) point of service product; or
1815 (ii) point of sale product.
1816 (b) The commissioner shall:
1817 (i) define the form, content, and due date of the report required by this Subsection (2); and
1818 [shall]
1819 (ii) require audited reports of the information on a yearly basis.
1820 (3) An organization may not offer a point of service [products] product or a point of sale
1821 product unless [it] the organization has secured contracts with participating providers located
1822 within the organization's service area for each covered service other than those unusual or
1823 infrequently used health services that are not available from the organization's health care
1824 providers.
1825 (4) An organization may not enroll [members] a member who [do] does not work or reside

1826 in the service area as defined by rule, except this Subsection (4) does not apply to [~~dependents~~] a
1827 dependent of [~~enrollees~~] an enrollee.
1828 (5) Any organization that exceeds the 10% limit of unusual or infrequently used health
1829 services as defined in Section 31A-8-101 is subject to a forfeiture of up to $50 per encounter.
1830 (6) An organization shall disclose to employees and members the existence of the 10%
1831 limit:
1832 (a) at enrollment; or
1833 (b) prior to enrollment.
1834 (7) The commissioner shall hold hearings and adopt rules providing any additional
1835 limitations or requirements necessary to secure the public interest in conformity with this section.
1836 Section 19. Section **31A-17-505** is amended to read:
1837 **31A-17-505. Computation of minimum standard for annuities.**
1838 (1) Except as provided in Section 31A-17-506, the minimum standard for the valuation
1839 of all individual annuity and pure endowment contracts issued on or after the operative date of this
1840 section, as defined in Subsection (2), and for all annuities and pure endowments purchased on or
1841 after such operative date under group annuity and pure endowment contracts, shall be the
1842 commissioner's reserve valuation methods defined in Sections 31A-17-507 and 31A-17-508 and
1843 the following tables and interest rates:
1844 (a) [~~For~~] for individual annuity and pure endowment contracts issued prior to April 2,
1845 1980, excluding any accident and health and accidental death benefits in [~~such~~] the contracts:
1846 (i) (A) the 1971 Individual Annuity Mortality Table[~~,~~]; or
1847 (B) any modification of [~~this table~~] the 1971 Individual Annuity Mortality Table approved
1848 by the commissioner[~~, and~~];
1849 (ii) 6% interest for single premium immediate annuity contracts[~~,~~]; and
1850 (iii) 4% interest for all other individual annuity and pure endowment contracts[~~.~~];
1851 (b) [~~For~~] for individual single premium immediate annuity contracts issued on or after
1852 April 2, 1980, excluding any accident and health and accidental death benefits in [~~such~~] the
1853 contracts: [~~the 1971 Individual Annuity Mortality Table or~~]
1854 (i) (A) any individual annuity mortality table[~~, adopted after 1980 by the National~~
1855 ~~Association of Insurance Commissioners~~] that is approved by rule [~~promulgated~~] by the
1856 commissioner for use in determining the minimum standard of valuation for such contracts[~~,~~]; or

1857 (B) any modification of [these tables] a table described in Subsection (1)(b)(i)(A) approved
1858 by the commissioner[;]; and
1859 (ii) 7.5% interest[.];
1860 (c) [For] for individual annuity and pure endowment contracts issued on or after April 2,
1861 1980, other than single premium immediate annuity contracts, excluding any accident and health
1862 and accidental death benefits in [such] the contracts: [the 1971 Individual Annuity Mortality Table
1863 or]
1864 (i) (A) any individual annuity mortality table [adopted after 1980 by the National
1865 Association of Insurance Commissioners,] that is approved by rule [promulgated] by the
1866 commissioner for use in determining the minimum standard of valuation for such contracts[;]; or
1867 (B) any modification of [these tables] a table described in Subsection (1)(c)(i)(A) approved
1868 by the commissioner[, and];
1869 (ii) 5.5% interest for single premium deferred annuity and pure endowment contracts; and
1870 (iii) 4.5% interest for all other such individual annuity and pure endowment contracts[.];
1871 (d) [For] for all annuities and pure endowments purchased prior to April 2, 1980, under
1872 group annuity and pure endowment contracts, excluding any accident and health and accidental
1873 death benefits purchased under [such] the contracts:
1874 (i) (A) the 1971 Group Annuity Mortality Table; or
1875 (B) any modification of [this table] the 1971 Group Annuity Mortality Table approved by
1876 the commissioner[;]; and
1877 (ii) 6.5% interest[.]; and
1878 (e) [For] for all annuities and pure endowments purchased on or after April 2, 1980, under
1879 group annuity and pure endowment contracts, excluding any accident and health and accidental
1880 death benefits purchased under [such] the contracts: [the 1971 Group Annuity Mortality Table, or]
1881 (i) (A) any group annuity mortality table [adopted after 1980 by the National Association
1882 of Insurance Commissioners,] that is approved by rule [and promulgated] by the commissioner for
1883 use in determining the minimum standard of valuation for such annuities and pure endowments[;];
1884 or
1885 (B) any modification of [these tables] a table described in Subsection (1)(e)(i)(A) approved
1886 by the commissioner[;]; and
1887 (ii) 7.5% interest.

1888 (2) (a) After June 1, 1973, any company may file with the commissioner a written notice
1889 of its election to comply with [~~the provisions of~~] this section after a specified date before January
1890 1, 1979, which shall be the operative date of this section for [~~such~~] the company[~~, provided, if~~].
1891 (b) If a company [~~makes no such~~] does not make an election under Subsection (2)(a), the
1892 operative date of this section for [~~such~~] the company shall be January 1, 1979.
1893 Section 20. Section **31A-17-506** is amended to read:
1894 **31A-17-506. Computation of minimum standard by calendar year of issue.**
1895 (1) Applicability of Section 31A-17-506: The interest rates used in determining the
1896 minimum standard for the valuation shall be the calendar year statutory valuation interest rates as
1897 defined in this section for:
1898 (a) all life insurance policies issued in a particular calendar year, on or after the operative
1899 date of Subsection 31A-22-408(6)(d);
1900 (b) all individual annuity and pure endowment contracts issued in a particular calendar
1901 year on or after January 1, [~~1994~~] 1982;
1902 (c) all annuities and pure endowments purchased in a particular calendar year on or after
1903 January 1, [~~1994~~] 1982, under group annuity and pure endowment contracts; and
1904 (d) the net increase, if any, in a particular calendar year after January 1, [~~1994~~] 1982, in
1905 amounts held under guaranteed interest contracts.
1906 (2) Calendar year statutory valuation interest rates:
1907 (a) The calendar year statutory valuation interest rates, "I," shall be determined as follows
1908 and the results rounded to the nearer 1/4 of 1%:
1909 (i) For life insurance:
1910 I =.03 + W(R1 -.03) + (W/2)(R2 -.09);
1911 (ii) For single premium immediate annuities and for annuity benefits involving life
1912 contingencies arising from other annuities with cash settlement options and from guaranteed
1913 interest contracts with cash settlement options:
1914 I =.03 + W(R -.03),
1915 where R1 is the lesser of R and.09,
1916 R2 is the greater of R and.09,
1917 R is the reference interest rate defined in Subsection (4), and
1918 W is the weighting factor defined in this section;

1919 (iii) For other annuities with cash settlement options and guaranteed interest contracts with
1920 cash settlement options, valued on an issue year basis, except as stated in Subsection (ii), the
1921 formula for life insurance stated in Subsection (i) shall apply to annuities and guaranteed interest
1922 contracts with guarantee durations in excess of ten years, and the formula for single premium
1923 immediate annuities stated in Subsection (ii) shall apply to annuities and guaranteed interest
1924 contracts with guarantee duration of ten years or less;
1925 (iv) For other annuities with no cash settlement options and for guaranteed interest
1926 contracts with no cash settlement options, the formula for single premium immediate annuities
1927 stated in Subsection (ii) shall apply.
1928 (v) For other annuities with cash settlement options and guaranteed interest contracts with
1929 cash settlement options, valued on a change in fund basis, the formula for single premium
1930 immediate annuities stated in Subsection (ii) shall apply.
1931 (b) However, if the calendar year statutory valuation interest rate for any life insurance
1932 policies issued in any calendar year determined without reference to this sentence differs from the
1933 corresponding actual rate for similar policies issued in the immediately preceding calendar year
1934 by less than 1/2 of 1% the calendar year statutory valuation interest rate for such life insurance
1935 policies shall be equal to the corresponding actual rate for the immediately preceding calendar
1936 year. For purposes of applying the immediately preceding sentence, the calendar year statutory
1937 valuation interest rate for life insurance policies issued in a calendar year shall be determined for
1938 1980, using the reference interest rate defined in 1979, and shall be determined for each subsequent
1939 calendar year regardless of when Subsection 31A-22-408(6)(d) becomes operative.
1940 (3) Weighting factors:
1941 (a) The weighting factors referred to in the formulas stated in Subsection (2) are given in
1942 the following tables:
1943 (i) Weighting factors for life insurance:

	Guarantee Duration (Years)	Weighting Factors
1944		
1945	10 or less:	.50
1946	More than 10, but less than 20:	.45
1947	More than 20:	.35

1948 For life insurance, the guarantee duration is the maximum number of years the life
1949 insurance can remain in force on a basis guaranteed in the policy or under options to convert to

1950 plans of life insurance with premium rates or nonforfeiture values or both which are guaranteed
1951 in the original policy;
1952 (ii) Weighting factor for single premium immediate annuities and for annuity benefits
1953 involving life contingencies arising from other annuities with cash settlement options and
1954 guaranteed interest contracts with cash settlement options: .80
1955 (iii) Weighting factors for other annuities and for guaranteed interest contracts, except as
1956 stated in Subsection (ii), shall be as specified in Tables (A), (B), and (C) below, according to the
1957 rules and definitions in (D), (E), and (F) below:
1958 (A) For annuities and guaranteed interest contracts valued on an issue year basis:

	Guarantee Duration (Years)	Weighting Factors for Plan Type		
1959				
1960		A	B	C
1961	5 or less:	.80	.60	.50
1962	More than 5, but not more than 10:	.75	.60	.50
1963	More than 10, but not more than 20:	.65	.50	.45
1964	More than 20:	.45	.35	.35

		Plan Type		
1965				
1966		A	B	C
1967–1969	(B) For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in (A) above increased by:	.15	.25	.05

		Plan Type		
1970				
1971		A	B	C

1972 (C) For annuities and guaranteed interest
1973 contracts valued on an issue year basis, other than
1974 those with no cash settlement options, which do
1975 not guarantee interest on considerations received
1976 more than one year after issue or purchase and for
1977 annuities and guaranteed interest contracts valued
1978 on a change in fund basis which do not guarantee
1979 interest rates on considerations received more
1980 than 12 months beyond the valuation date, the

1981 factors shown in (A) or derived in (B) increased
1982 by: .05 .05 .05
1983 (D) For other annuities with cash settlement options and guaranteed interest contracts with
1984 cash settlement options, the guarantee duration is the number of years for which the contract
1985 guarantees interest rates in excess of the calendar year statutory valuation interest rate for life
1986 insurance policies with guarantee duration in excess of 20 years. For other annuities with no cash
1987 settlement options and for guaranteed interest contracts with no cash settlement options, the
1988 guaranteed duration is the number of years from the date of issue or date of purchase to the date
1989 annuity benefits are scheduled to commence.
1990 (E) Plan type as used in the above tables is defined as follows:
1991 Plan Type A: At any time policyholder may withdraw funds only:
1992 (I) with an adjustment to reflect changes in interest rates or asset values since receipt of
1993 the funds by the insurance company, or (II) without such adjustment but installments over five
1994 years or more, or (III) as an immediate life annuity, or (IV) no withdrawal permitted.
1995 Plan Type B: Before expiration of the interest rate guarantee, policyholder withdraw funds
1996 only:
1997 (I) with an adjustment to reflect changes in interest rates or asset values since receipt of
1998 the funds by the insurance company, or (II) without such adjustment but in installments over five
1999 years or more, or (III) no withdrawal permitted. At the end of interest rate guarantee, funds may
2000 be withdrawn without such adjustment in a single sum or installments over less than five years.
2001 Plan Type C: Policyholder may withdraw funds before expiration of interest rate guarantee
2002 in a single sum or installments over less than five years either:
2003 (I) without adjustment to reflect changes in interest rates or asset values since receipt of
2004 the funds by the insurance company, or (II) subject only to a fixed surrender charge stipulated in
2005 the contract as a percentage of the fund.
2006 (F) A company may elect to value guaranteed interest contracts with cash settlement
2007 options and annuities with cash settlement options on either an issue year basis or on a change in
2008 fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with
2009 no cash settlement options must be valued on an issue year basis. As used in this section, an issue
2010 year basis of valuation refers to a valuation basis under which the interest rate used to determine
2011 the minimum valuation standard for the entire duration of the annuity or guaranteed interest

2012 contract is the calendar year valuation interest rate for the year of issue or year of purchase of the
2013 annuity or guaranteed interest contract, and the change in fund basis of valuation refers to a
2014 valuation basis under which the interest rate used to determine the minimum valuation standard
2015 applicable to each change in the fund held under the annuity or guaranteed interest contract is the
2016 calendar year valuation interest rate for the year of the change in the fund.
2017 (4) Reference interest rate: "Reference interest rate" referred to in Subsection (2)(a) is
2018 defined as follows:
2019 (a) For all life insurance, the lesser of the average over a period of 36 months and the
2020 average over a period of 12 months, ending on June 30 of the calendar year next preceding the year
2021 of issue, of the Monthly Average of the composite Yield on Seasoned Corporate Bonds, as
2022 published by Moody's Investors Service, Inc.
2023 (b) For single premium immediate annuities and for annuity benefits involving life
2024 contingencies arising from other annuities with cash settlement options and guaranteed interest
2025 contracts with cash settlement options, the average over a period of 12 months, ending on June 30
2026 of the calendar year of issue or year of purchase, of the Monthly Average of the Composite Yield
2027 on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.
2028 (c) For other annuities with cash settlement options and guaranteed interest contracts with
2029 cash settlement options, valued on a year of issue basis, except as stated in Subsection (b), with
2030 guarantee duration in excess of ten years, the lesser of the average over a period of 36 months and
2031 the average over a period of 12 months, ending on June 30 of the calendar year of issue or
2032 purchase, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds, as
2033 published by Moody's Investors Service, Inc.
2034 (d) For other annuities with cash settlement options and guaranteed interest contracts with
2035 cash settlement options, valued on a year of issue basis, except as stated in Subsection (b), with
2036 guarantee duration of ten years or less, the average over a period of 12 months, ending on June 30
2037 of the calendar year of issue or purchase, of the Monthly Average of the Composite Yield on
2038 Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.
2039 (e) For other annuities with no cash settlement options and for guaranteed interest
2040 contracts with no cash settlement options, the average over a period of 12 months, ending on June
2041 30 of the calendar year of issue or purchase, of the Monthly Average of the Composite Yield on
2042 Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.

2043 (f) For other annuities with cash settlement options and guaranteed interest contracts with
2044 cash settlement options, valued on a change in fund basis, except as stated in Subsection (b), the
2045 average over a period of 12 months, ending on June 30 of the calendar year of the change in the
2046 fund, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds, as published
2047 by Moody's Investors Service, Inc.
2048 (5) Alternative method for determining reference interest rates: In the event that the
2049 Monthly Average of the Composite Yield on Seasoned Corporate Bonds is no longer published
2050 by Moody's Investors Service, Inc. or in the event that the National Association of Insurance
2051 Commissioners determines that the Monthly Average of the Composite Yield on Seasoned
2052 Corporate Bonds as published by Moody's Investors Service, Inc. is no longer appropriate for the
2053 determination of the reference interest rate, then an alternative method for determination of the
2054 reference interest rate, which is adopted by the National Association of Insurance Commissioners
2055 and approved by rule promulgated by the commissioner, may be substituted.
2056 Section 21. Section **31A-19a-101** is amended to read:
2057 **31A-19a-101. Title -- Scope and purposes.**
2058 (1) This chapter is known as the "Utah Rate Regulation Act."
2059 (2) (a) (i) Except as provided in Subsection (2)(a)(ii), this chapter applies to all kinds and
2060 lines of direct insurance written on risks or operations in this state by an insurer authorized to do
2061 business in this state.
2062 (ii) This chapter does not apply to:
2063 (A) life insurance [~~other than~~];
2064 (B) credit life insurance;
2065 [~~(B)~~] (C) variable and fixed annuities;
2066 [~~(C)~~] (D) health and accident and health insurance [~~other than~~];
2067 (E) credit accident and health insurance; and
2068 [~~(D)~~] (F) reinsurance.
2069 (b) This chapter applies to all insurers authorized to do any line of business, except those
2070 specified in Subsection (2)(a)(ii).
2071 (3) It is the purpose of this chapter to:
2072 (a) protect policyholders and the public against the adverse effects of excessive,
2073 inadequate, or unfairly discriminatory rates;

2074 (b) encourage independent action by and reasonable price competition among insurers so
2075 that rates are responsive to competitive market conditions;
2076 (c) provide formal regulatory controls for use if independent action and price competition
2077 fail;
2078 (d) provide regulatory procedures for the maintenance of appropriate data reporting
2079 systems;
2080 (e) authorize cooperative action among insurers in the rate-making process, and regulate
2081 that cooperation to prevent practices that bring about a monopoly or lessen or destroy competition;
2082 (f) encourage the most efficient and economic marketing practices; and
2083 (g) regulate the business of insurance in a manner that, under the McCarran-Ferguson Act,
2084 15 U.S.C. Secs. 1011 through 1015, will preclude application of federal antitrust laws.
2085 (4) Rate filings made prior to July 1, 1986, under former Title 31, Chapter 18, are
2086 continued. Rate filings made after July 1, 1986, are subject to the requirements of this chapter.
2087 Section 22. Section **31A-21-104** is amended to read:
2088 **31A-21-104. Insurable interest and consent.**
2089 (1) (a) An insurer may not knowingly provide insurance to a person who does not have or
2090 expect to have an insurable interest in the subject of the insurance.
2091 (b) A person may not knowingly procure, directly, by assignment, or otherwise, an interest
2092 in the proceeds of an insurance policy unless [~~he~~] <u>that person</u> has or expects to have an insurable
2093 interest in the subject of the insurance.
2094 (c) Except as provided in Subsections (6), (7), and (8), any insurance provided in violation
2095 of this Subsection <u>(1)</u> is subject to Subsection (5).
2096 (2) As used in this chapter:
2097 (a) <u>(i)</u> "Insurable interest" in a person means[~~,~~]<u>:</u>
2098 <u>(A)</u> for persons closely related by blood or by law, a substantial interest engendered by
2099 love and affection[~~,~~]<u>;</u> or
2100 <u>(B)</u> in the case of other persons, a lawful and substantial interest in having the life, health,
2101 and bodily safety of the person insured continue.
2102 <u>(ii)</u> Policyholders in group insurance contracts <u>do not</u> need [~~no~~] <u>an</u> insurable interest if
2103 certificate holders or persons other than group policyholders who are specified by the certificate
2104 holders are the recipients of the proceeds of the policies.

2105 (iii) Each person has an unlimited insurable interest in [his] the person's own life and
2106 health.
2107 (iv) A shareholder or partner has an insurable interest in the life of other shareholders or
2108 partners for purposes of insurance contracts that are an integral part of a legitimate buy-sell
2109 agreement respecting shares or a partnership interest in the business.
2110 (v) Subject to Subsection (9), an employer or an employer sponsored trust for the benefit
2111 of the employer's employees:
2112 (A) has an insurable interest in the lives of the employer's:
2113 (I) directors;
2114 (II) officers;
2115 (III) managers;
2116 (IV) nonmanagement employees; and
2117 (V) retired employees; and
2118 (B) may insure the lives listed in Subsection (2)(a)(v)(A):
2119 (I) on an individual or group basis; and
2120 (II) with the written consent of the insured.
2121 (b) "Insurable interest" in property or liability means any lawful and substantial economic
2122 interest in the nonoccurrence of the event insured against.
2123 (c) "Viatical settlement" means a written contract:
2124 (i) entered into by a person who is the policyholder of a life insurance policy insuring the
2125 life of a terminally ill person[,];
2126 (ii) under which the insured assigns, transfers ownership, irrevocably designates a specific
2127 person or otherwise alienates all control and right in the insurance policy to another person[,
2128 when]; and
2129 (iii) the proceeds or a part of the proceeds of the contract is paid to the policyholder of the
2130 insurance policy or the policyholder's designee prior to the death of the subject.
2131 (3) (a) Except as provided in Subsection (4), an insurer may not knowingly issue an
2132 individual life or accident and health insurance policy to a person other than the one whose life or
2133 health is at risk unless that person, who is 18 years of age or older and not under guardianship
2134 under Title 75, Chapter 5, Protection of Persons Under Disability and Their Property, has given
2135 written consent to the issuance of the policy. [The]

2136 (b) A person shall express consent [either]:
2137 (i) by signing an application for the insurance with knowledge of the nature of the
2138 document[,]; or
2139 (ii) in any other reasonable way.
2140 (c) Any insurance provided in violation of this Subsection (3) is subject to Subsection (5).
2141 (4) (a) A life or accident and health insurance policy may be taken out without consent in
2142 [the following cases:] a circumstance described in this Subsection (4)(a).
2143 (i) A person may obtain insurance on a dependent who does not have legal capacity.
2144 (ii) A creditor may, at the creditor's expense, obtain insurance on the debtor in an amount
2145 reasonably related to the amount of the debt.
2146 (iii) A person may obtain life and accident and health insurance on an immediate family
2147 [members] member who is living with or dependent on the person.
2148 (iv) A person may obtain an accident and health insurance policy on others that would
2149 merely indemnify the policyholder against expenses [he] the person would be legally or morally
2150 obligated to pay.
2151 (v) The commissioner may adopt rules permitting issuance of insurance for a limited term
2152 on the life or health of a person serving outside the continental United States who is in the public
2153 service of the United States, if the policyholder is related within the second degree by blood or by
2154 marriage to the person whose life or health is insured.
2155 (b) Consent may be given by another in [the following cases:] a circumstance described
2156 in this Subsection (4)(b).
2157 (i) A parent, a person having legal custody of a minor, or a guardian of [the] a person
2158 under Title 75, Chapter 5, Protection of Persons Under Disability and Their Property, may consent
2159 to the issuance of a policy on a dependent child or on a person under guardianship under Title 75,
2160 Chapter 5, Protection of Persons Under Disability and Their Property.
2161 (ii) A grandparent may consent to the issuance of life or accident and health insurance on
2162 a grandchild.
2163 (iii) A court of general jurisdiction may give consent to the issuance of a life or accident
2164 and health insurance policy on an ex parte application showing facts the court considers sufficient
2165 to justify the issuance of that insurance.
2166 (5) (a) An insurance policy is not invalid because the policyholder lacks insurable interest

2167 or because consent has not been given[, but].

2168 (b) Notwithstanding Subsection (5)(a), a court with appropriate jurisdiction may:

2169 (i) order the proceeds to be paid to some person who is equitably entitled to [them] the

2170 proceeds, other than the one to whom the policy is designated to be payable[,]; or [it may]

2171 (ii) create a constructive trust in the proceeds or a part of [them] the proceeds on behalf

2172 of such a person, subject to all the valid terms and conditions of the policy other than those relating

2173 to insurable interest or consent.

2174 (6) This section does not prevent any organization described under 26 U.S.C. Sec.

2175 501(c)(3), (e), or (f), as amended, and the regulations made under this section, and which is

2176 regulated under Title 13, Chapter 22, Charitable Solicitations Act, from soliciting and procuring,

2177 by assignment or designation as beneficiary, a gift or assignment of an interest in life insurance on

2178 the life of the donor or assignor or from enforcing payment of proceeds from that interest.

2179 (7) This section does not prevent:

2180 (a) any policyholder of life insurance, whether or not the policyholder is also the subject

2181 of the insurance, from entering into a viatical settlement;

2182 (b) any person from soliciting a person to enter into a viatical settlement; or

2183 (c) a person from enforcing payment of proceeds from the interest obtained under a viatical

2184 settlement.

2185 (8) Notwithstanding Subsection (1), an insurer authorized under this title to issue a

2186 workers' compensation policy may issue a workers' compensation policy to a sole proprietorship,

2187 corporation, or partnership that elects not to include any owner, corporate officer, or partner as an

2188 employee under the policy even if at the time the policy is issued the sole proprietorship,

2189 corporation, or partnership has no employees.

2190 (9) The extent of an employer's or employer sponsored trust's insurable interest for a

2191 nonmanagement and retired employee under Subsection (2)(a)(v) is limited to an amount

2192 commensurate with the employer's unfunded liabilities.

2193 Section 23. Section **31A-21-106** is amended to read:

2194 **31A-21-106. Incorporation by reference.**

2195 (1) (a) Except as provided in Subsection (1)(b), an insurance policy may not contain any

2196 agreement or incorporate any provision not fully set forth in the policy or in an application or other

2197 document attached to and made a part of the policy at the time of its delivery, unless the policy,

2198 application, or agreement accurately reflects the terms of the incorporated agreement, provision,
2199 or attached document.
2200 (b) (i) A policy may by reference incorporate rate schedules and classifications of risks and
2201 short-rate tables filed with the commissioner.
2202 (ii) By rule or order, the commissioner may authorize incorporation by reference of
2203 provisions for:
2204 (A) administrative arrangements[,];
2205 (B) premium schedules[,]; and
2206 (C) payment procedures for complex contracts.
2207 (c) (i) A policy of title insurance insuring the mortgage or deed of trust of an institutional
2208 lender may, if requested by an institutional lender, incorporate by reference generally applicable
2209 policy terms that are contained in a specifically identified policy that has been filed with the
2210 commissioner.
2211 (ii) As used in Subsection (1)(c)(i), "institutional lender" means a person that regularly
2212 engages in the business of making loans secured by real estate.
2213 (d) A policy may incorporate by reference the following by citing in the policy:
2214 (i) a federal law or regulation;
2215 (ii) a state law or rule; or
2216 (iii) a public directive of a federal or state agency.
2217 (2) [~~Except as provided in Subsection (3) or (4), or as otherwise mandated by law, no~~] A
2218 purported modification of a contract during the term of the policy [~~affects~~] may not affect the
2219 obligations of a party to the contract:
2220 (a) unless the modification is:
2221 (i) in writing; and
2222 (ii) agreed to by the party against whose interest the modification operates[.]; and
2223 (b) except:
2224 (i) as provided in:
2225 (A) Subsection (3) or (4);
2226 (B) Subsection 31A-8-402.3(7);
2227 (C) Subsection 31A-22-721(8); or
2228 (D) Subsection 31A-30-107(7); or

2229 (ii) as otherwise mandated by law.
2230 (3) Subsection (2) does not prevent a change in coverage under group contracts resulting
2231 from:
2232 (a) provisions of an employer eligibility rule;
2233 (b) the terms of a collective bargaining agreement; or
2234 (c) provisions in federal Employee Retirement Income Security Act plan documents.
2235 (4) Subsection (2) does not prevent a premium increase at any renewal date that is
2236 applicable uniformly to all comparable persons.
2237 Section 24. Section **31A-21-311** is amended to read:
2238 **31A-21-311. Group and blanket insurance.**
2239 (1) (a) (i) Except under Subsection (1)(d), an insurer issuing a group insurance policy other
2240 than a blanket insurance policy shall, as soon as practicable after the coverage is effective, provide
2241 a certificate for each member of the insured group, except that only one certificate need be
2242 provided for the members of a family unit.
2243 (ii) The certificate required by this Subsection (1) shall contain a summary of the essential
2244 features of the insurance coverage, including:
2245 (A) any rights of conversion to an individual policy; and[,]
2246 (B) in the case of group life insurance, any:
2247 (I) continuation of coverage during total disability[.]; and
2248 (II) incontestability provision.
2249 (iii) Upon receiving a written request, the insurer shall [also] inform any insured how the
2250 insured may inspect, during normal business hours at a place reasonably convenient to the insured,
2251 a copy of the policy or a summary of the policy containing all the details [which] that are relevant
2252 to the certificate holder.
2253 (b) The commissioner may by rule impose a [similar] requirement similar to Subsection
2254 (1)(a) on any class of blanket insurance policies for which the commissioner finds that the group
2255 of persons covered is constant enough for that type of action to be practicable and not unreasonably
2256 expensive.
2257 (c) [The] (i) A certificate shall be provided in a manner reasonably calculated to bring [it]
2258 the certificate to the attention of the certificate holder.
2259 (ii) The insurer may deliver or mail [the certificates] a certificate:

2260 (A) directly to the certificate holders[,]; or [may deliver or mail them]
2261 (B) in bulk to the policyholder to transmit to certificate holders.
2262 (iii) An affidavit by the insurer that [it has] the insurer mailed the certificates in the usual
2263 course of business creates a rebuttable presumption that [it] the insurer has done so.
2264 (d) The commissioner may by rule or order prescribe substitutes for delivery or mailing
2265 of certificates that are reasonably calculated to inform a certificate holder of the certificate holder's
2266 rights, including:
2267 (i) booklets describing the coverage[,];
2268 (ii) the posting of notices in the place of business[,]; or
2269 (iii) publication in a house organ[, if the substitutes are reasonably calculated to inform
2270 certificate holders of their rights].
2271 (2) Unless a certificate or an authorized substitute has been made available to the
2272 certificate holder when required by this section, [no] an act or omission forbidden to or required
2273 of the certificate holder by the certificate after the coverage has become effective as to the
2274 certificate holder, other than intentionally causing the loss insured against or failing to make
2275 required contributory premium payments, [affects] may not affect the insurer's obligations under
2276 the insurance contract.
2277 Section 25. Section **31A-22-400** is amended to read:
2278 **31A-22-400. Scope of part.**
2279 Part IV applies to all life insurance policies and contracts, including:
2280 (1) an annuity contract;
2281 (2) a credit life[,] contract;
2282 (3) a franchise[,] contract;
2283 (4) a group[,] contract; and
2284 (5) a blanket [contracts, except where the application of a provision is specifically limited]
2285 contract.
2286 Section 26. Section **31A-22-402** is amended to read:
2287 **31A-22-402. Grace period.**
2288 (1) (a) Every life insurance policy other than a group policy shall contain a provision
2289 entitling the policyholder to a grace period within which the payment of any premium may be
2290 made after the first payment of any premium.

2291 (b) During the grace period described in Subsection (1)(a), the policy continues in full
2292 force.
2293 (2) The grace period required by Subsection (1) may not be less than:
2294 (a) 31 days; or
2295 (b) four weeks for policies whose premiums are payable more frequently than monthly.
2296 (3) The insurer may impose an interest charge during the grace period not in excess of the
2297 interest rate:
2298 (a) set by the policy for policy loans; or
2299 (b) in the absence of a provision described in Subsection (3)(a), a rate set by the
2300 commissioner by rule.
2301 (4) If a claim arises under the policy during the grace period, an insurer may deduct from
2302 the policy proceeds:
2303 (a) the amount of any premium due or overdue;
2304 (b) interest at the rate provided in this section; and
2305 (c) any deferred installment of the annual premium.
2306 (5) The insurer shall send written notice of termination of coverage:
2307 (a) to the policyholder's last known address; and
2308 (b) at least 30 days before the date that the coverage is terminated.
2309 Section 27. Section **31A-22-403** is amended to read:
2310 **31A-22-403. Incontestability.**
2311 (1) This section does not apply to group policies.
2312 (2) [~~Each~~] (a) Except as provided in Subsection (3), a life insurance policy is[~~, and shall~~
2313 ~~state that,~~] incontestable after [~~it~~] the policy has been in force [~~during the lifetime of the insured~~]
2314 for a period of two years from [~~its~~] the policy's date of issue[~~, it is incontestable except for the~~
2315 ~~following~~]:
2316 (i) during the lifetime of the insured; or
2317 (ii) for a survivorship life insurance policy, during the lifetime of the surviving insured.
2318 (b) A life insurance policy shall state that the life insurance policy is incontestable after
2319 the time period described in Subsection (2)(a).
2320 [~~(a) The policy~~] (3) (a) A life insurance policy described in Subsection (2) may be
2321 contested for nonpayment of premiums.

2322 [(b) The policy] (b) A life insurance policy described in Subsection (2) may be contested
2323 as to:
2324 (i) provisions relating to accident and health benefits allowed under Section 31A-22-609;
2325 and
2326 (ii) additional benefits in the event of death by accident.
2327 (c) If [the policy] a life insurance policy described in Subsection (2) allows the insured,
2328 after the policy's issuance and for an additional premium, to obtain a death benefit [which] that is
2329 larger than when the policy was originally issued, [then] the payment of the additional increment
2330 of benefit is contestable:
2331 (i) until two years after the incremental increase of benefits[, but the]; and
2332 (ii) based only on a ground [of contest] that may arise [is] in connection with the
2333 incremental increase.
2334 [(3)] (4) (a) A reinstated life insurance policy or annuity contract may be contested:
2335 (i) for two years following reinstatement on the same basis as at original issuance[, but];
2336 and
2337 (ii) only as to matters arising in connection with the reinstatement.
2338 (b) Any grounds for contest available at original issuance continue to be available for
2339 contest until the policy has been in force for a total of two years:
2340 (i) during the lifetime of the insured[.]; and
2341 (ii) for a survivorship life insurance policy, during the life of the surviving insured.
2342 (4) (a) The limitations on incontestability under this section:
2343 (i) preclude only a contest of the validity of the policy[,]; and
2344 (ii) do not preclude the good faith assertion at any time of defenses based upon provisions
2345 in the policy [which] that exclude or qualify coverage, whether or not those qualifications or
2346 exclusions are specifically excepted in the policy's incontestability clause. [Provisions]
2347 (b) A provision on which the contestable period would normally run may not be
2348 reformulated as a coverage [exclusions] exclusion or [restrictions] restriction to take advantage of
2349 this Subsection (4).
2350 (5) In accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, the
2351 commissioner may make rules to implement this section.
2352 Section 28. Section **31A-22-404** is amended to read:

2353 **31A-22-404. Suicide.**

2354 (1) (a) Suicide is not a defense to a claim under a life insurance policy that has been in
2355 force as to a policyholder or certificate holder for two years from the date of issuance of the later
2356 of:

2357 (i) the policy[,]; or

2358 (ii) the certificate.

2359 (b) Subsection (1)(a) applies whether:

2360 (i) the suicide was voluntary or involuntary; or

2361 (ii) the insured was sane or insane.

2362 [(b)] (c) If a suicide occurs within the two-year period described in Subsection (1)(a), the
2363 insurer shall pay to the beneficiary an amount not less than the premium paid for the life insurance
2364 policy.

2365 (2) (a) If after a life insurance policy is in effect the policy allows the insured to obtain a
2366 death benefit that is larger than when the policy was originally effective for an additional premium,
2367 the payment of the additional increment of benefit may be limited in the event of a suicide within
2368 a two-year period beginning on the date the increment increase takes effect.

2369 (b) If a suicide occurs within the two-year period described in Subsection (2)(a), the
2370 insurer shall pay to the beneficiary an amount not less than the additional premium paid for the
2371 additional increment of benefit.

2372 (3) This section does not apply to:

2373 (a) [policies] a policy insuring against death by accident only; or

2374 (b) the accident or double indemnity provisions of an insurance policy.

2375 Section 29. Section **31A-22-405** is amended to read:

2376 **31A-22-405. Misstated age or gender.**

2377 (1) Subject to Subsection (2), if the age or gender of the person whose life is at risk is
2378 misstated in an application for a policy of life insurance, and the error is not adjusted during the
2379 person's lifetime, the amount payable under the policy is what the premium paid would have
2380 purchased if the age or gender had been stated correctly.

2381 (2) If the person whose life is at risk was, at the time the insurance was applied for, beyond
2382 the maximum age limit designated by the insurer, the insurer shall refund at least the amount of
2383 the premiums collected under the policy.

2384 Section 30. Section **31A-22-409** is amended to read:

2385 **31A-22-409. Standard Nonforfeiture Law for Individual Deferred Annuities.**

2386 (1) This section is known as the "Standard Nonforfeiture Law for Individual Deferred

2387 Annuities."

2388 (2) This section does not apply to:

2389 (a) any reinsurance group annuity purchased under a retirement plan or plan of deferred

2390 compensation established or maintained by an employer, [(]including a partnership or sole

2391 proprietorship[)], or by an employee organization, or by both, other than a plan providing

2392 individual retirement accounts or individual retirement annuities under Section 408 [of the],

2393 Internal Revenue Code[, as now or hereafter amended,];

2394 (b) a premium deposit fund[,];

2395 (c) a variable annuity[,];

2396 (d) an investment annuity[,];

2397 (e) an immediate annuity[,];

2398 (f) a deferred annuity contract after annuity payments have commenced[,]; or

2399 (g) a reversionary annuity[, nor to]; or

2400 (h) any contract [which] that shall be delivered outside this state through an agent or other

2401 representative of the company issuing the contract.

2402 (3) (a) [In the case of policies] If a policy is issued after this section takes effect as set forth

2403 in Subsection (12), [no] a contract of annuity, except as stated in Subsection (2), [shall] may not

2404 be delivered or issued for delivery in this state unless [it] the contract or annuity contains in

2405 substance:

2406 (i) the [following] provisions[,] described in Subsection (3)(b); or [corresponding]

2407 (ii) provisions [which] corresponding to the provisions describe in Subsection (3)(b) that

2408 in the opinion of the commissioner are at least as favorable to the contractholder, governing

2409 cessation of payment of consideration under the contract[:].

2410 (b) Subsection (3)(a)(i) requires the following provisions:

2411 [(a) That] (i) upon cessation of payment of consideration under a contract, the company

2412 will grant a paid-up annuity benefit on a plan stipulated in the contract of such a value as specified

2413 in Subsections (5), (6), (7), (8), and (10)[.];

2414 [(b) If] (ii) if a contract provides for a lump-sum settlement at maturity, or at any other

2415 time, [that] upon surrender of the contract at or before the commencement of any annuity
2416 payments, the company will pay in lieu of any paid-up annuity benefit a cash surrender benefit of
2417 such amount as is specified in Subsections (5), (6), (8), and (10)[. The];
2418 (iii) the company shall reserve the right to defer the payment of the cash surrender benefit
2419 under Subsection (3)(b)(ii) for a period of six months after demand [therefor] for the payment of
2420 the cash surrender benefit with surrender of the contract[.];
2421 [(c) A] (iv) a statement of the mortality table, if any, and interest rates used in calculating
2422 any of the following that are guaranteed under the contract:
2423 (A) minimum paid-up annuity[,] benefits;
2424 (B) cash surrender benefits; or
2425 (C) death benefits [that are guaranteed under the contract, together with];
2426 (v) sufficient information to determine the amounts of [such] the benefits[.] described in
2427 Subsection (3)(b)(iv);
2428 [(d) A] (vi) a statement that any paid-up annuity, cash surrender, or death benefits that
2429 may be available under the contract are not less than the minimum benefits required by any statute
2430 of the state in which the contract is delivered; and
2431 (vii) an explanation of the manner in which the benefits described in Subsection (3)(b)(vi)
2432 are altered by the existence of any:
2433 (A) additional amounts credited by the company to the contract[, any];
2434 (B) indebtedness to the company on the contract; or [any]
2435 (C) prior withdrawals from or partial surrender of the contract.
2436 (c) Notwithstanding the requirements of this Subsection (3), any deferred annuity contract
2437 may provide that if no consideration has been received under a contract for a period of two full
2438 years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the
2439 contract arising from consideration paid before the period would be less than $20 monthly[,]:
2440 (i) the company may at [its] the company's option terminate the contract by payment in
2441 cash of the then present value of such portion of the paid-up annuity benefit, calculated on the
2442 basis of the mortality table specified in the contract, if any, and the interest rate specified in the
2443 contract for determining the paid-up annuity benefit[,]; and [by such]
2444 (ii) the payment [shall be relieved] described in Subsection (3)(c)(i), relieves the company
2445 of any further obligation under the contract.

2446 (4) The minimum values as specified in Subsections (5), (6), (7), (8), and (10) of any
2447 paid-up annuity, cash surrender, or death benefits available under an annuity contract shall be
2448 based upon minimum nonforfeiture amounts as established in this section.
2449 (a) (i) With respect to contracts providing for flexible considerations, the minimum
2450 nonforfeiture amount at any time at or before the commencement of any annuity payments shall
2451 be equal to an accumulation up to such time, at a rate of interest of 3% per annum of percentages
2452 of the net considerations [~~(as hereinafter defined)~~] paid prior to such time, decreased by the sum
2453 of: [~~(i)~~]
2454 (A) any prior withdrawals from or partial surrenders of the contract accumulated at a rate
2455 of interest of 3% per annum[~~,~~]; and [~~(ii)~~]
2456 (B) the amount of any indebtedness to the company on the contract[~~,~~]:
2457 (I) including interest due and accrued[~~,~~]; and
2458 (II) increased by any existing additional amounts credited by the company to the contract.
2459 [~~The~~] (ii) For purposes of this Subsection (4)(a), the net consideration for a given contract
2460 year used to define the minimum nonforfeiture amount shall be:
2461 (A) an amount not less than zero; and [~~shall be~~]
2462 (B) equal to the corresponding gross considerations credited to the contract during that
2463 contract year less:
2464 (I) an annual contract charge of $30; and [~~less~~]
2465 (II) a collection charge of $1.25 per consideration credited to the contract during that
2466 contract year.
2467 (iii) The percentages of net considerations shall be:
2468 (A) 65% of the net consideration for the first contract year; and
2469 (B) 87-1/2% of the net considerations for the second and later contract years.
2470 (iv) Notwithstanding [~~the provisions of the preceding sentence~~] Subsection (4)(a)(iii), the
2471 percentage shall be 65% of the portion of the total net consideration for any renewal contract year
2472 [~~which~~] that exceeds by not more than two times the sum of those portions of the net
2473 considerations in all prior contract years for which the percentage was 65%.
2474 (b) [~~With~~] (i) Except as provided in Subsection (4)(b)(ii) and (iii), with respect to
2475 contracts providing for fixed scheduled consideration, minimum nonforfeiture amounts shall be:
2476 (A) calculated on the assumption that considerations are paid annually in advance; and

2477 [shall be]
2478 (B) defined as for contracts with flexible considerations [which] that are paid annually
2479 [with two exceptions:].
2480 [(i)] (ii) The portion of the net consideration for the first contract year to be accumulated
2481 shall be equal to an amount that is:
2482 (A) the sum of:
2483 (I) 65% of the net consideration for the first contract year [plus]; and
2484 (II) 22-1/2% of the excess of the net consideration for the first contract year [over]; and
2485 (B) divided by the lesser of:
2486 (I) the net considerations for the second contract year; and
2487 (II) third contract [years] year.
2488 [(ii)] (iii) The annual contract charge shall be the lesser of $30 or 10% of the gross annual
2489 consideration.
2490 (c) With respect to contracts providing for a single consideration payment, minimum
2491 nonforfeiture amounts shall be defined as for contracts with flexible considerations except that:
2492 (i) the percentage of net consideration used to determine the minimum nonforfeiture
2493 amount shall be equal to 90%; and
2494 (ii) the net consideration shall be the gross consideration less a contract charge of $75.
2495 (5) (a) Any paid-up annuity benefit available under a contract shall be such that [its] the
2496 contract's present value on the date annuity payments are to commence is at least equal to the
2497 minimum nonforfeiture amount on that date. [Such]
2498 (b) The present value described in Subsection (5)(a) shall be computed using the mortality
2499 table, if any, and the interest rate specified in the contract for determining the minimum paid-up
2500 annuity benefits guaranteed in the contract.
2501 (6) (a) For contracts [which] that provide cash surrender benefits, the cash surrender
2502 benefits available before maturity may not be less than the present value as of the date of surrender
2503 of that portion of the cash surrender value [which] that would be provided under the contract at
2504 maturity arising from considerations paid before the time of cash surrender reduced by the amount
2505 appropriate to reflect any prior withdrawals from or partial surrender of the contract, the present
2506 value being calculated on the basis of an interest rate not more than 1% higher than the interest rate
2507 specified in the contract for accumulating the net considerations to determine the maturity value,

2508 decreased by the amount of any indebtedness to the company on the contract, including interest
2509 due and accrued, and increased by any existing additional amounts credited by the company to the
2510 contract.

2511 (b) In no event shall any cash surrender benefit be less than the minimum nonforfeiture
2512 amount at that time.

2513 (c) The death benefit under these contracts shall be at least equal to the cash surrender
2514 benefit.

2515 (7) (a) For contracts [~~which~~] that do not provide cash surrender benefits, the present value
2516 of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity may
2517 not be less than the present value of that portion of the maturity value of the paid-up annuity
2518 benefit provided under the contract arising from considerations paid before the time the contract
2519 is surrendered in exchange for, or changed to, a deferred paid-up annuity, this present value being
2520 calculated for the period prior to the maturity date on the basis of the interest rate specified in the
2521 contract for accumulating the net considerations to determine maturity value, and increased by any
2522 existing additional amounts credited by the company to the contract.

2523 (b) For contracts [~~which~~] that do not provide any death benefits before commencement of
2524 any annuity payments, the present values shall be calculated on the basis of the interest rate and
2525 the mortality table specified in the contract for determining the maturity value of the paid-up
2526 annuity benefit. [~~However, in~~]

2527 (c) In no event shall the present value of a paid-up annuity benefit be less than the
2528 minimum nonforfeiture amount at that time.

2529 (8) (a) For the purpose of determining the benefits calculated under Subsections (6) and
2530 (7), [~~in the case of annuity contracts under which an election may be made to have annuity~~
2531 ~~payments commence at optional maturity dates,~~] the maturity date shall be considered to be the
2532 latest date [~~for which election shall be~~] permitted by the contract, [~~but~~] except that it may not be
2533 considered to be later than the later of:

2534 (i) the anniversary of the contract next following the annuitant's 70th birthday; or

2535 (ii) the tenth anniversary of the contract[~~, whichever is later~~].

2536 (b) For a contract that provides cash surrender benefits on or past the maturity date, the
2537 cash surrender value shall be equal to the amount used to determine the annuity benefit payments.

2538 (c) A surrender charge may not be imposed on or past maturity.

2539 (9) Any contract [~~which~~] that does not provide cash surrender benefits or does not provide
2540 death benefits at least equal to the minimum nonforfeiture amount before the commencement of
2541 any annuity payments shall include a statement in a prominent place in the contract that [~~such~~]
2542 these benefits are not provided.
2543 (10) Any paid-up annuity, cash surrender, or death benefits available at any time, other
2544 than on the contract anniversary under any contract with fixed scheduled considerations, shall be
2545 calculated with allowance for the lapse of time and the payment of any scheduled considerations
2546 beyond the beginning of the contract year in which cessation of payment of considerations under
2547 the contract occurs.
2548 (11) (a) For any contract [~~which~~] that provides, within the same contract by rider or
2549 supplemental contract provisions, both annuity benefits and life insurance benefits that are in
2550 excess of the greater of cash surrender benefits or a return of the gross considerations with interest,
2551 the minimum nonforfeiture benefits shall:
2552 (i) be equal to the sum of:
2553 (A) the minimum nonforfeiture benefits for the annuity portion; and
2554 (B) the minimum nonforfeiture benefits, if any, for the life insurance portion; and
2555 (ii) computed as if each portion were a separate contract.
2556 (b) (i) Notwithstanding [~~the provisions of~~] Subsections (5), (6), (7), (8), and (10),
2557 additional benefits payable[~~: (a) in the event of total and permanent disability, (b) as reversionary~~
2558 ~~annuity or deferred reversionary annuity benefits, or (c) as other policy benefits additional to life~~
2559 ~~insurance, endowment, and annuity benefits, and considerations for all such additional benefits~~],
2560 as described in Subsection (11)(b)(ii), and consideration for the additional benefits payable, shall
2561 be disregarded in ascertaining, if required by this section:
2562 (A) the minimum nonforfeiture amounts[~~,~~];
2563 (B) paid-up annuity[~~,~~];
2564 (C) cash surrender[~~,~~]; and
2565 (D) death benefits [~~that may be required by this section~~].
2566 (ii) For purposes of this Subsection (11), an additional benefit is a benefit payable:
2567 (A) in the event of total and permanent disability;
2568 (B) as reversionary annuity or deferred reversionary annuity benefits; or
2569 (C) as other policy benefits additional to life insurance, endowment, and annuity benefits.

2570 (iii) The inclusion of [these] the additional benefits described in this Subsection (11) may
2571 not be required in any paid-up benefits, unless the additional benefits separately would require:
2572 (A) minimum nonforfeiture amounts[,];
2573 (B) paid-up annuity[,];
2574 (C) cash surrender; and
2575 (D) death benefits.
2576 (12) (a) After this section takes effect, any company may file with the commissioner a
2577 written notice of its election to comply with [the provisions of] this section after a specified date
2578 before [the second anniversary of the date this section takes effect. The provisions of this] July
2579 1, 1988.
2580 (b) This section [apply] applies to annuity contracts of a company issued on or after the
2581 date the company specifies in the notice.
2582 (c) If a company makes no [such] election under Subsection (12)(a), the operative date of
2583 this section for such company is [the second anniversary of the effective date of this section] July
2584 1, 1988.
2585 Section 31. Section **31A-22-522** is amended to read:
2586 **31A-22-522. Required provision for notice of termination.**
2587 (1) A policy for group or blanket life insurance coverage issued or renewed after July 1,
2588 2001, shall include a provision that obligates the policyholder to notify each employee or group
2589 member:
2590 (a) in writing;
2591 (b) 30 days before the date the coverage is terminated; and
2592 (c) (i) that the group or blanket life insurance coverage is being terminated; and
2593 (ii) the rights the employee or group member has to [continue] convert coverage upon
2594 termination.
2595 (2) For a policy for group or blanket life insurance coverage described in Subsection (1),
2596 an insurer shall:
2597 (a) include a statement of a policyholder's obligations under Subsection (1) in the insurer's
2598 monthly notice to the policyholder of premium payments due; and
2599 (b) provide a sample notice to the policyholder at least once a year.
2600 Section 32. Section **31A-22-602** is amended to read:

2601 **31A-22-602. Premium rates.**
2602 (1) This section does not apply to group accident and health insurance.
2603 (2) The benefits in an accident and health insurance policy shall be reasonable in relation
2604 to the premiums charged.
2605 (3) The commissioner shall [~~disapprove~~] prohibit the use of an accident and health
2606 insurance policy form or rates if [~~it does~~] the form or rates do not satisfy Subsection (2).
2607 Section 33. Section **31A-22-624** is amended to read:
2608 **31A-22-624. Primary care physician.**
2609 An accident and health insurance policy that requires an insured to select a primary care
2610 physician to receive optimum coverage:
2611 (1) shall permit an insured to select a participating provider who:
2612 (a) is an:
2613 (i) obstetrician[~~,~~];
2614 (ii) gynecologist; or
2615 (iii) pediatrician; and
2616 (b) is qualified and willing to provide primary care services, as defined by the health care
2617 plan, as the insured's provider from whom primary care services are received;
2618 (2) shall clearly state in literature explaining the policy the option available to [~~female~~]
2619 insureds under Subsection (1); and
2620 (3) may not impose a higher premium, higher copayment requirement, or any other
2621 additional expense on an insured [~~by virtue of~~] because the insured [~~selecting~~] selected a primary
2622 care physician in accordance with Subsection (1).
2623 Section 34. Section **31A-22-625** is amended to read:
2624 **31A-22-625. Catastrophic coverage of mental health conditions.**
2625 (1) As used in this section:
2626 (a) (i) "Catastrophic mental health coverage" means coverage in a health insurance policy
2627 or health maintenance organization contract that does not impose any lifetime limit, annual
2628 payment limit, episodic limit, inpatient or outpatient service limit, or maximum out-of-pocket limit
2629 that places a greater financial burden on an insured for the evaluation and treatment of a mental
2630 health condition than for the evaluation and treatment of a physical health condition.
2631 (ii) "Catastrophic mental health coverage" may include a restriction on cost sharing factors,

2632 such as deductibles, copayments, or coinsurance, prior to reaching any maximum out-of-pocket
2633 limit.
2634 (iii) "Catastrophic mental health coverage" may include one maximum out-of-pocket limit
2635 for physical health conditions and another maximum out-of-pocket limit for mental health
2636 conditions, provided that, if separate out-of-pocket limits are established, the out-of-pocket limit
2637 for mental health conditions may not exceed the out-of-pocket limit for physical health conditions.
2638 (b) (i) "50/50 mental health coverage" means coverage in a health insurance policy or
2639 health maintenance organization contract that pays for at least 50% of covered services for the
2640 diagnosis and treatment of mental health conditions.
2641 (ii) "50/50 mental health coverage" may include a restriction on episodic limits, inpatient
2642 or outpatient service limits, or maximum out-of-pocket limits.
2643 (c) "Large employer" [~~means an employer that does not come within the definition of~~
2644 ~~"small employer."~~] is as defined in Section 31A-1-301.
2645 (d) (i) "Mental health condition" means any condition or disorder involving mental illness
2646 that falls under any of the diagnostic categories listed in the Diagnostic and Statistical Manual, as
2647 periodically revised.
2648 (ii) "Mental health condition" does not include the following when diagnosed as the
2649 primary or substantial reason or need for treatment:
2650 (A) marital or family problem;
2651 (B) social, occupational, religious, or other social maladjustment;
2652 (C) conduct disorder;
2653 (D) chronic adjustment disorder;
2654 (E) psychosexual disorder;
2655 (F) chronic organic brain syndrome;
2656 (G) personality disorder;
2657 (H) specific developmental disorder or learning disability; or
2658 (I) mental retardation.
2659 (e) "Small employer" is as defined in Section [~~31A-30-103~~] 31A-1-301.
2660 (2) (a) At the time of purchase and renewal, an insurer shall offer to each small employer
2661 that it insures or seeks to insure a choice between catastrophic mental health coverage and 50/50
2662 mental health coverage.

2663 (b) In addition to Subsection (2)(a), an insurer may offer to provide:
2664 (i) catastrophic mental health coverage, 50/50 mental health coverage, or both at levels that
2665 exceed the minimum requirements of this section; or
2666 (ii) coverage that excludes benefits for mental health conditions.
2667 (c) A small employer may, at its option, choose either catastrophic mental health coverage,
2668 50/50 mental health coverage, or coverage offered under Subsection (2)(b), regardless of the
2669 employer's previous coverage for mental health conditions.
2670 (d) An insurer is exempt from the 30% index rating restriction in Subsection
2671 31A-30-106(1)(b) and, for the first year only that catastrophic mental health coverage is chosen,
2672 the 15% annual adjustment restriction in Subsection 31A-30-106(1)(c)(ii), for any small employer
2673 with 20 or less enrolled employees who chooses coverage that meets or exceeds catastrophic
2674 mental health coverage.
2675 (3) (a) At the time of purchase and renewal, an insurer shall offer catastrophic mental
2676 health coverage to each large employer that it insures or seeks to insure.
2677 (b) In addition to Subsection (3)(a), an insurer may offer to provide catastrophic mental
2678 health coverage at levels that exceed the minimum requirements of this section.
2679 (c) A large employer may, at its option, choose either catastrophic mental health coverage,
2680 coverage that excludes benefits for mental health conditions, or coverage offered under Subsection
2681 (3)(b).
2682 (4) (a) An insurer may provide catastrophic mental health coverage through a managed
2683 care organization or system in a manner consistent with the provisions in Chapter 8, Health
2684 Maintenance Organizations and Limited Health Plans, regardless of whether the policy or contract
2685 uses a managed care organization or system for the treatment of physical health conditions.
2686 (b) (i) Notwithstanding any other provision of this title, an insurer may:
2687 (A) establish a closed panel of providers for catastrophic mental health coverage; and
2688 (B) refuse to provide any benefit to be paid for services rendered by a nonpanel provider
2689 unless:
2690 (I) the insured is referred to a nonpanel provider with the prior authorization of the insurer;
2691 and
2692 (II) the nonpanel provider agrees to follow the insurer's protocols and treatment guidelines.
2693 (ii) If an insured receives services from a nonpanel provider in the manner permitted by

2694 Subsection (4)(b)(i)(B), the insurer shall reimburse the insured for not less than 75% of the average
2695 amount paid by the insurer for comparable services of panel providers under a noncapitated
2696 arrangement who are members of the same class of health care providers.
2697 (iii) Nothing in this Subsection (4)(b) may be construed as requiring an insurer to authorize
2698 a referral to a nonpanel provider.
2699 (c) To be eligible for catastrophic mental health coverage, a diagnosis or treatment of a
2700 mental health condition must be rendered:
2701 (i) by a mental health therapist as defined in Section 58-60-102; or
2702 (ii) in a health care facility licensed or otherwise authorized to provide mental health
2703 services pursuant to Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act, or
2704 Title 62A, Chapter 2, Licensure of Programs and Facilities, that provides a program for the
2705 treatment of a mental health condition pursuant to a written plan.
2706 (5) The commissioner may disapprove any policy or contract that provides mental health
2707 coverage in a manner that is inconsistent with the provisions of this section.
2708 (6) The commissioner shall:
2709 (a) adopt rules as necessary to ensure compliance with this section; and
2710 (b) provide general figures on the percentage of contracts and policies that include no
2711 mental health coverage, 50/50 mental health coverage, catastrophic mental health coverage, and
2712 coverage that exceeds the minimum requirements of this section.
2713 (7) The Health and Human Services Interim Committee shall review:
2714 (a) the impact of this section on insurers, employers, providers, and consumers of mental
2715 health services before January 1, 2004; and
2716 (b) make a recommendation as to whether the provisions of this section should be
2717 modified and whether the cost-sharing requirements for mental health conditions should be the
2718 same as for physical health conditions.
2719 (8) (a) An insurer shall offer catastrophic mental health coverage as part of a health
2720 maintenance organization contract that is governed by Chapter 8, Health Maintenance
2721 Organizations and Limited Health Plans, that is in effect on or after January 1, 2001.
2722 (b) An insurer shall offer catastrophic mental health coverage as a part of a health
2723 insurance policy that is not governed by Chapter 8, Health Maintenance Organizations and Limited
2724 Health Plans, that is in effect on or after July 1, 2001.

2725 (c) This section does not apply to the purchase or renewal of an individual insurance policy
2726 or contract.
2727 (d) Notwithstanding Subsection (8)(c), nothing in this section may be construed as
2728 discouraging or otherwise preventing insurers from continuing to provide mental health coverage
2729 in connection with an individual policy or contract.
2730 (9) This section shall be repealed in accordance with Section 63-55-231.
2731 Section 35. Section **31A-22-629** is amended to read:
2732 **31A-22-629. Adverse benefit determination review process.**
2733 (1) As used in this section:
2734 [~~(a) "Grievance" means a written or, if accepted by the insurer, oral statement that indicates~~
2735 ~~an insured's disagreement with an insurance-related decision of the insurer.~~]
2736 (a) (i) "Adverse benefit determination" means the:
2737 (A) denial of a benefit;
2738 (B) reduction of a benefit;
2739 (C) termination of a benefit; or
2740 (D) failure to provide or make payment, in whole or in part, for a benefit.
2741 (ii) "Adverse benefit determination" includes:
2742 (A) denial, reduction, termination, or failure to provide or make payment that is based on
2743 a determination of a insured's or beneficiary's eligibility to participate in a plan;
2744 (B) with respect to group health plans, a denial, reduction, or termination of, or a failure
2745 to provide or make payment, in whole or in part, for, a benefit resulting from the application of a
2746 utilization review; and
2747 (C) failure to cover an item or service for which benefits are otherwise provided because
2748 it is determined to be:
2749 (I) experimental;
2750 (II) investigational; or
2751 (III) not medically necessary or appropriate.
2752 (b) "Independent review" means a process that:
2753 (i) [~~may be created and operated internally by an insurer or externally by a third party~~] is
2754 a voluntary option for the resolution of an adverse benefit determination;
2755 (ii) [~~satisfies the requirements of Subsection (4)(b)(ii)~~] is conducted at the discretion of

2756 the claimant;
2757 (iii) [is designated by the insurer; and] is conducted by an independent review organization
2758 designated by the insurer;
2759 (iv) renders an independent and impartial decision on [a grievance] an adverse benefit
2760 determination submitted by an insured; and
2761 (v) may not require the insured to pay a fee for requesting the independent review.
2762 (c) "Insured" is as defined in Section 31A-1-301 and includes a person who is authorized
2763 to act on the insured's behalf.
2764 (d) "Insurer" is as defined in Section 31A-1-301 and includes:
2765 (i) a health maintenance organization; and
2766 (ii) a third-party administrator that offers, sells, manages, or administers a health insurance
2767 policy or health maintenance organization contract that is subject to this title.
2768 (e) "Internal review" means the process an insurer uses to review an insured's [grievance]
2769 adverse benefit determination before the [grievance] adverse benefit determination is submitted
2770 for independent review.
2771 (2) This section applies generally to health insurance policies and health maintenance
2772 organization contracts in effect on or after January 1, 2001.
2773 (3) (a) An insured may submit [a grievance] an adverse benefit determination to the
2774 insurer.
2775 (b) The insurer shall conduct an internal review of the insured's [grievance] adverse benefit
2776 determination.
2777 [(c) Consistent with rules adopted pursuant to Subsection (4), an insured who disagrees
2778 with the results of an internal review may submit the grievance for an independent review if the
2779 grievance involves the payment of a claim or the denial of coverage.]
2780 (4) Before October 1, 2000, the commissioner shall adopt rules that[: (a) establish a
2781 maximum flat fee that may be charged to an insured for requesting a decision from an independent
2782 review board and the circumstances under which the fee shall be waived on the basis of financial
2783 hardship; and (b)] establish minimum standards for:
2784 [(i)] (a) internal reviews;
2785 [(ii) internal and external]
2786 (b) independent reviews to ensure independence and impartiality;

2787 [(iii)] (c) the types of [grievances] adverse benefit determinations that may be submitted
2788 to an independent review; and
2789 [(iv)] (d) the timing of the review process, including an expedited review when medically
2790 necessary.
2791 (5) Nothing in this section may be construed as:
2792 (a) expanding, extending, or modifying the terms of a policy or contract with respect to
2793 benefits or coverage;
2794 (b) permitting an insurer to charge an insured for the internal review of [a grievance] an
2795 adverse benefit determination;
2796 (c) restricting the use of arbitration in connection with or subsequent to an independent
2797 review; or
2798 (d) altering the legal rights of any party to seek court or other redress in connection with:
2799 (i) an adverse decision resulting from an independent review, except that if the insurer is
2800 the party seeking legal redress, the insurer shall pay for the reasonable attorneys fees of the insured
2801 related to the action and court costs; or
2802 (ii) [a grievance] an adverse benefit determination or other claim that is not eligible for
2803 submission to independent review.
2804 Section 36. Section **31A-22-703** is amended to read:
2805 **31A-22-703. Conversion rights on termination of group accident and health**
2806 **insurance coverage.**
2807 (1) Except as provided in Subsections (2) through [(5)] (4), all policies of accident and
2808 health insurance offered on a group basis under this title or Title 49, Chapter 8, Group Insurance
2809 Program Act, shall provide that a person whose insurance under the group policy has been
2810 terminated for any reason, and who has been continuously insured under the group policy or its
2811 predecessor for at least six months immediately prior to termination, is entitled to choose:
2812 (a) a converted individual policy of accident and health insurance from the insurer [which]
2813 that conforms to Section 31A-22-708; or
2814 (b) an extension of benefits under the group policy as provided in Section 31A-22-714.
2815 (2) Subsection (1) does not apply if the policy:
2816 (a) provides:
2817 (i) catastrophic[,] benefits;

2818 (ii) aggregate stop loss[, or] benefits;
2819 (iii) specific stop loss benefits; or
2820 [(b) provides] (iv) benefits for:
2821 (A) specific diseases [or for];
2822 (B) accidental injuries only[;]; or
2823 (C) for dental service; or
2824 [(c)] (b) is an income replacement policy.
2825 (3) An employee or group member does not have conversion rights under Subsection (1)
2826 if:
2827 (a) termination of the group coverage occurred because [of failure of] the group member
2828 failed to pay any required individual contribution;
2829 (b) the individual group member acquires other group coverage covering all preexisting
2830 conditions including maternity, if the coverage existed under the replaced group coverage; or
2831 (c) the person has:
2832 (i) performed an act or practice that constitutes fraud; or
2833 (ii) made an intentional misrepresentation of material fact under the terms of the coverage.
2834 [(4) Notwithstanding Subsections (1), (2), and (3), an employee or group member does not
2835 have conversion rights under Subsection (1) if the individual or group member qualifies to
2836 continue coverage under his existing group policy in accordance with the terms of his policy.]
2837 [(5)] (4) (a) Notwithstanding Subsection 31A-22-613(1), an insurer may reduce benefits
2838 under a converted policy covering any person to the extent the benefits provided or available to
2839 that person under one or more of the sources listed under Subsection [(5)] (4)(b), together with the
2840 benefits provided by the converted policy, would result in coverage that would result in payment
2841 of more than 100% of the amount of the claim.
2842 (b) The benefits sources referred to under Subsection [(5)] (4)(a) include benefits under:
2843 (i) [benefits under] another insurance policy; and
2844 (ii) [benefits under] any arrangement of coverage for individuals in a group, whether on
2845 an insured or an uninsured basis.
2846 [(6)] (5) (a) The conversion policy shall provide maternity benefits equal to the lesser of
2847 the maternity benefits of the group policy or the conversion policy until termination of a pregnancy
2848 that exists on the date of conversion if:

2849 (i) one of the following is pregnant on the date of the conversion:
2850 (A) the insured;
2851 (B) a spouse of the insured; or
2852 (C) a dependent of the insured; and
2853 (ii) the accident and health policy had maternity benefits.
2854 (b) The requirements of this Subsection [~~(6)~~] (5) do not apply to a pregnancy that occurs
2855 after the date of conversion.
2856 Section 37. Section **31A-22-705** is amended to read:
2857 **31A-22-705. Provisions in conversion policies.**
2858 (1) A converted policy may include a provision under which the insurer may request from
2859 the person covered, information in advance of any premium due date as to whether there is other
2860 coverage as specified under Subsection 31A-22-703(4).
2861 [~~(2) The converted policy may provide that the insurer may refuse to renew the policy or~~
2862 ~~the coverage of any person insured:~~]
2863 [~~(a) for fraud or intentional misrepresentation of a material fact in applying for any benefits~~
2864 ~~under the converted policy; or~~]
2865 [~~(b) for any other reason approved by the commissioner by rule or order.~~]
2866 (2) (a) Except as provided in Subsection (2)(b), a converted policy is renewable with
2867 respect to all individuals or dependents at the option of the individual.
2868 (b) A converted policy may be nonrenewed if:
2869 (i) the individual fails to pay premiums or contributions in accordance with the terms of
2870 the health benefit plan, including any timeliness requirements;
2871 (ii) the individual:
2872 (A) performs an act or practice that constitutes fraud; or
2873 (B) made an intentional misrepresentation of material fact under the terms of the coverage;
2874 or
2875 (iii) for network plans:
2876 (A) the individual no longer resides, lives, or works in:
2877 (I) the service area of the insurer; or
2878 (II) the area for which the insurer is authorized to do business; and
2879 (B) coverage is terminated uniformly without regard to any health status-related factor of

2880 covered individuals.
2881 (3) An insurer may not be required to issue a converted policy which provides benefits in
2882 excess of those provided under the group policy from which conversion is made.
2883 (4) A converted policy may not exclude a preexisting condition not excluded under the
2884 group policy.
2885 (5) During the first policy year, the converted policy may provide that the benefits payable
2886 under the converted policy, together with the benefits paid for the individual under the group
2887 policy, do not exceed those that would have been payable had the individual's insurance under the
2888 group policy remained in force and effect.
2889 Section 38. Section **31A-22-708** is amended to read:
2890 **31A-22-708. Conversion of health benefit plan.**
2891 If the group insurance policy from which the conversion is made is a health benefit plan,
2892 as defined in [Subsection 31A-30-103(15)] Section 31A-1-301, the employee or member must be
2893 offered at least basic coverage as defined in [Subsection] Section 31A-30-103[(4)].
2894 Section 39. Section **31A-22-714** is amended to read:
2895 **31A-22-714. Extension of benefits.**
2896 (1) (a) In addition to the right of the employee to have a converted policy issued to the
2897 employee, and on the same bases of eligibility as for conversion of coverage under Sections
2898 31A-22-703 and 31A-22-704, the employee has the right to continue the employee's coverage
2899 under the group policy for a period of six months, unless the employee:
2900 (i) was terminated for gross misconduct; or
2901 (ii) is eligible for any extension of coverage required by federal law.
2902 (b) This right to continue coverage includes any dependent coverages.
2903 (2) In addition to the terminated insured, those classes of persons defined in Section
2904 31A-22-710 are [also] entitled to the continuation of coverage as provided in this section.
2905 (3) (a) (i) The employer shall provide the terminated insured written notification of the
2906 right to continue group coverage and the payment amounts required for continued coverage,
2907 including the manner, place, and time in which the payments shall be made.
2908 (ii) The notice required by this Subsection (3):
2909 (A) may be sent to the terminated insured's home address as shown on the records of the
2910 employer[. This notice]; and

2911 (B) shall be given not more than 30 days after the termination date of the group coverage.
2912 (b) The payment amount for continued group coverage may not exceed 102% of the group
2913 rate in effect for a group member, including an employer's contribution, if any, for a group
2914 insurance policy.
2915 (4) The insurer shall provide the employee or any eligible dependent the opportunity to
2916 continue the group coverage at the payment amount stated in Subsection (3)(b) if:
2917 (a) the employer policyholder does not provide the terminated insured the written
2918 notification as required by Subsection (3); and
2919 (b) the employee or other insured eligible for extension contacts the insurer within 30 days
2920 of coverage termination.
2921 [(4) If] (5) (a) Except as provided in Subsection (5)(c), the coverages described in
2922 Subsection (5)(b) continues without interruption and may not terminate if the terminated insured
2923 or, with respect to a minor, the parent or guardian of the terminated insured:
2924 (i) elects to continue group coverage; and
2925 (ii) tenders the amount required:
2926 (A) (I) to the employer [the amount required]; or
2927 (II) to the insured if the right to continue notice is received from the insurer; and
2928 (B) within 30 days after receiving notice as prescribed by this section[;].
2929 (b) Subsection (5)(a) applies to coverage of:
2930 (I) the terminated insured [and coverage of];
2931 (II) the covered spouse of the terminated insured; and
2932 (iii) dependents of the terminated insured [continues without interruption and may not
2933 terminate unless:].
2934 (c) A coverage described in Subsection (5)(b) may be terminated if:
2935 [(a)] (i) the terminated insured:
2936 (A) establishes residence outside of this state; or
2937 (B) moves out of the insurer's service area;
2938 [(b)] (ii) the terminated insured fails to make timely payment of a required contribution;
2939 [(c)] (iii) the terminated insured violates a material condition of the contract;
2940 [(d)] (iv) the terminated insured becomes eligible for similar coverage under another group
2941 policy; or

2942 [(c)] (v) the employer's coverage is terminated.
2943 [(5)] (6) If the employer replaces coverage with similar coverage under another group
2944 policy, without interruption, the terminated insured has the right to obtain coverage under the
2945 replacement group policy:
2946 (a) for the balance of the period the terminated insured would have continued coverage
2947 under the replaced group policy[, provided]; and
2948 (b) if the terminated insured is otherwise eligible for continuation of coverage.
2949 [(6)] (7) At the end of the continued benefit period as provided in this section, the covered
2950 person:
2951 (a) remains eligible for a converted policy under this chapter; and
2952 (b) shall be [so] informed that the person remains eligible:
2953 (i) by the employer or the insurer; and
2954 (ii) in the same manner and according to the same terms as required by Section
2955 31A-22-703.
2956 Section 40. Section **31A-22-721** is enacted to read:
2957 **31A-22-721. Employer sponsored health benefit plan.**
2958 (1) Except as otherwise provided in this section, an employer sponsored health benefit plan
2959 is renewable and continues in force:
2960 (a) with respect to all eligible employees and dependents; and
2961 (b) at the option of the plan sponsor.
2962 (2) A health benefit plan may be discontinued or nonrenewed:
2963 (a) for a network plan, if:
2964 (i) there is no longer any enrollee under the group health plan who lives, resides, or works
2965 in:
2966 (A) the service area of the insurer; or
2967 (B) the area for which the insurer is authorized to do business; and
2968 (ii) in the case of the small employer market, the insurer applies the same criteria the
2969 insurer would apply in denying enrollment in the plan under Subsection 31A-30-108(6); or
2970 (b) for coverage made available in the small or large employer market only through an
2971 association, if:
2972 (i) the employer's membership in the association ceases; and

2973 (ii) the coverage is terminated uniformly without regard to any health status-related factor
2974 relating to any covered individual.
2975 (3) A health benefit plan may be discontinued if:
2976 (a) a condition described in Subsection (2) exists;
2977 (b) the plan sponsor fails to pay premiums or contributions in accordance with the terms
2978 of the contract;
2979 (c) the plan sponsor:
2980 (i) performs an act or practice that constitutes fraud; or
2981 (ii) makes an intentional misrepresentation of material fact under the terms of the
2982 coverage;
2983 (d) the insurer:
2984 (i) elects to discontinue offering a particular health benefit plan delivered or issued for
2985 delivery in this state;
2986 (ii) (A) provides notice of the discontinuation in writing:
2987 (I) to each plan sponsor, employee, and dependent of a plan sponsor or employee; and
2988 (II) at least 180 days before the date the coverage will be discontinued;
2989 (B) provides notice of the discontinuation in writing:
2990 (I) to the commissioner in each state in which an affected insured individual is known to
2991 reside; and
2992 (II) at least three working days prior to the date the notice is sent to the affected plan
2993 sponsors, employees, and dependents of plan sponsors or employees;
2994 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase any
2995 other health benefit plans currently being offered:
2996 (I) by the insurer in the market; or
2997 (II) in the case of a large employer, any other health benefit plan currently being offered
2998 in that market; and
2999 (D) in exercising the option to discontinue that product and in offering the option of
3000 coverage in this section, the insurer acts uniformly without regard to:
3001 (I) the claims experience of a plan sponsor; or
3002 (II) any health status-related factor relating to any covered participant or beneficiary; or
3003 (III) any health status-related factor relating to a new participant or beneficiary who may

3004 become eligible for coverage; or
3005 (e) the insurer:
3006 (i) elects to discontinue all of the insurer's health benefit plans:
3007 (A) in the small employer market; or
3008 (B) the large employer market; or
3009 (C) both the small and large employer markets:
3010 (ii) (A) provides notice of the discontinuance in writing:
3011 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
3012 (II) at least 180 days before the date the coverage will be discontinued;
3013 (B) provides notice of the discontinuation in writing:
3014 (I) to the commissioner in each state in which an affected insured individual is known to
3015 reside; and
3016 (II) at least 30 business days prior to the date the notice is sent to the affected plan
3017 sponsors, employees, and dependents of a plan sponsor or employee;
3018 (C) discontinues and nonrenews all plans issued or delivered for issuance in the market;
3019 and
3020 (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.
3021 (4) A health benefit plan may be nonrenewed:
3022 (a) if a condition described in Subsection (2) exists; or
3023 (b) for noncompliance with the insurer's:
3024 (i) minimum participation requirements; or
3025 (ii) employer contribution requirements.
3026 (5) (a) Except as provided in Subsection (5)(d), an eligible employee may be discontinued
3027 if, after issuance, the eligible employee:
3028 (i) engages in an act or practice that constitutes fraud in connection with the coverage; or
3029 (ii) makes an intentional misrepresentation of material fact in connection with the
3030 coverage.
3031 (b) An eligible employee that is discontinued under Subsection (5)(a) may reenroll:
3032 (i) 12 months after the date of discontinuance; and
3033 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies to
3034 reenroll.

3035 (c) At the time the eligible employee's coverage is discontinued under Subsection (5)(a),
3036 the insurer shall notify the eligible employee of the right to reenroll when coverage is discontinued.
3037 (d) An eligible employee may not be discontinued under this Subsection (5) because of
3038 a fraud or misrepresentation that relates to health status.
3039 (6) (a) Except as provided in Subsection (5)(b), an insurer that elects to discontinue
3040 offering or not renew a health benefit plan under Subsection (1) shall be prohibited from writing
3041 new business in such market in this state for a period of five years beginning:
3042 (i) on the date of discontinuation; or
3043 (ii) the last date the coverage that is not renewed is provided.
3044 (b) The commissioner may waive the prohibition under Subsection (5)(a) when the
3045 commissioner finds that waiver is in the public interest:
3046 (i) to promote competition, or
3047 (ii) to resolve inequity in the marketplace;
3048 (7) If an insurer is doing business in one established geographic service area of the state,
3049 this section applies only to the insurer's operations in that geographic service area.
3050 (8) An insurer may modify a health benefit plan only:
3051 (a) at the time of coverage renewal; and
3052 (b) if the modification is effective uniformly among all plans with a particular product or
3053 service.
3054 (9) For purposes of this section, a reference to "plan sponsor" includes a reference to the
3055 employer:
3056 (a) with respect to coverage provided to an employer member of the association; and
3057 (b) if the health benefit plan is made available by an insurer in the employer market only
3058 through:
3059 (i) an association;
3060 (ii) a trust; or
3061 (iii) a discretionary group.
3062 (10) (a) A small employer that after purchasing a product in the small group market
3063 employees on average more than 50 eligible employees on each business day in a calendar year
3064 may keep the product the small employer purchased in the small group market.
3065 (b) A large employer that after purchasing a product in the large group market employs on

3066 average less than 51 eligible employees on each business day in a calendar year may continue to
3067 renew the coverage purchased in the large group market.
3068 (11) An insurer offering employer sponsored health benefit plans shall comply with the
3069 Health Insurance Portability and Accountability Act, P. L. 104-191, 110 Stat. 1962, Sec. 2701
3070 and 2702.
3071 Section 41. Section **31A-22-801** is amended to read:
3072 **31A-22-801. Scope of part.**
3073 (1) Except as provided under Subsection (2), all life insurance and accident and health
3074 insurance in connection with loans or other credit transactions are subject to this part.
3075 (2) (a) Insurance [~~in connection with a loan or other credit transaction~~] of more than ten
3076 years duration:
3077 (i) is not subject to this part[~~, but~~]; and
3078 (ii) is subject to other provisions of this title.
3079 (b) Isolated transactions on the part of an insurer that are not related to an agreement or
3080 plan for insuring debtors of the creditor are not subject to this part.
3081 Section 42. Section **31A-22-803.1** is enacted to read:
3082 **31A-22-803.1. Combinations of consumer credit insurance.**
3083 (1) Subject to Subsection (2), a type of consumer credit insurance defined in Section
3084 31A-22-802 may be written:
3085 (a) (i) separately; or
3086 (ii) in combination with another type of consumer credit insurance; or
3087 (b) (i) on an individual basis; or
3088 (ii) on a group policy basis.
3089 (2) The commissioner may by rule made in accordance with Title 63, Chapter 46a, Utah
3090 Administrator Rulemaking Act, prohibit or limit an insurer from writing a combination of types
3091 of consumer credit insurance.
3092 Section 43. Section **31A-22-804** is amended to read:
3093 **31A-22-804. Limitations on amounts of credit life insurance.**
3094 (1) Except as provided under Subsection (2), the [~~initial~~] amount of credit life insurance
3095 on the life of any one debtor at all times may not exceed [~~the total amount repayable under the~~
3096 ~~contract of indebtedness. Where an indebtedness is repayable in substantially equal periodic~~

3097 installments, the amount of insurance may not exceed] the greater of:
3098 (a) the scheduled [or actual] amount of [unpaid] net indebtedness[, whichever is greater];
3099 or
3100 (b) the actual amount of net indebtedness.
3101 (2) Subsection (1) does not apply to:
3102 (a) insurance on agricultural credit transaction commitments not exceeding the
3103 commitment period, which may be written for the amount of the commitment on a nondecreasing
3104 or level term plan;
3105 (b) insurance on educational credit transaction commitments, which may be written to
3106 include the portion of the commitment that has not been advanced by the creditor;
3107 (c) insurance on preauthorized lines of credit not exceeding the commitment period which
3108 may be written for the preauthorized amount on a nondecreasing or level term plan, whether
3109 secured or unsecured; and
3110 (d) insurance on any other class of lawful credit transaction or commitment, which in the
3111 commissioner's opinion does not require the application of the restrictions under Subsection (1),
3112 in which case the commissioner may authorize by rule a class exception to Subsection (1).
3113 (3) (a) The total amount of indemnity payable by credit accident and health insurance in
3114 the event of disability, as defined in the policy, may not exceed the aggregate of the periodic
3115 scheduled unpaid installments of the indebtedness.
3116 (b) The amount of each periodic indemnity payment may not exceed the total amount
3117 repayable under the contract of indebtedness divided by the number of periodic installments.
3118 Section 44. Section **31A-22-807** is amended to read:
3119 **31A-22-807. Filing and approval of forms -- Loss ratio standards.**
3120 (1) [All forms of policies, certificates of insurance, statements of insurance, endorsements,
3121 and riders] The following forms intended for use in Utah are subject to Section 31A-21-201[.]:
3122 (a) a policy;
3123 (b) a certificate of insurance;
3124 (c) a statement of insurance;
3125 (d) an endorsement; and
3126 (e) a rider.
3127 (2) In addition to the grounds [for disapproval] for the commissioner to prohibit use of a

3128 form under Subsection 31A-21-201(3), [~~it is a ground for disapproval that~~] the commissioner may
3129 prohibit use of a form if the benefits provided in the form are not reasonable in relation to the
3130 premium charge.
3131 (3) (a) In ascertaining whether the benefits are reasonable in relation to the premium
3132 charged, the commissioner shall consider:
3133 (i) the mortality cost of the life insurance [~~and~~];
3134 (ii) the morbidity cost of the accident and health insurance[~~,~~]; and
3135 (iii) the reserves set up for the payment of claims:
3136 (A) unreported; or
3137 (B) in the process of settlement.
3138 (b) The benefits are considered reasonable in relation to the premium charged if, given the
3139 costs described in Subsection (3)(a), the premium rate charged develops or may reasonably be
3140 expected to develop a loss ratio of:
3141 (i) not less than 50% for credit life insurance; and
3142 (ii) not less than 55% for credit accident and health insurance [~~given the above costs~~].
3143 (4) Benefits are considered reasonable in relation to premium charged if the ratio of claims
3144 incurred to premium earned during the most recent four-year period at the rates in use produces
3145 a loss ratio that is equal to or exceeds the minimum loss ratio standard specified in Subsection (3).
3146 (5) If the minimum loss ratio test produces a loss ratio that exceeds [~~Subsection (4)'s~~] the
3147 minimum loss ratio standard stated in Subsection (4) by five percentage points or more, the insurer
3148 may file for approval and use rates that are higher than prima facie rates, if it can be expected that
3149 the use of those higher rates will continue to produce a loss ratio for the accounts to which they
3150 are applied that will satisfy the minimum loss ratio test.
3151 (6) If the minimum loss ratio test produces a loss ratio that is lower than [~~Subsection (4)'s~~]
3152 the minimum loss standard stated in Subsection (4) by five percentage points or more, the
3153 commissioner may require that the insurer:
3154 (a) file adjusted rates that can be expected to produce a loss ratio that will satisfy the
3155 minimum loss ratio test[~~,~~]; or [~~to~~]
3156 (b) submit reasons acceptable to the commissioner why the insurer should not be required
3157 to file [~~these~~] adjusted rates.
3158 Section 45. Section **31A-22-808** is amended to read:

3159 **31A-22-808. Premiums and refunds.**
3160 (1) (a) Each policy, certificate, or statement of insurance shall provide that [~~in the event~~
3161 ~~of termination of~~] if the insurance [~~prior to~~] is terminated before the scheduled maturity date of the
3162 indebtedness, any refund of an amount paid by the debtor for insurance shall be paid or credited
3163 promptly to the person entitled to [~~it~~] the refund.
3164 (b) A refund formula used by an insurer shall result in refunds that are at least as favorable
3165 to the debtor as a refund that is equal to the premium cost of scheduled benefits subsequent to the
3166 date of cancellation or termination if computed at the schedule of premium rates in effect on the
3167 date of issue.
3168 (c) The formula described in Subsection (1)(b) used in computing the refund shall be filed
3169 with [~~and approved by~~] the commissioner [~~under Chapter 21, Part II. No~~].
3170 (d) A refund is not required if [~~it~~] the refund would be less than $5.
3171 (2) [~~If a creditor requires a debtor to make any payment for credit life or credit accident~~
3172 ~~and health insurance and an individual policy, certificate, or statement of insurance is not issued,~~
3173 ~~the~~] A creditor shall immediately give written notice to the debtor and credit the account[~~.~~] if:
3174 (a) a creditor requires a debtor to make any payment for:
3175 (i) credit life insurance; or
3176 (ii) credit accident and health insurance; and
3177 (b) an individual policy, certificate, or statement of insurance is not issued.
3178 (3) The amount charged the debtor for credit life or accident and health insurance may not
3179 exceed the premiums charged by the insurer as computed at the time the charge to the debtor is
3180 determined.
3181 Section 46. Section **31A-23-102** is amended to read:
3182 **31A-23-102. Definitions.**
3183 As used in this chapter:
3184 (1) "Actuary" means a person who is a member in good standing of the American
3185 Academy of Actuaries.
3186 (2) "Agency" means a person other than an individual, and includes a sole proprietorship
3187 by which a natural person does business under an assumed name.
3188 (3) "Broker" means an insurance broker or any other person, firm, association, or
3189 corporation that for any compensation, commission, or other thing of value acts or aids in any

3190 manner in soliciting, negotiating, or procuring the making of any insurance contract on behalf of
3191 an insured other than itself.
3192 (4) "Bail bond agent" means an individual:
3193 (a) appointed by an authorized bail bond surety insurer or appointed by a licensed bail
3194 bond surety company to execute or countersign undertakings of bail in connection with judicial
3195 proceedings; and
3196 (b) who receives or is promised money or other things of value for this service.
3197 (5) "Captive insurer" means:
3198 (a) an insurance company owned by another organization whose exclusive purpose is to
3199 insure risks of the parent organization and affiliated companies; or
3200 (b) in the case of groups and associations, an insurance organization owned by the insureds
3201 whose exclusive purpose is to insure risks of member organizations, group members, and their
3202 affiliates.
3203 (6) "Controlled insurer" means a licensed insurer that is either directly or indirectly
3204 controlled by a broker.
3205 (7) "Controlling broker" means a broker who either directly or indirectly controls an
3206 insurer.
3207 (8) "Controlling person" means any person, firm, association, or corporation that directly
3208 or indirectly has the power to direct or cause to be directed, the management, control, or activities
3209 of a reinsurance intermediary.
3210 (9) "Escrow" means [~~a license category that allows a person to conduct~~] conducting real
3211 estate escrows, settlements, or closings on behalf of:
3212 (a) a title insurance agency; or
3213 (b) a title insurer.
3214 (10) "Home state" means any state or territory of the United States or the District of
3215 Columbia in which an insurance producer:
3216 (a) maintains the insurance producer's principal:
3217 (i) place of residence; or
3218 (ii) place of business; and
3219 (b) is licensed to act as an insurance producer.
3220 (11) "Insurer" is as defined in Section 31A-1-301, except the following persons or similar

3221 persons are not insurers for purposes of Part 6, Broker Controlled Insurers:
3222 (a) all risk retention groups as defined in:
3223 (i) the Superfund Amendments and Reauthorization Act of 1986, Pub. L. No. 99-499;
3224 (ii) the Risk Retention Act, 15 U.S.C. Sec. 3901 et seq.; and
3225 (iii) Chapter 15, Part II, Risk Retention Groups Act;
3226 (b) all residual market pools and joint underwriting authorities or associations; and
3227 (c) all captive insurers.
3228 (12) "License" is defined in Section 31A-1-301.
3229 (13) "Limited license" means a license that:
3230 (a) is issued for a specific product of insurance; and
3231 (b) limits an individual or agency to transact only for that product or insurance.
3232 (14) "Limited line insurance" includes:
3233 (a) bail bond;
3234 (b) limited line credit [~~life~~] insurance;
3235 [~~(c) credit disability;~~]
3236 [~~(d) credit property;~~]
3237 [~~(e) credit unemployment;~~]
3238 [~~(f) involuntary unemployment;~~]
3239 [~~(g)~~] (c) legal expense insurance;
3240 [~~(h) mortgage life;~~]
3241 [~~(i) mortgage guaranty;~~]
3242 [~~(j) mortgage disability;~~]
3243 [~~(k)~~] (d) motor club insurance;
3244 [~~(l)~~] (e) rental car-related insurance;
3245 [~~(m)~~] (f) travel insurance; and
3246 [~~(n)~~] (g) any other form of limited insurance [~~or insurance offered in connection with an~~
3247 ~~extension of credit that: (i) is limited to partially or wholly extinguishing that credit obligation;~~
3248 ~~and(ii)~~] that the commissioner determines by rule should be designated a form of limited line
3249 insurance.
3250 (15) "Limited line credit insurance" includes the following forms of insurance:
3251 (a) credit life;

3252 (b) credit accident and health;
3253 (c) credit property;
3254 (d) credit unemployment;
3255 (e) involuntary unemployment;
3256 (f) mortgage life;
3257 (g) mortgage guaranty;
3258 (h) mortgage accident and health;
3259 (i) guaranteed automobile protection; and
3260 (j) any other form of insurance offered in connection with an extension of credit that:
3261 (i) is limited to partially or wholly extinguishing that credit obligation; and
3262 (ii) the commissioner determines by rule should be designated as a form of limited line
3263 credit insurance.
3264 (16) "Limited line credit insurance producer" means a person who sells, solicits, or
3265 negotiates one or more forms of limited line credit insurance coverage to individuals through a
3266 master, corporate, group, or individual policy.
3267 (17) "Limited lines insurance" includes:
3268 (a) the lines of insurance listed in Subsection (14); or
3269 (b) any other line of insurance that the commissioner considers necessary to recognize in
3270 the public interest.
3271 (18) "Limited lines producer" means a person authorized to sell, solicit, or negotiate
3272 limited lines insurance.
3273 [~~(15)~~] (19) (a) "Managing general agent" means any person, firm, association, or
3274 corporation that:
3275 (i) manages all or part of the insurance business of an insurer, including the management
3276 of a separate division, department, or underwriting office;
3277 (ii) acts as an agent for the insurer whether it is known as a managing general agent,
3278 manager, or other similar term;
3279 (iii) with or without the authority, either separately or together with affiliates, directly or
3280 indirectly produces and underwrites an amount of gross direct written premium equal to, or more
3281 than 5% of, the policyholder surplus as reported in the last annual statement of the insurer in any
3282 one quarter or year; and

3283 (iv) (A) adjusts or pays claims in excess of an amount determined by the commissioner;
3284 or
3285 (B) negotiates reinsurance on behalf of the insurer.
3286 (b) Notwithstanding Subsection [~~(15)~~] (19)(a), the following persons may not be
3287 considered as managing general agent for the purposes of this chapter:
3288 (i) an employee of the insurer;
3289 (ii) a United States manager of the United States branch of an alien insurer;
3290 (iii) an underwriting manager that, pursuant to contract:
3291 (A) manages all the insurance operations of the insurer;
3292 (B) is under common control with the insurer;
3293 (C) is subject to Chapter 16, Insurance Holding Companies; and
3294 (D) is not compensated based on the volume of premiums written; and
3295 (iv) the attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer
3296 or inter-insurance exchange under powers of attorney.
3297 [~~(16)~~] (20) "Negotiate" means the act of conferring directly with or offering advice directly
3298 to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the
3299 substantive benefits, terms, or conditions of the contract if the person engaged in that act:
3300 (a) sells insurance; or
3301 (b) obtains insurance from insurers for purchasers.
3302 (21) "Personal lines" means property and casualty insurance coverage sold to individuals
3303 and families for primarily noncommercial purposes.
3304 [~~(17)~~] (22) "Producer" means a person required to be licensed under the laws of this state
3305 to sell, solicit, or negotiate insurance.
3306 [~~(18)~~] (23) "Qualified United States financial institution" means an institution that:
3307 (a) is organized or, in the case of a United States office of a foreign banking organization
3308 licensed, under the laws of the United States or any state;
3309 (b) is regulated, supervised, and examined by United States federal or state authorities
3310 having regulatory authority over banks and trust companies; and
3311 (c) meets the standards of financial condition and standing that are considered necessary
3312 and appropriate to regulate the quality of financial institutions whose letters of credit will be
3313 acceptable to the commissioner as determined by:

3314 (i) the commissioner; or
3315 (ii) the Securities Valuation Office of the National Association of Insurance
3316 Commissioners.
3317 [~~(19)~~] (24) "Reinsurance intermediary" means a reinsurance intermediary-broker or a
3318 reinsurance intermediary-manager as these terms are defined in Subsections [~~(20)~~] (25) and [~~(21)~~]
3319 (26).
3320 [~~(20)~~] (25) "Reinsurance intermediary-broker" means a person other than an officer or
3321 employee of the ceding insurer, firm, association, or corporation who solicits, negotiates, or places
3322 reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power
3323 to bind reinsurance on behalf of the insurer.
3324 [~~(21)~~] (26) (a) "Reinsurance intermediary-manager" means a person, firm, association, or
3325 corporation who:
3326 (i) has authority to bind or who manages all or part of the assumed reinsurance business
3327 of a reinsurer, including the management of a separate division, department, or underwriting
3328 office; and
3329 (ii) acts as an agent for the reinsurer whether the person, firm, association, or corporation
3330 is known as a reinsurance intermediary-manager, manager, or other similar term.
3331 (b) Notwithstanding Subsection [~~(21)~~] (26)(a), the following persons may not be
3332 considered reinsurance intermediary-managers for the purpose of this chapter with respect to the
3333 reinsurer:
3334 (i) an employee of the reinsurer;
3335 (ii) a United States manager of the United States branch of an alien reinsurer;
3336 (iii) an underwriting manager that, pursuant to contract:
3337 (A) manages all the reinsurance operations of the reinsurer;
3338 (B) is under common control with the reinsurer;
3339 (C) is subject to Chapter 16, Insurance Holding Companies; and
3340 (D) is not compensated based on the volume of premiums written; and
3341 (iv) the manager of a group, association, pool, or organization of insurers that:
3342 (A) engage in joint underwriting or joint reinsurance; and
3343 (B) are subject to examination by the insurance commissioner of the state in which the
3344 manager's principal business office is located.

3345 [(22)] (27) "Reinsurer" means any person, firm, association, or corporation duly licensed
3346 in this state as an insurer with the authority to assume reinsurance.
3347 [(23)] (28) "Search" means a license category that allows a person to issue title insurance
3348 commitments or policies on behalf of a title insurer.
3349 [(24)] (29) "Sell" means to exchange a contract of insurance:
3350 (a) by any means;
3351 (b) for money or its equivalent; and
3352 (c) on behalf of an insurance company.
3353 [(25)] (30) "Solicit" means:
3354 (a) attempting to sell insurance; or
3355 (b) asking or urging a person to apply:
3356 (i) for a particular kind of insurance; and
3357 (ii) from a particular insurance company.
3358 [(26)] (31) "Surplus lines broker" means a person licensed under Subsection
3359 31A-23-204(5) to place insurance with unauthorized insurers in accordance with Section
3360 31A-15-103.
3361 [(27)] (32) "Terminate" means:
3362 (a) the cancellation of the relationship between:
3363 (i) an insurance producer; and
3364 (ii) a particular insurer; or
3365 (b) the termination of the producer's authority to transact insurance on behalf of a
3366 particular insurance company.
3367 [(28)] (33) "Title marketing representative" means a person who:
3368 (a) represents a title insurer in soliciting, requesting, or negotiating the placing of:
3369 (i) title insurance; or
3370 (ii) escrow[, settlement, or closing] services; and
3371 (b) does not have a search or escrow license.
3372 [(29)] (34) "Underwrite" means the authority to accept or reject risk on behalf of the
3373 insurer.
3374 [(30)] (35) "Uniform application" means the version of the National Association of
3375 Insurance Commissioner's uniform application for resident and nonresident producer licensing at

3376 the time the application is filed.

3377 [(31)] (36) "Uniform business entity application" means the version of the National
3378 Association of Insurance Commissioner's uniform business entity application for resident and
3379 nonresident business entities at the time the application is filed.

3380 Section 47. Section **31A-23-204** is amended to read:

3381 **31A-23-204. License classifications.**

3382 A resident or nonresident license issued under this chapter shall be issued under the
3383 classifications described under Subsections (1) through (6). These classifications are intended to
3384 describe the matters to be considered under any education, examination, and training required of
3385 license applicants under Sections 31A-23-206 through 31A-23-208.

3386 (1) An agent and broker license classification includes:

3387 (a) life insurance, including nonvariable contracts;

3388 (b) variable contracts;

3389 (c) accident and health insurance, including contracts issued to policyholders under
3390 Chapter 7 or 8;

3391 (d) property/liability insurance, which includes:

3392 (i) property insurance;

3393 (ii) liability insurance;

3394 (iii) surety and other bonds; and

3395 (iv) policies containing any combination of these coverages;

3396 (e) title insurance under one of the following categories:

3397 (i) search, including authority to act as a title marketing representative;

3398 (ii) escrow, including authority to act as a title marketing representative;

3399 (iii) search and escrow, including authority to act as a title marketing representative; and

3400 (iv) title marketing representative only; [and]

3401 (f) workers' compensation insurance[.]; and

3402 (g) personal lines.

3403 (2) A limited license classification includes:

3404 (a) limited line credit [life and credit accident and health] insurance;

3405 (b) travel insurance;

3406 (c) motor club insurance;

3407 (d) car rental related insurance;

3408 [(e) credit involuntary unemployment insurance;]

3409 [(f) credit property insurance;]

3410 (e) legal expense insurance;

3411 [(g)] (f) bail bond agent; and

3412 [(h)] (g) customer service representative.

3413 (3) A consultant license classification includes:

3414 (a) life insurance, including nonvariable contracts;

3415 (b) variable contracts;

3416 (c) accident and health insurance, including contracts issued to policyholders under Chapter

3417 7 or 8;

3418 (d) property/liability insurance, which includes:

3419 (i) property insurance;

3420 (ii) liability insurance;

3421 (iii) surety and other bonds; and

3422 (iv) policies containing any combination of these coverages; and

3423 (e) workers' compensation insurance.

3424 (4) A holder of licenses under Subsections (1)(a) and (1)(c) has all qualifications necessary

3425 to act as a holder of a license under Subsection (2)(a).

3426 (5) (a) Upon satisfying the additional applicable requirements, a holder of a brokers license

3427 may obtain a license to act as a surplus lines broker.

3428 (b) A license to act as a surplus lines broker gives the holder the authority to arrange

3429 insurance contracts with unauthorized insurers under Section 31A-15-103, but only as to the types

3430 of insurance under Subsection (1) for which the broker holds a brokers license.

3431 (6) The commissioner may by rule recognize other agent, broker, limited license, or

3432 consultant license classifications as to kinds of insurance not listed under Subsections (1), (2), and

3433 (3).

3434 Section 48. Section **31A-23-206** is amended to read:

3435 **31A-23-206. Continuing education requirements -- Regulatory authority.**

3436 (1) The commissioner shall by rule prescribe the continuing education requirements for

3437 each class of agent's license under Subsection 31A-23-204(1), except that the commissioner may

3438 not impose a continuing education requirement on a holder of a license under:
3439 (a) Subsection 31A-23-204(2); or
3440 (b) a license classification other than under Subsection 31A-23-204(2) that is recognized
3441 by the commissioner by rule as provided in Subsection 31A-23-204(6).
3442 (2) (a) The commissioner may not state a continuing education requirement in terms of
3443 formal education.
3444 (b) The commissioner may state a continuing education requirement in terms of classroom
3445 hours, or their equivalent, of insurance-related instruction received.
3446 (c) Insurance-related formal education may be a substitute, in whole or in part, for
3447 classroom hours, or their equivalent, required under Subsection (2)(b).
3448 (3) (a) The commissioner shall impose continuing education requirements in accordance
3449 with a two-year licensing period in which the licensee meets the requirements of this Subsection
3450 (3).
3451 (b) Except as provided in Subsection (3)(c), for a two-year licensing period described in
3452 Subsection (3)(a) the commissioner shall require that the licensee for each line of authority held
3453 by the licensee:
3454 (i) receive [~~six~~] five hours of continuing education; or
3455 (ii) pass a line of authority continuing education examination.
3456 (c) Notwithstanding Subsection (3)(b):
3457 (i) the commissioner may not require continuing education for more than four lines of
3458 authority held by the licensee;
3459 (ii) the commissioner shall require:
3460 (A) a minimum of:
3461 (I) 12 hours of continuing education;
3462 (II) passage of two line of authority continuing education examinations; or
3463 (III) a combination of Subsections (3)(c)(ii)(A)(I) and (II);
3464 (B) that the minimum continuing education requirement of Subsection (3)(c)(ii)(A)
3465 include:
3466 (I) at least [~~six~~] five hours or one line of authority continuing education examination for
3467 each line of authority held by the licensee not to exceed four lines of authority held by the licensee;
3468 and

3469 (II) three hours of ethics training[~~, which may be taken in place of three hours of the hours~~
3470 ~~required for a line of authority~~].
3471 (d) (i) If a licensee completes the licensee's continuing education requirement without
3472 taking a line of authority continuing education examination, the licensee shall complete at least 1/2
3473 of the required hours through classroom hours of insurance-related instruction.
3474 (ii) The hours not completed through classroom hours in accordance with Subsection
3475 (3)(d)(i) may be obtained through:
3476 (A) home study;
3477 (B) video tape;
3478 (C) experience credit; or
3479 (D) other method provided by rule.
3480 (e) (i) A licensee may obtain continuing education hours at any time during the two-year
3481 licensing period.
3482 (ii) The licensee may not take a line of authority continuing education examination more
3483 than 90 calendar days before the date on which the licensee's license is renewed.
3484 (f) The commissioner shall make rules for the content and procedures for line of authority
3485 continuing education examinations.
3486 (g) (i) Beginning May 3, 1999, a licensee is exempt from continuing education
3487 requirements under this section if:
3488 (A) as of April 1, 1990, the licensee has completed 20 years of licensure in good standing;
3489 (B) the licensee requests an exemption from the department; and
3490 (C) the department approves the exemption.
3491 (ii) If the department approves the exemption under Subsection (3)(g)(i), the licensee is
3492 not required to apply again for the exemption.
3493 (h) A licensee with a variable contract line of authority is exempt from the requirement
3494 for continuing education for that line of authority so long as the:
3495 (i) National Association of Securities Dealers requires continuing education for licensees
3496 having a securities license; and
3497 (ii) licensee complies with the National Association of Securities Dealers' continuing
3498 education requirements for securities licensees.
3499 (i) The commissioner shall, by rule:

3500 (i) publish a list of insurance professional designations whose continuing education
3501 requirements can be used to meet the requirements for continuing education under Subsection
3502 (3)(c); and
3503 (ii) authorize professional agent associations to:
3504 (A) offer qualified programs for all classes of licenses on a geographically accessible basis;
3505 and
3506 (B) collect reasonable fees for funding and administration of the continuing education
3507 program, subject to the review and approval of the commissioner.
3508 (j) (i) The fees permitted under Subsection (3)(i)(ii) that are charged to fund and administer
3509 the program shall reasonably relate to the costs of administering the program.
3510 (ii) Nothing in this section prohibits a provider of continuing education programs or
3511 courses from charging fees for attendance at courses offered for continuing education credit.
3512 (iii) The fees permitted under Subsection (3)(i)(ii) that are charged for attendance at a
3513 professional agent association program may be less for an association member, based on the
3514 member's affiliation expense, but shall preserve the right of a nonmember to attend without
3515 affiliation.
3516 (4) The commissioner shall designate courses, including those presented by insurers,
3517 which satisfy the requirements of this section.
3518 (5) The requirements of this section apply only to applicants who are natural persons.
3519 (6) A nonresident producer is considered to have satisfied this state's continuing education
3520 requirements if:
3521 (a) the nonresident producer satisfies the nonresident producer's home state's continuing
3522 education requirements for a licensed insurance producer; and
3523 (b) on the same basis as under this Subsection (6) the nonresident producer's home state
3524 considers satisfaction of Utah's continuing education requirements for a producer as satisfying the
3525 continuing education requirements of the home state.
3526 Section 49. Section **31A-23-211** is amended to read:
3527 **31A-23-211. Special requirements for title insurance agents.**
3528 Title insurance agents shall be licensed in accordance with this chapter, with the
3529 [~~following~~] additional requirements[~~:~~] listed in this section.
3530 (1) (a) Every title insurance agency or agent appointed by an insurer shall maintain:

3531 (i) a fidelity bond [or];
3532 (ii) a professional liability insurance policy[,]; or [an equivalent]
3533 (iii) a financial protection:
3534 (A) equivalent to that described in Subsection (1)(a)(i) or (ii); and
3535 (b) that the commissioner considers adequate. [This]
3536 (b) The bond or insurance required by this Subsection (1):
3537 (i) shall be supplied under a contract approved by the commissioner to provide protection
3538 against the improper performance of any service in conjunction with the issuance of a contract or
3539 policy of title insurance[. The bond or professional liability policy shall]; and
3540 (ii) be in a face amount no less than $50,000.
3541 (c) The commissioner may by rule exempt title insurance agents from the requirements of
3542 this Subsection (1) upon a finding that, and only so long as, the required policy or bond is generally
3543 unavailable at reasonable rates.
3544 (2) (a) (i) Every title insurance agency or agent appointed by an insurer shall maintain a
3545 reserve fund. [This]
3546 (ii) The reserve fund required by this Subsection (2) shall be:
3547 (A) (I) composed of assets approved by the commissioner [and];
3548 (II) maintained as a separate account; and
3549 (III) charged as a reserve liability of the title insurance agent in determining the agent's
3550 financial condition[. The reserve fund shall be]; and
3551 (B) accumulated by segregating 1% of all gross income received from the title insurance
3552 business.
3553 (iii) Assets accumulated within the reserve fund for more than ten full years shall be:
3554 (A) withdrawn from the fund; and
3555 (B) restored to the income of the agent.
3556 (iv) The title insurance agent may withdraw interest from the reserve fund related to the
3557 principal amount as it accrues.
3558 (b) (i) A disbursement may not be made from the reserve fund except as provided in
3559 Subsection (2)(a) unless the title insurance agent ceases doing business as a result of:
3560 (A) sale of assets[,];
3561 (B) merger of the agent with another agent[,];

3562 (C) termination of the agent's license[,];
3563 (D) insolvency[,]; or
3564 (E) any cessation of business by the agent.
3565 (ii) Any disbursements from the reserve fund may be made only to settle claims arising
3566 from the improper performance of the title insurance agent in providing services defined in Section
3567 31A-23-307.
3568 (iii) The commissioner shall be notified ten days before any disbursements from the
3569 reserve fund.
3570 (iv) The notice [must] required by this Subsection (2)(b) shall contain:
3571 (A) the amount of claim[,];
3572 (B) the nature of the claim[,]; and
3573 (C) the name of the payee.
3574 (c) (i) The reserve fund shall be maintained by the title insurance agent or [his] the title
3575 insurance agent's representative for a period of two years after the agent ceases doing business.
3576 (ii) Any assets remaining in the reserve fund at the end of the two years specified in
3577 Subsection (2)(c)(i) may be withdrawn and restored to the former agent.
3578 (3) Any examination for licensure shall include questions regarding the search and
3579 examination of title to real property.
3580 (4) A title insurance agent may not perform the functions of escrow[, closing, or
3581 settlement,] unless the agent has been examined on the fiduciary duties and procedures involved
3582 in those functions.
3583 (5) The commissioner shall adopt rules outlining an examination that will satisfy this
3584 section.
3585 (6) [Licenses] A license may be issued to a title insurance [agents] agent who [have] has
3586 qualified:
3587 (a) to perform only searches and examinations of title as specified in Subsection (3)[, or
3588 to title insurance agents who have qualified];
3589 (b) to handle only [escrow, settlement, and closing arrangements] escrows as specified in
3590 Subsection (4)[,]; or [to title insurance agents who have qualified]
3591 (c) to act as a title marketing [representatives] representative.
3592 (7) A person licensed to practice law in Utah is exempt from the requirements of

3593 Subsections (1) and (2) if[:] that person issues 12 or fewer policies in any 12-month period.
3594 [(a) (i) the issuance of title insurance is an incidental part of that person's practice of law;
3595 and]
3596 [(ii) that person does not hire employees or independent contractors to investigate title or
3597 otherwise assist in the issuance of title insurance; or]
3598 [(b) that person does not maintain a title plant, or operate primarily as a title insurance
3599 agent.]
3600 Section 50. Section **31A-23-216** is amended to read:
3601 **31A-23-216. Termination of license.**
3602 (1) A license issued under this chapter remains in force until:
3603 (a) revoked, suspended, or limited under Subsection (2);
3604 (b) lapsed under Subsection (3);
3605 (c) surrendered to and accepted by the commissioner; or
3606 (d) the licensee dies or is adjudicated incompetent as defined under:
3607 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
3608 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and
3609 Minors.
3610 (2) (a) If the commissioner makes a finding under Subsection (2)(b), after an adjudicative
3611 proceeding under Title 63, Chapter 46b, Administrative Procedures Act, the commissioner may:
3612 (i) revoke a license of an agent, broker, surplus lines broker, or consultant;
3613 (ii) suspend for a specified period of 12 months or less a license of an agent, broker,
3614 surplus lines broker, or consultant; or
3615 (iii) limit in whole or in part the license of any agent, broker, surplus lines broker, or
3616 consultant.
3617 (b) The commissioner may take an action described in Subsection (2)(a) if the
3618 commissioner finds that the licensee:
3619 (i) is unqualified for a license under Section 31A-23-203;
3620 (ii) has violated:
3621 (A) an insurance statute;
3622 (B) a rule that is valid under Subsection 31A-2-201(3); or
3623 (C) an order that is valid under Subsection 31A-2-201(4);

3624 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other
3625 delinquency proceedings in any state;
3626 (iv) fails to pay any final judgment rendered against the person in this state within 60 days
3627 after the day the judgment became final;
3628 (v) fails to meet the same good faith obligations in claims settlement that is required of
3629 admitted insurers;
3630 (vi) is affiliated with and under the same general management or interlocking directorate
3631 or ownership as another insurance producer that transacts business in this state without a license;
3632 (vii) refuses to be examined or to produce its accounts, records, and files for examination;
3633 (viii) has an officer who refuses to:
3634 (A) give information with respect to the administrator's affairs; or
3635 (B) perform any other legal obligation as to an examination;
3636 (ix) provided information in the license application that is:
3637 (A) incorrect;
3638 (B) misleading;
3639 (C) incomplete; or
3640 (D) materially untrue;
3641 (x) has violated any insurance law, valid rule, or valid order of another state's insurance
3642 department;
3643 (xi) has obtained or attempted to obtain a license through misrepresentation or fraud;
3644 (xii) has improperly withheld, misappropriated, or converted any monies or properties
3645 received in the course of doing insurance business;
3646 (xiii) has intentionally misrepresented the terms of an actual or proposed:
3647 (A) insurance contract; or
3648 (B) application for insurance;
3649 (xiv) has been convicted of a felony;
3650 (xv) has admitted or been found to have committed any insurance unfair trade practice or
3651 fraud;
3652 (xvi) in the conduct of business in this state or elsewhere has:
3653 (A) used fraudulent, coercive, or dishonest practices; or
3654 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;

3655 (xvii) has had an insurance license, or its equivalent, denied, suspended, or revoked in any
3656 other state, province, district, or territory;
3657 (xviii) has forged another's name to:
3658 (A) an application for insurance; or
3659 (B) any document related to an insurance transaction;
3660 (xix) has improperly used notes or any other reference material to complete an
3661 examination for an insurance license;
3662 (xx) has knowingly accepted insurance business from an individual who is not licensed;
3663 (xxi) has failed to comply with an administrative or court order imposing a child support
3664 obligation;
3665 (xxii) has failed to:
3666 (A) pay state income tax; or
3667 (B) comply with any administrative or court order directing payment of state income tax;
3668 (xxiii) has violated or permitted others to violate the federal Violent Crime Control and
3669 Law Enforcement Act of 1994, 18 U.S.C. Secs. 1033 and 1034; or
3670 (xxiv) has engaged in methods and practices in the conduct of business that endanger the
3671 legitimate interests of customers and the public.
3672 (3) (a) Any license issued under this chapter shall lapse if the licensee fails:
3673 (i) to pay when due a fee under Section 31A-3-103[.];
3674 (ii) to complete continuing education requirements under Section 31A-23-206 before
3675 submitting the license renewal application;
3676 (iii) to submit a completed renewal application as required by Section 31A-23-202; or
3677 (iv) to submit additional documentation required to complete the licensing process as
3678 related to a specific license type.
3679 (b) A licensee whose license lapses due to military service or some other extenuating
3680 circumstances such as long-term medical disability may request:
3681 (i) reinstatement of the license; and
3682 (ii) waiver of any of the following imposed for failure to comply with renewal procedures:
3683 (A) an examination requirement;
3684 (B) a fine; or
3685 (C) other sanction imposed for failure to comply with renewal procedures.

3686 (c) The commissioner shall by rule prescribe the license renewal and reinstatement
3687 procedures, in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act.
3688 (4) A licensee under this chapter whose license is suspended, revoked, or lapsed, but who
3689 continues to act as a licensee, is subject to the penalties for acting as a licensee without a license.
3690 (5) Any person licensed in this state shall immediately report to the commissioner:
3691 (a) a suspension or revocation of that person's license in any other state, District of
3692 Columbia, or territory of the United States;
3693 (b) the imposition of a disciplinary sanction imposed on that person by any other state,
3694 District of Columbia, or territory of the United States; and
3695 (c) a judgment or injunction entered against that person on the basis of conduct involving
3696 fraud, deceit, misrepresentation, or violation of an insurance law or rule.
3697 (6) (a) An order revoking a license under Subsection (2) may specify a time, not to exceed
3698 five years, within which the former licensee may not apply for a new license.
3699 (b) If no time is specified in an order revoking a license under Subsection (2), the former
3700 licensee may not apply for a new license for five years without express approval by the
3701 commissioner.
3702 (7) (a) Any person whose license is suspended or revoked under Subsection (2) shall, when
3703 the suspension ends or a new license is issued, pay all fees that would have been payable if the
3704 license had not been suspended or revoked, unless the commissioner by order waives the payment
3705 of the interim fees.
3706 (b) If a new license is issued more than three years after the revocation of a similar license,
3707 this Subsection (7) applies only to the fees that would have accrued during the three years
3708 immediately following the revocation.
3709 (8) The division shall promptly withhold, suspend, restrict, or reinstate the use of a license
3710 issued under this part if so ordered by a court.
3711 Section 51. Section **31A-23-307** is amended to read:
3712 **31A-23-307. Title insurance agents' business.**
3713 (1) A title insurance agent may engage in the escrow[~~, settlement, or closing~~] business[~~,~~
3714 ~~or any combination of such businesses, and operate as escrow, settlement, or closing agent~~
3715 ~~provided that~~] involving real property transactions if all of the following exist:
3716 [~~(1) The~~] (a) the title insurance agent is properly licensed under this chapter[~~.~~];

3717 (b) the title insurance agent is appointed by a title insurer authorized to do business in the
3718 state;
3719 (c) one or more of the following is to be issued as part of the transaction:
3720 (i) an owner's policy of title insurance; or
3721 (ii) a lender's policy of title insurance;
3722 [(2) (a) (i) All] (d) (i) all funds deposited with the agent in connection with any escrow[,
3723 settlement, or closing]:
3724 (A) are deposited:
3725 (I) in a federally insured financial institution; and
3726 (II) in [separate] trust accounts[, with the funds being] that are separate from all other
3727 funds held in trust; and
3728 (B) are the property of the persons entitled to them under the provisions of the escrow[,
3729 settlement, or closing.]; and
3730 (ii) [The funds shall be] are segregated escrow by escrow[, settlement by settlement, or
3731 closing by closing] in the records of the agent[.];
3732 [(iii) Earnings] (e) earnings on funds held in escrow may be paid out of the escrow
3733 account to any person in accordance with the provisions of the escrow [agreement if the
3734 agreement];
3735 (f) the escrow does not involve retention of funds by the agent that are related to
3736 construction funding or exchanges under Section 1031, Internal Revenue Code; and
3737 (g) the escrow does not otherwise provide for payment of the earnings or any portion of
3738 the earnings on the escrow funds.
3739 [(iv)] (2) Funds held in escrow:
3740 [(A)] (a) are not subject to any debts of the agent; [and]
3741 [(B)] (b) may only be used to fulfill the terms of the individual escrow[, settlement, or
3742 closing] under which the funds were accepted[.]; and
3743 [(v) Funds held in escrow]
3744 (c) may not be used until all conditions of the escrow[, settlement, or closing] have been
3745 met.
3746 [(b)] (3) Assets or property other than escrow funds received by an agent in accordance
3747 with an escrow [agreement] shall be maintained in a manner that will:

3748 [(i)] (a) reasonably preserve and protect the asset or property from loss, theft, or damages;
3749 and
3750 [(ii)] (b) otherwise comply with all general duties and responsibilities of a fiduciary or
3751 bailee.
3752 [(c)] (4) (a) A check may not be drawn, executed or dated, or funds otherwise disbursed
3753 unless the segregated escrow account from which funds are to be disbursed contains a sufficient
3754 credit balance consisting of collected or cleared funds at the time the check is drawn, executed or
3755 dated, or funds are otherwise disbursed.
3756 [(d)] (b) As used in this Subsection [(2)] (4), funds are considered to be "collected or
3757 cleared," and may be disbursed as follows:
3758 (i) cash may be disbursed on the same day [it] the cash is deposited;
3759 (ii) a wire [transfers] transfer may be disbursed on the same day [they are] the wire transfer
3760 is deposited;
3761 (iii) [cashier's checks, certified checks, teller's checks, U.S. Postal Service money orders,
3762 and checks drawn on a Federal Reserve Bank or Federal Home Loan Bank] the following may be
3763 disbursed on the day following the date of deposit:
3764 (A) a cashier's check;
3765 (B) a certified check;
3766 (C) a teller's check;
3767 (D) a U.S. Postal Service money order; and
3768 (E) a check drawn on a Federal Reserve Bank or Federal Home Loan Bank; and
3769 (iv) any other [checks] check or [deposits] deposit may be disbursed:
3770 (A) within the time limits provided under the Expedited Funds Availability Act, 12 U.S.C.
3771 Section 4001 et seq., as amended, and related regulations of the Federal Reserve System; or
3772 (B) upon written notification from the financial institution to which the funds have been
3773 deposited, that final settlement has occurred on the deposited item.
3774 [(3)] (5) The title insurance agent shall maintain records of all receipts and disbursements
3775 of escrow[, settlement, and closing] funds.
3776 [(4)] (6) The title insurance agent shall comply with:
3777 (a) Section 31A-23-310; and
3778 (b) any rules adopted by the commissioner [governing] in accordance with Title 63,

3779 Chapter 46a, Utah Administrative Rulemaking Act, that govern escrows[, settlements, or closings].
3780 Section 52. Section **31A-23-308** is amended to read:
3781 **31A-23-308. Liability of title insurers for acts of title insurance agents.**
3782 (1) Any title company, represented by one or more title insurance agents, is directly and
3783 primarily liable to others dealing with the title insurance agents for the receipt and disbursement
3784 of funds deposited in escrows[, closings, or settlements] with the title insurance agents [in all those
3785 transactions where a commitment or binder for or policy or contract of title insurance of that title
3786 insurance company has been ordered, or a preliminary report of the title insurance company has
3787 been issued or distributed. This].
3788 (2) The liability described in Subsection (1) does not modify, mitigate, impair, or affect
3789 the contractual obligations between:
3790 (a) the title insurance agents; and
3791 (b) the title insurance company.
3792 Section 53. Section **31A-23-503** is amended to read:
3793 **31A-23-503. Duties of insurers.**
3794 (1) The insurer shall have on file an independent financial examination, in a form
3795 acceptable to the commissioner, of each managing general agent with which [it] the insurer has
3796 done business.
3797 (2) (a) If a managing general agent establishes loss reserves, the insurer shall annually
3798 obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses
3799 incurred and outstanding on business produced by the managing general agent. [This]
3800 (b) The requirement of Subsection (2)(a) is in addition to any other required loss reserve
3801 certification.
3802 (3) The insurer shall at least semiannually conduct an on-site review of the underwriting
3803 and claims processing operations of the managing general agent.
3804 (4) Binding authority for all reinsurance contracts or participation in insurance or
3805 reinsurance syndicates shall rest with an officer of the insurer, who may not be affiliated with the
3806 managing general agent.
3807 (5) (a) Within 30 days after entering into or terminating a contract with a managing general
3808 agent, the insurer shall provide written notification of the appointment or termination to the
3809 commissioner.

3810 (b) A notice of appointment of a managing general agent shall include:
3811 [(a)] (i) a statement of duties that the applicant is expected to perform on behalf of the
3812 insurer;
3813 [(b)] (ii) the lines of insurance for which the applicant is to be authorized to act; and
3814 [(c)] (iii) any other information the commissioner may request.
3815 (6) (a) An insurer shall review [its] the insurer's books and records each quarter to
3816 determine if any producer, as defined [by Subsection] in Section 31A-23-102[(17)], has become
3817 a managing general agent as defined in [Subsection] Section 31A-23-102[(15)].
3818 (b) If the insurer determines that a producer has become a managing general agent[,]:
3819 (i) the insurer shall promptly notify the producer and the commissioner of the
3820 determination[. The]; and
3821 (ii) the insurer and producer shall fully comply with the provisions of this chapter within
3822 30 days.
3823 (7) (a) An insurer may not appoint officers, directors, employees, subproducers, or
3824 controlling shareholders of [its] the insurer's managing general agents to [its] the insurer's board
3825 of directors.
3826 (b) This Subsection (7) does not apply to relationships governed by [Title 31A,]:
3827 (i) Chapter 16, Insurance Holding Companies[,]; or
3828 (ii) Chapter 23, Part 6, Broker Controlled Insurers, if it applies.
3829 Section 54. Section **31A-23-601** is amended to read:
3830 **31A-23-601. Applicability.**
3831 (1) This part applies to licensed insurers, as defined in [Subsection] Section
3832 31A-23-102[(11), which], that are [either]domiciled:
3833 (a) in this state; or [domiciled]
3834 (b) in a state that does not have a substantially similar law.
3835 (2) All provisions of [Title 31A,] Chapter 16, Insurance Holding Companies, to the extent
3836 they are not superseded by this part, continue to apply to all parties within holding company
3837 systems subject to this part.
3838 Section 55. Section **31A-25-205** is amended to read:
3839 **31A-25-205. Financial responsibility.**
3840 (1) Every person licensed under this chapter shall[, while licensed and for one year after

3841 that date,] maintain an insurance policy or surety bond[,]:
3842 (a) (i) while licensed; and
3843 (ii) for one year after the person is licensed; and
3844 (b) issued:
3845 (i) by an authorized insurer[,];
3846 (ii) in an amount specified under Subsection (2)[,]; and
3847 (iii) on a policy or contract form [which] that is acceptable under Subsection (3).
3848 (2) (a) Insurance policies or surety bonds satisfying the requirement of Subsection (1) shall
3849 be in a face amount equal to:
3850 (i) at least the greater of:
3851 (A) 10% of the total funds handled by the administrator[. However, no policy or bond
3852 under this Subsection (2)(a) may be in a face amount of less than]; or
3853 (B) $5,000 [nor more than]; and
3854 (ii) may not exceed $500,000.
3855 (b) In fixing the policy or bond face amount under Subsection (2)(a), the total funds
3856 handled is:
3857 (i) the greater of:
3858 (A) the premiums received during the previous calendar year; or
3859 (B) claims paid through the administrator during the previous calendar year; or
3860 (ii) if no funds were handled during the preceding year, the total funds reasonably
3861 anticipated to be handled by the administrator during the current calendar year.
3862 (c) This section does not prohibit any person dealing with the administrator from requiring,
3863 by contract, insurance coverage in amounts greater than the insurance coverage required under this
3864 section.
3865 (3) (a) Insurance policies or surety bonds issued to satisfy Subsection (1) shall:
3866 (i) be on forms approved by the commissioner[. The policies or bonds shall]; and
3867 (ii) require the insurer to pay, up to the policy or bond face amount, any judgment:
3868 (A) obtained by participants in or beneficiaries of plans administered by the insured
3869 licensee [which arise]; and
3870 (B) that arises from the negligence or culpable acts of the licensee or any employee or
3871 agent of the licensee in connection with the activities [described under Subsection] of third party

3872 administrator as defined in Section 31A-1-301[(111)].
3873 (b) The commissioner may require that policies or bonds issued to satisfy the requirements
3874 of this section require the insurer to give the commissioner 20 day prior notice of policy
3875 cancellation.
3876 (4) The commissioner shall establish annual reporting requirements and forms to monitor
3877 compliance with this section.
3878 (5) This section may not be construed as limiting any cause of action an insured would
3879 otherwise have against the insurer.
3880 Section 56. Section **31A-26-202 (Effective 07/01/02)** is amended to read:
3881 **31A-26-202 (Effective 07/01/02). Application for license.**
3882 (1) (a) The application for a license as an independent adjuster or public adjuster shall be:
3883 (i) made to the commissioner on forms and in a manner the commissioner prescribes; and
3884 (ii) accompanied by the applicable fee, which is not refunded if the application is denied.
3885 (b) The application shall provide:
3886 (i) information about the applicant's identity[;] including:
3887 [(ii)] (A) the applicant's:
3888 [(A)] (I) social security number; or
3889 [(B)] (II) federal employer identification number;
3890 [(iii)] (B) the applicant's personal history, experience, education, and business record;
3891 [(iv)] (C) if the applicant is a natural person, whether the applicant is 18 years of age or
3892 older; and
3893 [(v)] (D) whether the applicant has committed an act that is a ground for denial,
3894 suspension, or revocation as set forth in Section 31A-25-208; and
3895 [(vi)] (ii) any other information as the commissioner reasonably requires.
3896 (2) The commissioner may require documents reasonably necessary to verify the
3897 information contained in the application.
3898 (3) The following are private records under Subsection 63-2-302(1)(a)(vii):
3899 (a) the applicant's social security number; and
3900 (b) the applicant's federal employer identification number.
3901 Section 57. Section **31A-26-202 (Superseded 07/01/02)** is amended to read:
3902 **31A-26-202 (Superseded 07/01/02). Application for license.**

3903 (1) (a) The application for a license as an independent adjuster or public adjuster shall be:
3904 (i) made to the commissioner on forms and in a manner the commissioner prescribes; and
3905 (ii) accompanied by the applicable fee, which is not refunded if the application is denied.
3906 (b) The application shall provide:
3907 (i) information about the applicant's identity[;], including:
3908 [(ii)] (A) the applicant's:
3909 [(A)] (I) social security number; or
3910 [(B)] (II) federal employer identification number;
3911 [(iii)] (B) the applicant's personal history, experience, education, and business record;
3912 [(iv)] (C) if the applicant is a natural person, whether the applicant is 18 years of age or
3913 older; and
3914 [(v)] (D) whether the applicant has committed an act that is a ground for denial,
3915 suspension, or revocation as set forth in Section 31A-25-208; and
3916 [(vi)] (ii) any other information as the commissioner reasonably requires.
3917 (2) The commissioner may require documents reasonably necessary to verify the
3918 information contained in the application.
3919 (3) The following are private records under Subsection 63-2-302(1)(g):
3920 (a) the applicant's social security number; and
3921 (b) the applicant's federal employer identification number.
3922 Section 58. Section **31A-26-206** is amended to read:
3923 **31A-26-206. Continuing education requirements.**
3924 (1) The commissioner shall by rule prescribe continuing education requirements for each
3925 class of license under Section 31A-26-204.
3926 (2) (a) The commissioner shall impose continuing education requirements in accordance
3927 with a two-year licensing period in which the licensee meets the requirements of this Subsection
3928 (2).
3929 (b) Except as provided in Subsection (2)(c), for a two-year licensing period described in
3930 Subsection (2)(a) the commissioner shall require that the licensee for each line of authority held
3931 by the licensee:
3932 (i) receive [six] five hours of continuing education; or
3933 (ii) pass a line of authority continuing education examination.

3934 (c) Notwithstanding Subsection (2)(b):
3935 (i) the commissioner may not require continuing education for more than four lines of
3936 authority held by the licensee;
3937 (ii) the commissioner shall require:
3938 (A) a minimum of:
3939 (I) 12 hours of continuing education;
3940 (II) passage of two line of authority continuing education examinations; or
3941 (III) a combination of Subsection (2)(c)(ii)(A)(I) and (II);
3942 (B) that the minimum continuing education requirement of Subsection (2)(c)(ii)(A)
3943 include:
3944 (I) at least [~~six~~] five hours or one line of authority continuing education examination for
3945 each line of authority held by the licensee not to exceed four lines of authority held by the licensee;
3946 and
3947 (II) three hours of ethics training[~~, which may be taken in place of three hours of the hours~~
3948 ~~required for a line of authority~~].
3949 (d) (i) If a licensee completes the licensee's continuing education requirement without
3950 taking a line of authority continuing education examination, the licensee shall complete at least 1/2
3951 of the required hours through classroom hours of insurance-related instruction.
3952 (ii) The hours not completed through classroom hours in accordance with Subsection
3953 (2)(d)(i) may be obtained through:
3954 (A) home study;
3955 (B) video tape;
3956 (C) experience credit; or
3957 (D) other method provided by rule.
3958 (e) (i) A licensee may obtain continuing education hours at any time during the two-year
3959 licensing period.
3960 (ii) The licensee may not take a line of authority continuing education examination more
3961 than 90 calendar days before the date on which the licensee's license is renewed.
3962 (f) The commissioner shall make rules for the content and procedures for line of authority
3963 continuing education examinations.
3964 (g) (i) Beginning May 3, 1999, a licensee is exempt from the continuing education

3965 requirements of this section if:
3966 (A) as of April 1, 1990, the licensee has completed 20 years of licensure in good standing;
3967 (B) the licensee requests an exemption from the department; and
3968 (C) the department approves the exemption.
3969 (ii) If the department approves the exemption under Subsection (2)(g)(i), the licensee is
3970 not required to apply again for the exemption.
3971 (h) A licensee with a variable annuity line of authority is exempt from the requirement for
3972 continuing education for that line of authority so long as:
3973 (i) the National Association of Securities Dealers requires continuing education for
3974 licensees having a securities license; and
3975 (ii) the licensee complies with the National Association of Securities Dealers' continuing
3976 education requirements for securities licensees.
3977 (i) The commissioner shall by rule:
3978 (i) publish a list of insurance professional designations whose continuing education
3979 requirements can be used to meet the requirements for continuing education under Subsection
3980 (2)(c); and
3981 (ii) authorize professional adjuster associations to:
3982 (A) offer qualified programs for all classes of licenses on a geographically accessible basis;
3983 and
3984 (B) collect reasonable fees for funding and administration of the continuing education
3985 programs, subject to the review and approval of the commissioner.
3986 (j) (i) The fees permitted under Subsection (2)(i) that are charged to fund and administer
3987 a program shall reasonably relate to the costs of administering the program.
3988 (ii) Nothing in this section shall prohibit a provider of continuing education programs or
3989 courses from charging fees for attendance at courses offered for continuing education credit.
3990 (iii) The fees permitted under Subsection (2)(i)(ii) that are charged for attendance at an
3991 association program may be less for an association member, based on the member's affiliation
3992 expense, but shall preserve the right of a nonmember to attend without affiliation.
3993 (3) The requirements of this section apply only to licensees who are natural persons.
3994 (4) The requirements of this section do not apply to members of the Utah State Bar.
3995 (5) The commissioner shall designate courses that satisfy the requirements of this section,

3996 including those presented by insurers.
3997 (6) A nonresident adjuster is considered to have satisfied this state's continuing education
3998 requirements if:
3999 (a) the nonresident adjuster satisfies the nonresident producer's home state's continuing
4000 education requirements for a licensed insurance adjuster; and
4001 (b) on the same basis the nonresident adjuster's home state considers satisfaction of Utah's
4002 continuing education requirements for a producer as satisfying the continuing education
4003 requirements of the home state.
4004 Section 59. Section **31A-26-213** is amended to read:
4005 **31A-26-213. Termination of license.**
4006 (1) A license issued under this chapter remains in force until:
4007 (a) revoked, suspended, or limited under Subsection (2);
4008 (b) lapsed under Subsection (3);
4009 (c) surrendered to and accepted by the commissioner; or
4010 (d) the licensee dies or is adjudicated incompetent as defined under Title 75, Chapter 5,
4011 Part 3 or 4.
4012 (2) (a) After an adjudicative proceeding under Title 63, Chapter 46b, Administrative
4013 Procedures Act, if the commissioner makes a finding described in Subsection (2)(b), the
4014 commissioner may:
4015 (i) revoke[~~,~~] a license of an adjustor;
4016 (ii) suspend a license of an adjustor for a specified period of 12 months or less[~~,~~]; or
4017 (iii) limit in whole or in part the license of any adjuster[~~, found to:~~].
4018 (b) The commissioner may take an action described in Subsection (2)(a) if the
4019 commissioner finds that the adjustor:
4020 [~~(a) be~~] (i) is unqualified for a license under Section 31A-26-203;
4021 [~~(b) have~~] (ii) has violated:
4022 [~~(i)~~] (A) an insurance statute;
4023 [~~(ii)~~] (B) a valid rule under Subsection 31A-2-201(3); or
4024 [~~(iii)~~] (C) a valid order under Subsection 31A-2-201(4);
4025 [~~(c) be~~] (iii) is insolvent, or the subject of receivership, conservatorship, rehabilitation,
4026 or other delinquency proceedings in any state;

4027 [(d) fail] (iv) has failed to pay any final judgment rendered against [it] the adjustor in this
4028 state within 60 days after the judgment became final;
4029 [(e) fail] (v) has failed to meet the same good faith obligations in claims settlement as that
4030 required of admitted insurers;
4031 [(f) be] (vi) is affiliated with and under the same general management or interlocking
4032 directorate or ownership as another adjuster [which] that transacts business in this state without
4033 a license;
4034 [(g) refuse] (vii) refuses to be examined or to produce [its] the adjustor's accounts,
4035 records, and files for examination;
4036 [(h) have] (viii) has an officer who:
4037 [(i)] (A) refuses to give information with respect to the administrator's affairs; or
4038 [(ii)] (B) refuses to perform any other legal obligation as to an examination;
4039 [(i) have] (ix) has provided incorrect, misleading, incomplete, or materially untrue
4040 information in the license application;
4041 [(j) have] (x) has violated any insurance law, valid rule, or valid order of another state's
4042 insurance department;
4043 [(k) have] (xi) has obtained or attempted to obtain a license through misrepresentation or
4044 fraud;
4045 [(l) have] (xii) has improperly withheld, misappropriated, or converted any monies or
4046 properties received in the course of doing insurance business;
4047 [(m) have] (xiii) has intentionally misrepresented the terms of an actual or proposed
4048 insurance contract or application for insurance;
4049 [(n) have] (xiv) has been convicted of a felony;
4050 [(o) have] (xv) has admitted or been found to have committed any insurance unfair trade
4051 practice or fraud;
4052 [(p) have] (xvi) has used fraudulent, coercive, or dishonest practices in the conduct of
4053 business in this state or elsewhere;
4054 [(q) have] (xvii) has demonstrated incompetence, untrustworthiness, or financial
4055 irresponsibility in the conduct of business in this state or elsewhere;
4056 [(r) have] (xviii) has had an insurance license, or its equivalent, denied, suspended, or
4057 revoked in any other state, province, district, or territory;

4058 [(s) have] (xix) has forged another's name to:
4059 [(i)] (A) an application for insurance; or
4060 [(ii)] (B) any document related to an insurance transaction;
4061 [(t) have] (xx) has improperly used notes or any other reference material to complete an
4062 examination for an insurance license;
4063 [(u) have] (xxi) has knowingly accepted insurance business from an individual who is not
4064 licensed;
4065 [(v) have] (xxii) has failed to comply with an administrative or court order imposing a
4066 child support obligation;
4067 [(w) have] (xxiii) has failed to:
4068 [(i)] (A) pay state income tax; or
4069 [(ii)] (B) comply with any administrative or court order directing payment of state income
4070 tax;
4071 [(x) have] (xxiv) has violated or permitted others to violate the federal Violent Crime
4072 Control and Law Enforcement Act of 1994, 18 U.S.C. Secs. 1033 and 1034; or
4073 [(y) have] (xxv) has engaged in methods and practices in the conduct of business [which]
4074 that endanger the legitimate interests of customers and the public.
4075 (3) (a) Any license issued under this chapter [lapses] shall lapse if the licensee fails to:
4076 (i) pay when due any fee under Section 31A-3-103[.];
4077 (ii) complete continuing education requirements under Section 31A-26-206 before
4078 submitting the license renewal application; or
4079 (iii) submit a completed renewal application as required by Section 31A-26-202.
4080 (b) A licensee whose license lapses due to military service or some other extenuating
4081 circumstance such as a long-term medical disability may request:
4082 (i) reinstatement; and
4083 (ii) a waiver of any of the following imposed for failure to comply with renewal
4084 procedures:
4085 (A) an examination requirement;
4086 (B) a fine; or
4087 (C) other sanction.
4088 (c) The commissioner shall by rule prescribe the license renewal and reinstatement

4089 procedures, in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act.
4090 (4) A licensee under this chapter whose license is suspended, revoked, or lapsed, but who
4091 continues to act as a licensee, is subject to the penalties for conducting an insurance business
4092 without a license.
4093 (5) (a) An order revoking a license under Subsection (2) may specify a time not to exceed
4094 five years within which the former licensee may not apply for a new license.
4095 (b) If no time is specified in the order revoking a license under Subsection (2), the former
4096 licensee may not apply for a new license for five years without the express approval of the
4097 commissioner.
4098 (6) (a) Any person whose license is suspended or revoked under Subsection (2) shall, when
4099 the suspension ends or a new license is issued, pay all fees that would have been payable if the
4100 license had not been suspended or revoked, unless the commissioner by order waives the payment
4101 of the interim fees.
4102 (b) If a new license is issued more than three years after the revocation of a similar license,
4103 this Subsection (6) applies only to the fees that would have accrued during the three years
4104 immediately following the revocation.
4105 (7) The [~~division~~] commissioner shall promptly withhold, suspend, restrict, or reinstate
4106 the use of a license issued under this part if so ordered by a court.
4107 Section 60. Section **31A-26-301.6** is amended to read:
4108 **31A-26-301.6. Health care provider claims practices.**
4109 (1) As used in this section:
4110 (a) "Articulable reason" may include a determination regarding:
4111 (i) eligibility for coverage;
4112 (ii) preexisting conditions;
4113 (iii) applicability of other public or private insurance;
4114 (iv) medical necessity; and
4115 (v) any other reason that would justify an extension of the time to investigate a claim.
4116 (b) "Health care provider" means a person licensed to provide health care under:
4117 (i) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act[~~,~~]; or
4118 (ii) Title 58, Occupations and Professions.
4119 (c) "Insurer" means an admitted or authorized insurer, as defined in Section 31A-1-301,

4120 and includes:
4121 (i) a health maintenance organization; and
4122 (ii) a third-party administrator that is subject to this title, provided that nothing in this
4123 section may be construed as requiring a third party administrator to use its own funds to pay claims
4124 that have not been funded by the entity for which the third party administrator is paying claims.
4125 (d) "Provider" means a health care provider to whom an insurer is obligated to pay directly
4126 in connection with a claim by virtue of:
4127 (i) an agreement between the insurer and the provider;
4128 (ii) a health insurance policy or contract of the insurer; or
4129 (iii) state or federal law.
4130 (2) An insurer shall timely pay every valid insurance claim submitted by a provider in
4131 accordance with this section.
4132 (3) (a) Within 30 days of receiving a written claim, an insurer shall do one of the
4133 following:
4134 (i) pay the claim unless Subsection (3)(a)(ii), (iii), (iv), or (v) applies;
4135 (ii) provide a written explanation if the claim is denied;
4136 (iii) specifically describe and request any additional information from the provider that is
4137 necessary to process the claim;
4138 (iv) inform the provider, pursuant to Subsection (4), of the 30-day extension of the
4139 insurer's investigation of the claim; or
4140 (v) request additional information and inform the provider of the 30-day extension if both
4141 Subsections (3)(a)(iii) and (iv) apply.
4142 (b) A provider shall respond to each request by an insurer for additional necessary
4143 information made under Subsection (3)(a)(iii) or (v) within 30 days of receipt of the request by
4144 providing the requested information that is in the possession of the provider, unless:
4145 (i) the provider has requested and received the permission of the insurer to extend the
4146 30-day period; or
4147 (ii) the provider explains to the insurer in writing that additional time, which may not
4148 exceed 30 days, is necessary to comply with the request for information.
4149 (c) Subsection (7) shall apply after an insurer has received the information requested.
4150 (4) The time to investigate a claim may be extended by the insurer for an additional

4151 30-days if:
4152 (a) the investigation of the claim cannot reasonably be completed within the initial 30-day
4153 period of Subsection (3)(a);
4154 (b) before the end of the 30-day period in Subsection (3)(a), the insurer informs the
4155 provider in writing of the reason for the payment delay, the nature of the investigation, the
4156 timelines for investigations established in this section, and the anticipated completion date.
4157 (5) Notwithstanding Subsection (4), the time to investigate a claim may be extended
4158 beyond the initial 30-day period and the extended 30-day period if:
4159 (a) due to matters beyond the control of the insurer, the investigation cannot reasonably
4160 be completed within 60 days as to some part or all of the claim;
4161 (b) before the end of the combined 60-day period, the insurer makes a written request to
4162 the commissioner for an extension, including the reason for the delay, the nature of the
4163 investigation, the anticipated completion date, and the amount of any partial payment of the claim
4164 made pursuant to Subsection (5)(d);
4165 (c) before the end of the combined 60-day period, the commissioner informs the insurer
4166 that the request for an extension has been granted, based on a finding that:
4167 (i) there is a good faith and articulable reason to believe that the insurer is not obligated
4168 to pay some part or all of the claim; and
4169 (ii) the investigation cannot reasonably be completed within 60 days; and
4170 (d) the insurer identifies and pays all sums the insurer is obligated to pay on the claim and
4171 which are not subject to the extension requested under this Subsection (5).
4172 (6) An extension granted by the commissioner under Subsection (5)(c) shall include the
4173 completion date for the investigation.
4174 (7) (a) An insurer shall pay all sums to the provider that the insurer is obligated to pay on
4175 the claim, and provide a written explanation of any part of the claim that is denied within 20 days
4176 of:
4177 (i) receiving the information requested under Subsection (3)(a)(iii);
4178 (ii) completing an investigation under Subsection (4) or (5); or
4179 (iii) the latter of Subsection (3)(a)(iii) or (iv), if Subsection (3)(a)(v) applies.
4180 (b) (i) Except as provided in Subsection (7)(c), an insurer may send a follow-up request
4181 for additional information within the 20-day time period in Subsection (7)(a) if the previous

4182 response of the provider was not sufficient for the insurer to make a decision on the claim.
4183 (ii) A follow-up request for additional necessary information shall state with specificity:
4184 (A) the reason why the previous response was insufficient;
4185 (B) the information that is necessary to comply with the request for information; and
4186 (C) the reason why the requested information is necessary to process the claim.
4187 (c) Unless an insurer has an extension for an investigation pursuant to Subsection (4) or
4188 (5), the insurer shall pay all sums it is obligated to pay on a claim and provide a written
4189 explanation of any part of the claim that is denied within [~~15~~] <u>20</u> days of receiving a notice from
4190 the provider that the provider has submitted all requested information in the provider's possession
4191 that is related to the claim.
4192 (8) (a) Whenever an insurer makes a payment to a provider on any part of a claim under
4193 this section, the insurer shall also send to the insured an explanation of benefits paid.
4194 (b) Whenever an insurer denies any part of a claim under this section, the insurer shall also
4195 send to the insured a written explanation of the part of the claim that was denied and notice of the
4196 [~~grievance~~] <u>adverse benefit determination</u> review process established under Section 31A-22-629.
4197 (c) This Subsection (8) does not apply to a person receiving benefits under the state
4198 Medicaid program as defined in Section 26-18-2, unless required by the Department of Health or
4199 federal law.
4200 (9) (a) Beginning with health care claims submitted on or after January 1, 2002, a late fee
4201 shall be imposed on:
4202 (i) an insurer that fails to timely pay a claim in accordance with this section; and
4203 (ii) a provider that fails to timely provide information on a claim in accordance with this
4204 section.
4205 (b) For the first 90 days that a claim payment or a provider response to a request for
4206 information is late, the late fee shall be determined by multiplying together:
4207 (i) the total amount of the claim;
4208 (ii) the total number of days the response or the payment <u>is late</u>; and
4209 (iii) .1%.
4210 (c) For a claim payment or a provider response to a request for information that is 91 or
4211 more days late, the late fee shall be determined by adding together:
4212 (i) the late fee for a 90-day period under Subsection (9)(b); and

4213 (ii) the following [~~sum~~] multiplied together:
4214 (A) the total amount of the claim;
4215 (B) the total number of days the response or payment was late beyond the initial 90-day
4216 period; and
4217 (C) the rate of interest set in accordance with Section 15-1-1.
4218 (d) Any late fee paid or collected under this section shall be separately identified on the
4219 documentation used by the insurer to pay the claim.
4220 (e) For purposes of this Subsection (9), "late fee" does not include an amount that is less
4221 than $1.
4222 (10) Each insurer shall establish a [~~grievance~~] adverse benefit determination review
4223 process to resolve claims-related disputes between the insurer and providers.
4224 (11) No insurer or person representing an insurer may engage in any unfair claim
4225 settlement practice with respect to a provider. Unfair claim settlement practices include:
4226 (a) knowingly misrepresenting a material fact or the contents of an insurance policy in
4227 connection with a claim;
4228 (b) failing to acknowledge and substantively respond within 15 days to any written
4229 communication from a provider relating to a pending claim;
4230 (c) denying or threatening to deny the payment of a claim for any reason that is not clearly
4231 described in the insured's policy;
4232 (d) failing to maintain a payment process sufficient to comply with this section;
4233 (e) failing to maintain claims documentation sufficient to demonstrate compliance with
4234 this section;
4235 (f) failing, upon request, to give to the provider written information regarding the specific
4236 rate and terms under which the provider will be paid for health care services;
4237 (g) failing to timely pay a valid claim in accordance with this section as a means of
4238 influencing, intimidating, retaliating, or gaining an advantage over the provider with respect to an
4239 unrelated claim, an undisputed part of a pending claim, or some other aspect of the contractual
4240 relationship;
4241 (h) failing to pay the sum when required and as required under Subsection (9) when a
4242 violation has occurred;
4243 (i) threatening to retaliate or actual retaliation against a provider for availing himself of

4244 the provisions of this section;

4245 (j) any material violation of this section; and

4246 (k) any other unfair claim settlement practice established in rule or law.

4247 (12) (a) The provisions of this section shall apply to each contract between an insurer and

4248 a provider for the duration of the contract.

4249 (b) Notwithstanding Subsection (12)(a), this section may not be the basis for a bad faith

4250 insurance claim.

4251 (c) Nothing in Subsection (12)(a) may be construed as limiting the ability of an insurer and

4252 a provider from including provisions in their contract that are more stringent than the provisions

4253 of this section.

4254 (13) (a) Pursuant to Chapter 2, Part 2, Duties and Powers of Commissioner, and beginning

4255 January 1, 2002, the commissioner may conduct examinations to determine an insurer's level of

4256 compliance with this section and impose sanctions for each violation.

4257 (b) The commissioner may adopt rules only as necessary to implement this section.

4258 (c) After December 31, 2002, the commissioner may establish rules to facilitate the

4259 exchange of electronic confirmations when claims-related information has been received.

4260 (d) Notwithstanding the provisions of Subsection (13)(b), the commissioner may not adopt

4261 rules regarding the [~~grievance~~] adverse benefit determination process required by Subsection (10).

4262 (14) Nothing in this section may be construed as limiting the collection rights of a provider

4263 under Section 31A-26-301.5.

4264 (15) Nothing in this section may be construed as limiting the ability of an insurer to:

4265 (a) recover any amount improperly paid to a provider:

4266 (i) in accordance with Section 31A-31-103 or any other provision of state or federal law;

4267 (ii) within 36 months for a coordination of benefits error; or

4268 (iii) within 18 months for any other reason not identified in Subsection (15)(a)(i) or (ii);

4269 (b) take any action against a provider that is permitted under the terms of the provider

4270 contract and not prohibited by this section;

4271 (c) report the provider to a state or federal agency with regulatory authority over the

4272 provider for unprofessional, unlawful, or fraudulent conduct; or

4273 (d) enter into a mutual agreement with a provider to resolve alleged violations of this

4274 section through mediation or binding arbitration.

4275 Section 61. Section **31A-27-102** is amended to read:

4276 **31A-27-102. Definitions.**

4277 (1) As used in this chapter:

4278 (a) "Alien insurer domiciled in Utah" means an insurer domiciled outside the United States
4279 whose entry into the United States is through Utah.

4280 (b) "Ancillary state" means any state other than an insurer's state of domicile.

4281 (c) "Contingent claims" means a claim or demand upon which:

4282 (i) a right of action has accrued at the date of the order of liquidation; and

4283 (ii) liability has not been determined.

4284 (d) "Date of liquidation" means the date of the filing of a petition for liquidation that
4285 results in an order for liquidation.

4286 (e) "Delinquency proceeding" means any:

4287 (i) proceeding commenced against an insurer for the purpose of liquidating, rehabilitating,
4288 reorganizing, or conserving the insurer; and

4289 (ii) summary proceeding under Sections 31A-27-201 through 31A-27-203.

4290 (f) "Domestic insurer" includes, for purposes of this chapter, foreign insurers commercially
4291 domiciled in this state under Section 31A-14-206.

4292 (g) (i) "Estate" or "property of the estate" means:

4293 (A) all legal or equitable interests of an insurer that are the subject of a rehabilitation,
4294 liquidation, conservation, or other proceeding under this chapter in property as of the date of filing
4295 of the petition for rehabilitation, liquidation, or conservation;

4296 (B) any interest in property recoverable by the receiver under the provisions of this title;

4297 (C) any interest in property acquired after the date of filing of the petition; and

4298 (D) all proceeds, products, rents, and profits from this property.

4299 (ii) "Estate" or "property of the estate" includes property in which the insurer holds only
4300 legal title, but no equitable interest, only to the extent of the insolvent insurer's interest.

4301 (h) "Fair consideration" is given for property or an obligation:

4302 (i) when in exchange for the property or obligation, as a fair equivalent for it, and in good
4303 faith:

4304 (A) property is conveyed;

4305 (B) services are rendered;

4306 (C) an obligation is incurred; or
4307 (D) an antecedent debt is satisfied; or
4308 (ii) when the property or obligation is received in good faith to secure a present advance
4309 or an antecedent debt in amount not disproportionately small compared to the value of the property
4310 or obligation obtained.
4311 (i) (i) "General assets" means all property not encumbered by a security agreement for the
4312 security or benefit of specified persons or classes of persons.
4313 (ii) "General assets" does not include separate account assets under Section 31A-5-217.
4314 (iii) For encumbered property, "general assets" includes all that property or its proceeds
4315 which is in excess of the amount necessary to discharge the sums secured by the property.
4316 (iv) Assets held in trust or on deposit for the security or benefit of all policyholders, or all
4317 policyholders and creditors, in more than a single state, are general assets.
4318 (j) "Guaranty association" means:
4319 (i) the applicable association under Chapter 28, Guaranty Associations; or
4320 (ii) the similar association under the laws of another state.
4321 (k) "Immature claim" means a claim or demand upon which payment is due, except for the
4322 passage of time.
4323 (l) "Insolvency" has the same meaning as in Section 31A-1-301.
4324 (m) "Insurer" means any person who is doing, has done, purports to do, or is licensed to
4325 do an insurance business on its own account and is or has been subject to the authority of, or to
4326 liquidation, rehabilitation, reorganization, or supervision by, a commissioner. A separate account
4327 created under Section 31A-5-217 is an "insurer" for purposes of Chapter 27, Insurers
4328 Rehabilitation and Liquidation.
4329 (n) "Preferred claim" means any claim that the law gives priority of payment from the
4330 general assets of the insurer.
4331 (o) "Receiver" means receiver, liquidator, rehabilitator, or conservator[;]:
4332 (i) as the context requires[.]; and
4333 (ii) as consistent with the definition of "receiver" in Subsections 31A-27-110(1)(c)(i)
4334 through (vii).
4335 (p) "Reciprocal state" means any state other than this state:
4336 (i) in which in substance Subsection 31A-27-310(1), Subsections 31A-27-403(1) and (3),

4337 Sections 31A-27-404 and 31A-27-406 through 31A-27-409 are in force;
4338 (ii) which has laws requiring the commissioner to be the receiver of a delinquent insurer;
4339 and
4340 (iii) which has laws for the avoidance of fraudulent conveyances and preferential transfers
4341 by the receiver of a delinquent insurer.
4342 (q) "Secured claim" means any claim secured by mortgage, trust deed, security agreement,
4343 pledge, deposit as security, escrow or otherwise, but not including special deposit claims. The
4344 term also includes claims that have become liens upon specific assets through judicial processes.
4345 (r) "Separate account assets" means those assets allocated to separate accounts under
4346 Section 31A-5-217.
4347 (s) "Special deposit claim" means any claim secured by a deposit in trust made pursuant
4348 to this title for the security or benefit of one or more limited classes of persons.
4349 (t) "Transfer" means every mode, direct or indirect, absolute or conditional, voluntarily
4350 or involuntarily, by or without judicial proceedings, of disposing of or parting with property or
4351 with an interest in property. The retention of a security interest in or title to property delivered to
4352 a debtor is considered a transfer by the debtor.
4353 (u) "Unliquidated claim" means a claim or demand upon which:
4354 (i) a right of action has accrued at the date of the order of liquidation; and
4355 (ii) liability has been established but the amount of which has not been determined.
4356 (2) If the subject of a rehabilitation or liquidation proceeding under this chapter is an
4357 insurer engaged in a surety business, then as used in this chapter:
4358 (a) "Policy" includes a bond issued by a surety.
4359 (b) "Policyholder" includes a principal on a bond.
4360 (c) "Beneficiary" includes an obligee of a bond.
4361 (d) "Insured" includes both the principal and obligee of a bond.
4362 Section 62. Section **31A-27-103** is amended to read:
4363 **31A-27-103. Jurisdiction and venue.**
4364 (1) Except as provided in Subsection (2), [~~no~~] a delinquency proceeding may not be
4365 commenced under this chapter by anyone other than the Utah commissioner.
4366 (2) (a) Three or more judgment creditors holding unrelated judgments against an insurer,
4367 which judgments aggregate more than $5,000 in excess of any security held by those creditors may

4368 commence proceedings against the insurer under the conditions and in the manner prescribed in
4369 this Subsection (2), by serving notice upon the commissioner and the insurer of intention to file
4370 a petition for liquidation under Section 31A-27-307 or 31A-27-402.
4371 (b) Each of the judgments described in Subsection (2)(a):
4372 (i) shall have been rendered against the insurer by a Utah court having jurisdiction over
4373 the subject matter and the insurer;
4374 (ii) shall have been entered more than 60 days before the service of notice under
4375 Subsection (2)(a);
4376 (iii) may not have been satisfied in full;
4377 (iv) may not be the subject of a valid contract between the insurer and any judgment
4378 creditor for payment of the judgment, unless that contract has been breached by the insurer;
4379 (v) may not be a judgment assigned in order to institute proceedings under this Subsection
4380 (2); and
4381 (vi) may not be a judgment on which an appeal or review is pending or may yet be brought.
4382 [~~(b)~~] (c) If any one of the judgments in favor of a petitioning creditor remains unpaid for
4383 30 days after service of the notice under Subsection (2)(a), and the commissioner has not then filed
4384 a petition for liquidation[~~,~~]:
4385 (i) the creditor may file a verified petition for liquidation of the insurer:
4386 (A) in the manner prescribed by Section 31A-27-307 or 31A-27-402[~~,~~]; and
4387 (B) alleging the conditions stated in this Subsection[~~. The~~] (2); and
4388 (ii) the commissioner shall be served and joined in the action.
4389 (3) [~~No~~] Except in accordance with this chapter, a court of this state [~~has~~] does not have
4390 jurisdiction to entertain, hear, or determine any complaint praying for:
4391 (a) the dissolution, liquidation, rehabilitation, sequestration, conservation, or receivership
4392 of any insurer[~~,~~]; or [~~praying for~~]
4393 (b) an injunction or restraining order or other relief preliminary to, incidental to, or relating
4394 to [~~that~~] the type of proceedings [~~other than in accordance with this chapter~~] described in
4395 Subsection (3)(a).
4396 (4) (a) Venue for proceedings arising under this chapter shall be laid initially as specified
4397 in the sections providing for those proceedings.
4398 (b) All other actions and proceedings initiated by the receiver may be commenced and tried

4399 where:

4400 (i) the delinquency proceedings are then pending[,]; or [where]

4401 (ii) venue would be laid by applicable Utah law.

4402 (c) All other actions and proceedings against the receiver shall be commenced and tried

4403 in the county where the delinquency proceedings are pending.

4404 (d) Upon motion of any party, venue may be changed by order of the court or the presiding

4405 judge of the court to any other district court in Utah, whenever the convenience of the parties and

4406 witnesses and the ends of justice require it.

4407 (e) This Subsection (4) relates only to venue and is not jurisdictional.

4408 (5) In addition to other grounds for jurisdiction provided by the law of Utah, a Utah court

4409 having jurisdiction of the subject matter has jurisdiction over a person properly served in an action

4410 brought by the receiver of a domestic insurer or an alien insurer domiciled in Utah:

4411 (a) if the person served is obligated to the insurer in any way as an incident to any agency

4412 or brokerage arrangement that may exist or has existed between them, in any action on or incident

4413 to the obligation;

4414 (b) if the person served is a reinsurer who has at any time written a policy of reinsurance

4415 for an insurer against which a rehabilitation or liquidation order is in effect when the action is

4416 commenced[, or];

4417 (c) if the person served is an agent of or broker for the reinsurer described in Subsection

4418 (5)(b), in any action on or incident to the reinsurance contract; or

4419 [(c)] (d) if the person served is or has been an officer, manager, trustee, organizer,

4420 promoter, or person in a position of comparable authority or influence in an insurer against which

4421 a rehabilitation or liquidation order is in effect when the action is commenced, in any action

4422 resulting from the relationship with the insurer.

4423 (6) (a) Subject to Section 31A-27-305 and 31A-27-317, the court in which a delinquency

4424 proceeding is pending has exclusive jurisdiction for:

4425 (i) all actions and proceedings brought against the receiver of a rehabilitation or liquidation

4426 estate of the insurer; or

4427 (ii) any action or proceeding in any way related to a rehabilitation or liquidation estate of

4428 an insurer.

4429 (b) An action described in Subsection (6)(a) shall be commenced and tried in the court

4430 having exclusive jurisdiction.

4431 [(6)] (7) If the court on the motion of any party finds that any action commenced under
4432 Subsection (5) should, as a matter of substantial justice, be tried in a forum outside Utah, the court
4433 may enter an order to stay further proceedings on the action in Utah.

4434 Section 63. Section **31A-27-305** is amended to read:

4435 **31A-27-305. Actions by and against rehabilitator.**

4436 (1) [The] (a) An order for rehabilitation under Section 31A-27-303 [automatically] stays
4437 any action or proceeding [in this state in which the insurer is a party or is obligated to defend a
4438 party. The stay continues until the rehabilitator obtains proper representation and prepares for
4439 further proceedings. The court that entered the rehabilitation order shall order the rehabilitator
4440 to take that action respecting pending litigation and other proceedings as the court considers
4441 necessary in the interests of justice and for the protection of creditors, policyholders, and the
4442 public. The rehabilitator shall immediately evaluate all litigation or other proceedings pending
4443 outside this state and shall petition the courts or agencies having jurisdiction over that litigation
4444 or those proceedings for stays whenever the rehabilitator determines it necessary to protect the
4445 estate of the insurer.]:

4446 (i) (A) at law;

4447 (B) in equity; or

4448 (C) in arbitration;

4449 (ii) brought against the insurer or rehabilitator; and

4450 (iii) regardless of whether the action is brought in this state or elsewhere.

4451 (b) An action or proceeding existing at the time the order for rehabilitation is issued may
4452 not be enforced, perfected, maintained, or further presented after issuance of the order for
4453 rehabilitation.

4454 (c) The stay of all actions or proceedings provided in this Subsection (1) is automatic.

4455 (d) The rehabilitator may not intervene or defend in an action or proceeding except as
4456 provided in this section.

4457 (2) (a) If the rehabilitator determines that the protection of the estate of the insurer
4458 necessitates intervention in an action pending against the insurer, the rehabilitator may intervene
4459 in the action.

4460 (b) An action described in Subsection (2)(a) is not stayed if:

4461 (i) the rehabilitator applies to the court for:
4462 (A) leave to intervene or defend; or
4463 (B) for ratification by the court of intervention; and
4464 (ii) the court grants the application.
4465 (c) The estate of the insurer may be charged for the expenses incurred if the rehabilitator
4466 is defending any action in which the rehabilitator intervenes under this section.
4467 [(2)] (3) (a) No statute of limitations runs and no defense of laches arises with respect to
4468 any action by or against an insurer between the filing of a petition for rehabilitation against an
4469 insurer and the denial of the petition or an order of rehabilitation.
4470 (b) Any action by the insurer that might have been commenced when the petition was filed
4471 may be commenced by the insurer or rehabilitator for:
4472 (i) at least 60 days after:
4473 (A) the order of rehabilitation is entered; or
4474 (B) the petition is denied[,]; or [for]
4475 (ii) a longer period if ordered by the court.
4476 (c) This Subsection (3) does not limit the powers of the rehabilitator to bring actions under
4477 Sections 31A-27-319, 31A-27-320, 31A-27-321, 31A-27-322, and other provisions of this chapter.
4478 Section 64. Section **31A-27-311.5** is amended to read:
4479 **31A-27-311.5. Continuance of coverage -- Health maintenance organizations.**
4480 (1) As used in this section:
4481 (a) "basic health care services" is as defined in Section 31A-8-101;
4482 (b) "enrollee" is as defined in Section 31A-8-101;
4483 (c) "health care" is as defined in Section 31A-1-301;
4484 (d) "health maintenance organization" is as defined in Section 31A-8-101;
4485 (e) "limited health plan" is as defined in Section 31A-8-101;
4486 (f) (i) "managed care organization" means any entity licensed by, or holding a certificate
4487 of authority from, the department to furnish health care services or health insurance;
4488 (ii) "managed care organization" includes:
4489 (A) a limited health plan;
4490 (B) a health maintenance organization;
4491 (C) a preferred provider organization;

4492 (D) a fraternal benefit society; or
4493 (E) any entity similar to an entity described in Subsections (1)(f)(ii)(A) through (D);
4494 (iii) "managed care organization" does not include:
4495 (A) an insurer or other person that is eligible for membership in a guaranty association
4496 under Chapter 28, Guaranty Associations;
4497 (B) a mandatory state pooling plan;
4498 (C) a mutual assessment company or any entity that operates on an assessment basis; or
4499 (D) any entity similar to an entity described in Subsections (1)(f)(iii)(A) through (C);
4500 (g) "participating provider" means a provider who, under a contract with a managed care
4501 organization authorized under Section 31A-8-407, [has agreed] agrees to provide health care
4502 services to enrollees with an expectation of receiving payment, directly or indirectly, from the
4503 managed care organization, other than copayment;
4504 (h) "participating provider contract" means the agreement between a participating provider
4505 and a managed care organization authorized under Section 31A-8-407;
4506 (i) "preferred provider" means a provider who agrees to provide health care services under
4507 an agreement authorized under Subsection 31A-22-617(1);
4508 (j) "preferred provider contract" means the written agreement between a preferred provider
4509 and a managed care organization authorized under Subsection 31A-22-617(1);
4510 (k) (i) except as provided in Subsection (1)(k)(ii), "preferred provider organization" means
4511 any person[, other than an insurer licensed under Chapter 7 or an individual who contracts to
4512 render professional or personal services that the individual performs himself,] that:
4513 [(i)] (A) furnishes at a minimum, through preferred providers, basic health care services
4514 to an enrollee in return for prepaid periodic payments in an amount agreed to prior to the time
4515 during which the health care may be furnished;
4516 [(ii)] (B) is obligated to the enrollee to arrange for the services described in Subsection
4517 (1)(k)(i)(A); and
4518 [(iii)] (C) permits the enrollee to obtain health care services from providers who are not
4519 preferred providers; and
4520 (ii) "preferred provider organization" does not include:
4521 (A) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance Corporation;
4522 or

4523 (B) an individual who contracts to render professional or personal services that the
4524 individual performs.
4525 (l) "provider" is as defined in Section 31A-8-101; and
4526 (m) "uncovered expenditure" means the costs of health care services that are covered by
4527 an organization for which an enrollee is liable in the event of the managed care organization's
4528 insolvency.
4529 (2) The rehabilitator or liquidator may take one or more of the actions described in
4530 Subsections (2)(a) through (f) to assure continuation of health care coverage for enrollees of an
4531 insolvent managed care organization.
4532 (a) (i) Subject to Subsection (2)(a)(ii), a rehabilitator or liquidator may require a
4533 participating provider and preferred provider of health care services to continue to provide the
4534 health care services the provider is required to provide under the [~~respective~~] provider's
4535 participating provider contract or preferred provider contract until the later of:
4536 (A) 90 days from the date of the filing of:
4537 (I) a petition for rehabilitation; or [~~the~~]
4538 (II) a petition for liquidation; or
4539 (B) the date the term of the contract ends.
4540 (ii) A requirement by the rehabilitator or liquidator under Subsection (2)(a)(i) that a
4541 participating provider or preferred provider continue to provide health care services under a
4542 provider's participating provider contract or preferred providers contract expires when health care
4543 coverage for all enrollees of the insolvent managed care organization is obtained from another
4544 managed care organization or insurer.
4545 (b) (i) Subject to Subsection (2)(b)(ii), a rehabilitator or liquidator may reduce the fees a
4546 participating provider or preferred provider is otherwise entitled to receive from the managed care
4547 organization under its participating provider contract or preferred provider contract during the time
4548 period in Subsection (2)(a)(i).
4549 (ii) Notwithstanding Subsection (2)(b)(i) a rehabilitator or liquidator may not reduce a fee
4550 to less than 75% of the regular fee set forth in the respective participating provider contract or
4551 preferred provider contract.
4552 (iii) An enrollee shall continue to pay the same copayments, deductibles, and other
4553 payments for services received from the participating provider or preferred provider that the

4554 enrollee was required to pay before the date of filing of:
4555 (A) the petition for rehabilitation; or
4556 (B) the petition for liquidation.
4557 (c) (i) A participating provider or preferred provider shall:
4558 (A) accept the amounts specified in Subsection (2)(b) as payment in full; and
4559 (B) relinquish the right to collect additional amounts from the insolvent managed care
4560 organization's enrollee.
4561 (ii) [~~Subsection~~] Subsections (2)(b) and [~~Subsections~~] (2)(c)(i)[~~(A) and (B)~~] shall apply
4562 to the fees paid to a provider who agrees to provide health care services to an enrollee but is not
4563 a preferred or participating provider.
4564 (d) If the managed care organization is a health maintenance organization, Subsections
4565 (2)(d)(i) through [~~(v)~~] (vi) apply.
4566 (i) Subject to Subsections (2)(d)(ii), (iii), and [~~(iv)~~] (v), upon notification from and subject
4567 to the direction of the rehabilitator or liquidator of a health maintenance organization licensed
4568 under Chapter 8, Health Maintenance Organizations and Limited Health Plans, a solvent health
4569 maintenance organization licensed under Chapter 8, Health Maintenance Organizations and
4570 Limited Health Plans, and operating within a portion of the insolvent health maintenance
4571 organization's service area shall extend to the enrollees all rights, privileges, and obligations of
4572 being an enrollee in the accepting health maintenance organization[~~, except that~~].
4573 (ii) Notwithstanding Subsection (2)(d)(i), the accepting health maintenance organization
4574 shall give credit to an enrollee for any waiting period already satisfied under the provisions of the
4575 enrollee's contract with the insolvent health maintenance organization.
4576 [~~(ii)~~] (iii) A health maintenance organization accepting an enrollee of an insolvent health
4577 maintenance organization under Subsection (2)(d)(i) shall charge the enrollee the premiums
4578 applicable to the existing business of the accepting health maintenance organization.
4579 [~~(iii)~~] (iv) A health maintenance organization's obligation to accept an enrollee under
4580 Subsection (2)(d)(i) is limited in number to [~~its~~] the accepting health maintenance organization's
4581 pro rata share of all health maintenance organization enrollees in this state, as determined after
4582 excluding the enrollees of the insolvent insurer.
4583 [~~(iv)~~] (v) (A) The rehabilitator or liquidator of an insolvent health maintenance
4584 organization shall take those measures that are possible to ensure that no health maintenance

4585 organization is required to accept more than its pro rata share of the adverse risk represented by
4586 the enrollees of the insolvent health maintenance organization. [As long as]
4587 (B) If the methodology used by the rehabilitator or liquidator to assign an enrollee is one
4588 [which] that can be expected to produce a reasonably equitable distribution of adverse risk, that
4589 methodology and its results are acceptable under this Subsection (2)(d)[(iv)](v).
4590 [(v)] (vi) (A) Notwithstanding Section 31A-27-311, the rehabilitator or liquidator may
4591 require all solvent health maintenance organizations to pay for the covered claims incurred by the
4592 enrollees of the insolvent health maintenance organization.
4593 (B) As determined by the rehabilitator or liquidator, payments required under this
4594 Subsection (2)(d)[(v)](vi) may:
4595 (I) begin as of the filing of the petition for reorganization or the petition for liquidation;
4596 and
4597 (II) continue for a maximum period through the time all enrollees are assigned pursuant
4598 to this section.
4599 (C) If the rehabilitator or liquidator makes an assessment under this Subsection
4600 (2)(d)[(v)](vi), the rehabilitator or liquidator shall assess each solvent health maintenance
4601 organization its pro rata share of the total assessment based upon its premiums from the previous
4602 calendar year.
4603 (D) (I) A solvent health maintenance organization required to pay for covered claims under
4604 this Subsection (2)(d)(vi) shall be entitled to file a claim against the estate of the insolvent health
4605 maintenance organization.
4606 (II) Any claim described in Subsection (2)(a)(vi)(D)(I), if allowed by the rehabilitator or
4607 liquidator, shall share in any distributions from the estate of the insolvent health maintenance
4608 organization as a Class 3 claim.
4609 (e) (i) A rehabilitator or liquidator may transfer, through sale, or otherwise, the group and
4610 individual health care obligations of the insolvent managed care organization to other managed
4611 care organizations or other insurers, if those other managed care organizations and other insurers
4612 are licensed or have a certificate of authority to provide the same health care services in this state
4613 that is held by the insolvent managed care organization [has].
4614 [(i)] (ii) The rehabilitator or liquidator may combine group and individual health care
4615 obligations of the insolvent managed care organization in any manner the rehabilitator or liquidator

4616 considers best to provide for continuous health care coverage for the maximum number of
4617 enrollees of the insolvent managed care organization.
4618 [(ii)] (iii) If the terms of a proposed transfer of the same combination of group and
4619 individual policy obligations to more than one other managed care organization or insurer are
4620 otherwise equal, the rehabilitator or liquidator shall give preference to the transfer of the group and
4621 individual policy obligations of an insolvent managed care organization as follows:
4622 (A) from one category of managed care organization to another managed care organization
4623 of the same category, as follows:
4624 (I) from a limited health plan to a limited health plan;
4625 (II) from a health maintenance organization to a health maintenance organization;
4626 (III) from a preferred provider organization to a preferred provider organization;
4627 (IV) from a fraternal benefit society to a fraternal benefit society; and
4628 (V) from any entity similar to any of the above to a category that is similar;
4629 (B) from one category of managed care organization to another managed care organization,
4630 regardless of the category of the transferee managed care organization; and
4631 (C) from a managed care organization to a nonmanaged care provider of health care
4632 coverage, including insurers.
4633 (f) A rehabilitator or liquidator may use the insolvent managed care organization's required
4634 capital or permanent surplus, and compulsory surplus, to continue to provide coverage for the
4635 insolvent managed care organization's enrollees, including paying uncovered expenditures.
4636 Section 65. Section **31A-27-315** is amended to read:
4637 **31A-27-315. Notice to creditors and others.**
4638 (1) (a) The liquidator shall give notice of the liquidation order as soon as possible:
4639 (i) by first class mail and [either by telegram or telephone] electronic communication to
4640 the insurance commissioner of each jurisdiction in which the insurer is [licensed to do] doing
4641 business;
4642 (ii) by first class mail and [by telephone] electronic communication to any guaranty fund
4643 or association [which] that may become obligated [because] as a result of the liquidation;
4644 [(iii) by first class mail and by telephone to the Labor Commission of this state if the
4645 insurer is or has been an insurer of workers' compensation;]
4646 [(iv)] (iii) by first class mail to all insurance agents [and], brokers, and reinsurers doing

4647 business with the insurer;
4648 [(v)] (iv) by first class mail to the persons designated in Subsection 31A-2-212(5), if the
4649 insurer does a surety business;
4650 [(vi)] (v) by first class mail to the last known address of all persons known or reasonably
4651 expected from the insurer's records to have claims against the insurer, including all policyholders;
4652 and
4653 [(vii)] (vi) unless the court orders otherwise, by publication under Section 31A-2-303, with
4654 the last publication being not less than three months before the earliest deadline specified in the
4655 notice under Subsection (2).
4656 (b) Notice to policyholders shall include:
4657 (i) notice of impairment and termination of coverage under Section 31A-27-311[. When
4658 it is]; and
4659 (ii) when applicable[, notice to policyholders shall also include]:
4660 [(i)] (A) notice of withdrawal of the insurer from the defense of any case in which the
4661 insured is interested; and
4662 [(ii)] (B) information about the existence of any:
4663 (I) applicable assigned risk plans or residual market facilities [and of a]; or
4664 (ii) guaranty [fund] funds under Chapter 28, Guaranty Associations, or similar laws of
4665 another state.
4666 (c) (i) Within [15] 45 days of the date of entry of the liquidation order, the liquidator shall
4667 report to the court what notice has been given.
4668 (ii) The court may order [any additional] notice [it] in addition to the notice required by
4669 this Subsection (1) that the court considers appropriate.
4670 (2) (a) Notice to potential claimants under Subsection (1) shall require claimants to file
4671 with the liquidator [their claims together with proper proofs under Section 31A-27-329,] on or
4672 before a date the liquidator specifies in the notice[, which may not be less than six months nor
4673 more than one year after entry of the liquidation order.]:
4674 (i) the claimants' claims; and
4675 (ii) proper proofs under Section 31A-27-329.
4676 (b) The liquidator need not require [persons] the following to file a claim:
4677 (i) a person claiming unearned premium [and persons]; or

4678 (ii) a person claiming cash surrender values or other investment values in life insurance
4679 and annuities [to file a claim].
4680 (c) The liquidator may specify different dates for filing the different kinds of claims.
4681 (3) If notice is given in accordance with this section, the distribution of the assets of the
4682 insurer under this chapter is conclusive with respect to all claimants, whether or not [they] the
4683 claimants received actual notice.
4684 Section 66. Section **31A-27-317** is amended to read:
4685 **31A-27-317. Actions by and against liquidator.**
4686 (1) (a) The filing of a petition for liquidation of a domestic insurer or of an alien insurer
4687 domiciled in this state stays all actions and all proceedings [against the insurer in Utah or
4688 elsewhere and the liquidator may not intervene in them, except as provided in this subsection.
4689 Whenever, in the liquidator's judgment, an action in Utah has proceeded to a point where fairness
4690 or convenience would be served by its continuation to judgment, the liquidator may apply to the
4691 court for leave to defend or to be substituted for the insurer, and if the court grants the application,
4692 the action is not stayed. Whenever in the liquidator's judgment, the protection of the estate of the
4693 insurer necessitates intervention in an action against the insurer that is pending outside Utah, with
4694 approval of the court the liquidator may intervene in the action.]:
4695 (i) (A) at law;
4696 (B) in equity; or
4697 (C) in arbitration;
4698 (ii) against the insurer or liquidator; and
4699 (iii) regardless of whether the action is brought in this state or elsewhere.
4700 (b) Any action or proceeding existing at the time the petition for liquidation is filed may
4701 not be enforced, perfected, maintained, or further presented after the filing of the petition.
4702 (c) The stay of all actions under this Subsection (1) is automatic.
4703 (d) The liquidator may not intervene or defend in an action or proceeding except as
4704 provided in this section.
4705 (2) Except as provided under Section 31A-27-323, filing a petition for liquidation stays
4706 the exercise of any right of setoff against the insurer.
4707 (3) (a) If the liquidator determines that protection of the estate of the insurer necessitates
4708 intervention in an action pending against the insurer, the liquidator may intervene in the action.

4709 (b) An action described in Subsection (3)(a) is not stayed if:
4710 (i) the liquidator applies to the court for:
4711 (A) leave to intervene or defend; or
4712 (B) ratification by the court of intervention; and
4713 (ii) the court grants the application.
4714 (c) The estate of the insurer may be charged for the expenses incurred by the liquidator in
4715 defending any action in which the liquidator intervenes under this section.
4716 [(3)] (4) (a) The liquidator may[, within two years subsequent to an order for liquidation
4717 or within any further time as applicable law permits,] institute an action or proceeding on behalf
4718 of the estate of the insurer upon any cause of action against which the period of limitation fixed
4719 by applicable law had not expired at the time of the filing of the petition.
4720 (b) Where, by any agreement, a period of limitation is fixed for instituting [a suit] an action
4721 or proceeding upon any claim or for filing any claim, proof of claim, proof of loss, demand, notice,
4722 or the like, or where in any proceeding, judicial or otherwise, a period of limitation is fixed, either
4723 in the proceeding or by applicable law, for taking any action, filing any claim or pleading, or doing
4724 any act, and where in any of these sections the period had not expired at the date of the filing of
4725 the petition for liquidation, the liquidator may, for the benefit of the estate, take any action or do
4726 any act, required of or permitted to the insurer, within a period of 180 days subsequent to the entry
4727 of an order for liquidation, or within any further period as is permitted by the agreement, in the
4728 proceeding, or by applicable law, or within any further time period as is shown to the satisfaction
4729 of the court not to be unfairly prejudicial to the other party.
4730 [(4)] (5) (a) No statute of limitations runs and no defense of laches is available with respect
4731 to any action against an insurer between the filing of a petition for liquidation and the denial of the
4732 petition.
4733 (b) Any action against the insurer that might have been commenced when the petition was
4734 filed may be commenced for at least 60 days after the petition is denied.
4735 [(5)] (5) Any guaranty fund or association that may become liable as a result of the
4736 liquidation of an insurer may intervene in any court proceeding concerning the liquidation of the
4737 insurer.
4738 Section 67. Section **31A-27-332** is amended to read:
4739 **31A-27-332. Disputed claims.**

4740 (1) (a) When a claim is disallowed in whole or in part by the liquidator, written notice of
4741 the determination and of the right to object shall be given promptly to the claimant or the
4742 claimant's attorney of record, if any, by first-class mail at the addresses shown in the proof of
4743 claim.
4744 (b) (i) Within 60 days from the mailing of the notice required by Subsection (1)(a), the
4745 claimant may file objections with the court.
4746 (ii) If objections are not filed within the period provided in Subsection (1)(b)(i), the
4747 claimant may not further object to the determination.
4748 (2) (a) Whenever objections are filed with the court and the liquidator does not alter the
4749 liquidator's ruling, the liquidator shall ask the court for a hearing as soon as practicable.
4750 (b) [~~The~~] If the liquidator asks for a hearing under Subsection (2)(a), the court shall issue
4751 an order setting a date as early as possible.
4752 (c) At the request of the liquidator, the court may establish procedures for the objections
4753 hearing.
4754 (d) The liquidator shall give notice of [~~the~~] a hearing under this Subsection (2) by
4755 first-class mail to:
4756 (i) the claimant or the claimant's attorney; and
4757 (ii) any other persons directly affected.
4758 (e) A hearing under this Subsection (2):
4759 (i) shall be heard without a jury[~~.~~]; and
4760 [~~(f) The matter~~] (ii) may be heard by:
4761 [~~(i)~~] (A) the court; or
4762 [~~(ii)~~] (B) a court-appointed referee.
4763 (g) [~~If a referee is appointed under Subsection (2)(f), the referee~~] A hearing under this
4764 Subsection (2) shall[~~: (i) review and~~] be limited to the evidence upon which the liquidator made
4765 the determination of the claims[~~; and~~].
4766 [~~(ii)~~] (h) If a referee is appointed under this Subsection (2), the referee shall submit to the
4767 court:
4768 (i) findings of fact [~~together with~~]; and
4769 (ii) recommendations.
4770 [~~(h)~~] (i) Consistent with Subsection 31A-27-336(2), the court may approve, disapprove,

4771 or modify:

4772 (i) the liquidator's determination of a claim; or

4773 (ii) a referee's recommendations on a claim.

4774 (3) A court order issued after a hearing and pursuant to this section may be appealed as a

4775 final order for purposes of Rule 54 [of the], Utah Rules of Civil Procedure.

4776 Section 68. Section **31A-27-337** is amended to read:

4777 **31A-27-337. Distribution of assets.**

4778 (1) (a) Subject to any instructions the court may give, the liquidator shall make

4779 distributions in a manner that will assure the proper recognition of priorities and a reasonable

4780 balance between the expeditious completion of the liquidation and the protection of unliquidated

4781 and undetermined claims, including third party claims.

4782 (b) Distribution of assets in kind may be made at valuations set by agreement between the

4783 liquidator and the creditor and approved by the court in advance of the distribution.

4784 (2) (a) The liquidator shall make distributions to guaranty funds and associations under

4785 Subsection (1) to satisfy their claims under Chapter 28, Guaranty Associations, or similar laws of

4786 other states, if the claims have been filed pursuant to rules established under Subsections

4787 31A-27-328(1) and (4).

4788 (b) The total distributions to guaranty funds and associations paid under this Subsection

4789 (2) may not exceed the total of the claims properly made by the funds and associations under

4790 Subsections 31A-27-328(1) and (4).

4791 (c) The liquidator shall pay distributions as frequently as is practicable and in sums as large

4792 as possible without sacrificing asset values by untimely disposition or inequitable allocation of

4793 available assets.

4794 (d) The liquidator may protect against inequitable allocations by making payments to funds

4795 and associations subject to binding agreements by [them] the funds or associations to repay any

4796 portions of the distributions [which] that are later found to be in excess of an equitable allocation.

4797 (e) If assets are available, the liquidator may [also] lend to guaranty funds and associations,

4798 subject to express advance court approval.

4799 (3) (a) The liquidator shall report to the court within [four months] 120 days after the

4800 [issuance of] day the liquidation order is issued under Section 31A-27-310, [and every three

4801 months thereafter] on the status of the assets [and the payment of distributions and loans under

4802 Subsection (2).] of the liquidation estate.
4803 (b) (i) After the report required by Subsection (3)(a), the liquidator will report to the court
4804 on the status of the liquidation on a calendar quarter basis.
4805 (ii) A report required by this Subsection (3)(b) shall be due within 45 days of the end of
4806 the calendar quarter unless the court orders otherwise.
4807 (c) The court may order the liquidator to make distributions to guaranty funds and
4808 associations under Subsection (2) more expeditiously to minimize the need for assessments under
4809 Chapter 28, Guaranty Associations, or similar laws of other states.
4810 (4) (a) Upon liquidation of a domestic nonlife mutual insurance company, any assets held
4811 in excess of [its] the company's liabilities and of the amounts [which] that may be paid to [its] the
4812 company's members as provided under Subsection (4)(b) shall be paid into the state treasury to the
4813 credit of the Uniform School Fund.
4814 (b) The maximum amount payable upon liquidation to any member for and on account of
4815 [his] that member's membership in a domestic nonlife mutual insurance company, in addition to
4816 the insurance benefits promised in the policy, is the total of all premium payments made by the
4817 member within the past five years with interest at the legal rate compounded annually.
4818 Section 69. Section **31A-27-340** is amended to read:
4819 **31A-27-340. Reopening liquidation.**
4820 (1) After the liquidation proceeding has been terminated and the liquidator discharged, [the
4821 commissioner or other interested party may at any time] within a reasonable time any of the
4822 following may petition the court to reopen the proceedings for good cause, including the discovery
4823 of additional assets[.]:
4824 (a) the commissioner;
4825 (b) a policyholder;
4826 (c) a creditor; or
4827 (d) a claimant of the closed liquidation estate.
4828 (2) If the court is satisfied that there is justification for reopening, [it] the court shall order
4829 [it] the reopening.
4830 Section 70. Section **31A-27-341** is amended to read:
4831 **31A-27-341. Disposition of records.**
4832 [Records] Upon a motion of the liquidator, the records of any insurer in the process of

4833 liquidation or completely liquidated under this chapter may be disposed of in the [~~same~~] manner
4834 [~~as records under Section 31A-2-207~~] <u>ordered by the court</u>.
4835 Section 71. Section **31A-28-203** is amended to read:
4836 **31A-28-203. Definitions.**
4837 As used in this part:
4838 (1) "Affiliate" is as defined in Section 31A-1-301.
4839 <u>(2) "Association account" means the Utah Property and Casualty Insurance Guaranty</u>
4840 <u>Association Account created by Section 31A-28-205.</u>
4841 [~~(2)~~] <u>(3)</u> (a) "Claimant" means:
4842 (i) an insured making a first-party claim; or
4843 (ii) a person instituting a liability claim.
4844 (b) A person who is an affiliate of the insolvent insurer may not be a claimant.
4845 [~~(3)~~] <u>(4)</u> (a) "Covered claim" means an unpaid claim, including an unpaid claim under a
4846 personal lines policy for unearned premiums submitted by a claimant, if:
4847 (i) the claim arises out of the coverage;
4848 (ii) the claim is within the coverage;
4849 (iii) the claim is not in excess of the applicable limits of an insurance policy to which this
4850 part applies;
4851 (iv) the insurer who issued the policy becomes an insolvent insurer; and
4852 (v) (A) the claimant or insured is a resident of this state at the time of the insured event;
4853 or
4854 (B) the claim is a first-party claim for damage to property that is permanently located in
4855 this state.
4856 (b) "Covered claim" does not include:
4857 (i) any amount awarded as punitive or exemplary damages or any amount due any
4858 reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or
4859 otherwise, nor does it include any supplementary payment obligation, including adjustment fees
4860 and expenses, attorneys' fees and expenses, court costs, interest, and bond premiums, prior to the
4861 appointment of a liquidator;
4862 (ii) any amount sought as a return of premium under a retrospective rating plan;
4863 (iii) any first-party claim by an insured if:

4864 (A) the insured's net worth exceeds $25,000,000 on December 31 of the year preceding
4865 the date the insurer becomes an insolvent insurer; and
4866 (B) the insured's net worth includes the aggregate net worth of the insured and all of its
4867 subsidiaries as calculated on a consolidated basis; or
4868 (iv) any first-party claims by an insured that is an affiliate of the insolvent insurer.
4869 [~~(4)~~] (5) "Insolvent insurer" means a member insurer that is placed under an order of
4870 liquidation by a court of competent jurisdiction with a finding of insolvency.
4871 [~~(5)~~] (6) "Member insurer" means any person who:
4872 (a) writes any kind of insurance to which this part applies under Section 31A-28-202,
4873 including the exchange of reciprocal or inter-insurance contracts; and
4874 (b) is licensed to transact insurance in this state.
4875 [~~(6)~~] (7) (a) "Net direct written premiums" means direct gross premiums written in this
4876 state on insurance policies that this part applies to, less return premiums and dividends paid or
4877 credited to policyholders on the direct business.
4878 (b) "Net direct written premiums" does not include premiums on contracts between
4879 insurers or reinsurers.
4880 [~~(7)~~] (8) "Personal lines policy" means an insurance policy issued to an individual that:
4881 (a) insures a motor vehicle used for personal purposes and not used in trade or business;
4882 or
4883 (b) insures a residential dwelling.
4884 [~~(8)~~] (9) "Residence" means, for entities other than a natural person, the state where the
4885 principal place of business of a claimant, insured, or policyholder is located at the time of the
4886 insured event.
4887 Section 72. Section **31A-28-205** is amended to read:
4888 **31A-28-205. Creation of the association.**
4889 (1) (a) The Utah Property and Casualty Insurance Guaranty Association shall continue as
4890 a nonprofit legal entity.
4891 (b) All member insurers of the association are, and remain, members of the association as
4892 a condition of their authority to transact insurance business in this state.
4893 (c) The association shall:
4894 (i) perform its functions under the plan of operation established and approved under

4895 Section 31A-28-209; and
4896 (ii) exercise its powers through a board of directors established under Section 31A-28-206.
4897 (d) For the purposes of administration and assessment, the association shall maintain[: (i)
4898 a workers' compensation insurance] an account[;] known as the Property and Casualty Insurance
4899 Guarantee Association Account.
4900 [(ii) an automobile insurance account; and]
4901 [(iii) a miscellaneous account for all other insurance to which this part applies.]
4902 (e) (i) If as of May 6, 2002, the association has more than one account, the association
4903 shall consolidate all accounts into the Property and Casualty Insurance Guarantee Association
4904 Account.
4905 (ii) The Property and Casualty Insurance Guarantee Association Account:
4906 (A) succeeds to all funds held by the association in an account existing on May 6, 2002;
4907 and
4908 (B) is subject to any liability or obligation attributable to an account of the association
4909 existing on May 6, 2002.
4910 (2) (a) An insurer shall cease to be a member insurer on the day following the termination
4911 or expiration of the insurer's license to transact the kinds of insurance to which this part applies.
4912 (b) Notwithstanding Subsection (2)(a), the insurer shall remain liable as a member insurer
4913 for all obligations, including assessments levied:
4914 (i) before the termination or expiration of the insurer's license; and
4915 (ii) after the termination or expiration of the insurer's license but that relate to an insurer
4916 that became an insolvent insurer before the termination or expiration of the insurer's license.
4917 (3) Meetings or records of the association shall be open to the public upon a majority vote
4918 of the board of directors of the association.
4919 (4) The association is not an agency of the state.
4920 Section 73. Section **31A-28-207** is amended to read:
4921 **31A-28-207. Powers and duties of the association.**
4922 (1) (a) The association is obligated on the amount of the covered claims:
4923 (i) existing prior to the order of liquidation; and
4924 (ii) arising:
4925 (A) within 30 days after the order of liquidation; or

4926 (B) (I) before the policy expiration date if it is less than 30 days after the order of
4927 liquidation; or
4928 (II) before the insured replaces the policy or causes its cancellation, if the insured does so
4929 within 30 days of the order of liquidation.
4930 (b) The obligation under Subsection (1)(a) includes only that amount of each covered
4931 claim that is less than $300,000.
4932 (c) A claim under a personal lines policy for unearned premiums shall include only those
4933 claims that exceed $100 in amount, subject to a maximum of $10,000 per policy.
4934 (d) The association shall pay the full amount of any covered claim arising out of a workers'
4935 compensation policy. The association is not obligated to a policyholder or claimant in an amount
4936 in excess of the obligation of the insolvent insurer under the policy from which the claim arises.
4937 (e) Any obligation of the association to defend an insured on a covered claim shall cease:
4938 (i) upon payment by the association, as part of a settlement releasing the insured; or
4939 (ii) on a judgment, of the lesser of:
4940 (A) the association's covered claim obligation limit; or
4941 (B) the applicable policy limit.
4942 (f) The association:
4943 (i) is considered as the insurer only to the extent of its obligation on the covered claims,
4944 subject to the limitations provided in this part;
4945 (ii) has all the rights, duties, and obligations of the insolvent insurer as if the insurer had
4946 not yet become insolvent, including the right to pursue and retain salvage and subrogation
4947 recoverable on paid covered claim obligations; and
4948 (iii) may not be considered the insolvent insurer for any purpose relating to whether the
4949 association is subject to personal jurisdiction in the courts of any state.
4950 (g) (i) Notwithstanding any other provisions of this part, except in the case of a claim for
4951 benefits under workers' compensation coverage, any obligation of the association to or on behalf
4952 of a particular insured and its affiliates on covered claims shall cease when:
4953 (A) a total amount of $10,000,000 has been paid to or on behalf of the insured and its
4954 affiliates on covered claims by the association or a similar association; and
4955 (B) all payments on covered claims arise under one or more policies of a single insolvent
4956 insurer.

4957 (ii) The association may establish a plan to allocate the amounts payable by the association
4958 in a manner the association considers equitable if the association determines that:
4959 (A) there is more than one claimant asserting a covered claim against:
4960 (I) the association;
4961 (II) a similar association; or
4962 (III) a property or casualty insurance security fund in another state; and
4963 (B) all claims arise under the policy or policies of a single insolvent insurer.
4964 (h) The association shall [~~allocate claims paid and expenses incurred among the accounts~~
4965 ~~established under Section 31A-28-205 separately, and~~] assess member insurers [~~separately for each~~
4966 ~~account~~] amounts necessary to pay:
4967 (i) the obligations of the association under Subsection (1)(a), as limited by Subsections
4968 (1)(e) through (g), subsequent to the liquidation of an insolvent insurer;
4969 (ii) the expenses of handling covered claims subsequent to the liquidation of an insolvent
4970 insurer;
4971 (iii) the cost of examinations under Section 31A-28-214; and
4972 (iv) other expenses authorized by this part.
4973 (i) (i) The association shall:
4974 (A) investigate claims brought against the association; and
4975 (B) adjust, compromise, settle, and pay covered claims to the extent of the association's
4976 obligation and deny all other claims.
4977 (ii) The association is not bound by a settlement, release, compromise, waiver, or judgment
4978 executed or entered into by the insolvent insurer:
4979 (A) less than 12 months before the entry of an order of liquidation; or
4980 (B) more than 12 months before the entry of an order of liquidation if the settlement,
4981 release, compromise, waiver, or judgment is:
4982 (I) based on a claim that is not a covered claim; or
4983 (II) the result of fraud, collusion, default, or failure to defend.
4984 (iii) The association may assert all defenses available including defenses applicable to
4985 determining and enforcing the association's statutory rights and obligations to a claim.
4986 (iv) The association may appoint and direct legal counsel retained under a liability
4987 insurance policy for the defense of a covered claim.

4988 (j) (i) The association shall handle claims through:
4989 (A) its employees;
4990 (B) one or more insurers; or
4991 (C) other persons designated as servicing facilities.
4992 (ii) Designation of a servicing facility is subject to the approval of the commissioner, but
4993 this designation may be declined by a member insurer.
4994 (k) The association shall:
4995 (i) reimburse each servicing facility for:
4996 (A) obligations of the association paid by the facility; and
4997 (B) expenses incurred by the facility while handling claims on behalf of the association;
4998 and
4999 (ii) pay the other expenses of the association as authorized by this title.
5000 (2) The association may:
5001 (a) employ or retain the persons, including private legal counsel, necessary to handle
5002 claims and perform other duties of the association;
5003 (b) borrow funds necessary to implement the purposes of this part in accord with the plan
5004 of operation;
5005 (c) sue or be sued;
5006 (d) negotiate and become a party to the contracts necessary to carry out the purpose of this
5007 part;
5008 (e) perform any other acts necessary or proper to accomplish the purposes of this chapter;
5009 or
5010 (f) refund to the member insurers, in proportion to the contribution of each member insurer
5011 to [~~that~~] the association account, the amount that the assets of the account exceed the liabilities,
5012 if, at the end of any calendar year, the board of directors finds that:
5013 (i) the assets of the association in [~~any~~] the association account exceed the liabilities [~~of~~
5014 ~~that account~~] as estimated by the board of directors for the coming year; and
5015 (ii) the excess assets are not needed for other purposes of this part.
5016 (3) For a refund due to a member insurer for an assessment that has been offset against
5017 premium taxes, the association may pay the amount of the refund directly to the State Tax
5018 Commission.

5019 (4) The courts of the state shall have exclusive jurisdiction over all actions brought against
5020 the association that relate to or arise out of this part.
5021 (5) (a) Any person recovering under this part is considered to have assigned that person's
5022 rights under the policy to the association to the extent of that person's recovery from the
5023 association.
5024 (b) Every insured or claimant seeking the protection of this chapter shall cooperate with
5025 the association to the same extent the person would have been required to cooperate with the
5026 insolvent insurer.
5027 (c) Except as provided in Subsection (5)(e), the association has no cause of action against
5028 the insured of the insolvent insurer for any sums the association has paid out except those causes
5029 of action the insolvent insurer would have had if the sums had been paid by the insolvent insurer.
5030 (d) When an insolvent insurer operates on a plan with assessment liability, payments of
5031 claims of the association do not reduce the liability for unpaid assessments of the insurer to:
5032 (i) the receiver;
5033 (ii) liquidator; or
5034 (iii) statutory successor.
5035 (e) The association may recover from the following persons the amount of any "covered
5036 claim" paid on behalf of that person pursuant to this part:
5037 (i) any insured whose:
5038 (A) net worth on December 31 of the year next preceding the date the insurer becomes
5039 insolvent, exceeds $25,000,000; and
5040 (B) liability obligations to other persons are satisfied in whole or in part by payments made
5041 under this part; and
5042 (ii) any person:
5043 (A) who is an affiliate of the insolvent insurer; and
5044 (B) whose liability obligations to other persons are satisfied in whole or in part by
5045 payments made under this part.
5046 (f) (i) The receiver, liquidator, or statutory successor of an insolvent insurer is bound by:
5047 (A) a determination of a covered claim eligibility under this part; and
5048 (B) a settlement of a covered claim by the association or a similar organization in another
5049 state.

5050 (ii) The court having jurisdiction shall grant settled claims a priority equal to that which
5051 the claimant would have been entitled to in the absence of this part, against the assets of the
5052 insolvent insurer.
5053 (g) The association or any similar organization in another state shall:
5054 (i) be recognized as a claimant in the liquidation of an insolvent insurer for any amounts
5055 paid on a covered claim obligation as determined under this part or a similar law in another state;
5056 and
5057 (ii) receive dividends or distributions at the priority set forth in Section 31A-27-335.
5058 (h) (i) The association shall periodically file with the receiver or liquidator of the insolvent
5059 insurer:
5060 (A) statements of the covered claims paid by the association; and
5061 (B) estimates of anticipated claims on the association.
5062 (ii) The filing under this Subsection (5)(h) preserves the rights of the association for claims
5063 against the assets of the insolvent insurer.
5064 (i) The association need not pay any claim filed after the final date under Sections
5065 31A-27-315 and 31A-27-328, or similar statutes of other states, for filing the same type of claim
5066 with the liquidator of the insolvent insurer.
5067 Section 74. Section **31A-28-208** is amended to read:
5068 **31A-28-208. Assessments.**
5069 (1) (a) To provide the funds necessary to carry out the powers and duties of the association,
5070 the board of directors shall assess the member insurers[~~, separately for each account established~~
5071 ~~under Section 31A-28-205,~~] at the time and in the amount the board finds necessary.
5072 (b) An assessment under this section:
5073 (i) is due not less than 30 days after written notice to the member insurers; and
5074 (ii) accrues interest to the extent unpaid after the due date at the greater of:
5075 (A) 10% per annum; or
5076 (B) the then legal rate of interest provided in Section 15-1-1.
5077 [~~(c) The association shall allocate claims and incurred expenses among the accounts.~~]
5078 (2) An assessment [~~for each account~~] is to be made in the amount necessary to carry out
5079 the powers and duties of the association under Section 31A-28-207 for an insolvent insurer.
5080 (3) An assessment against a member insurer [~~for each account~~] is in the proportion that

5081 the net direct written premiums of the member insurer for the preceding calendar year on the kinds
5082 of insurance [in the account] for which this part applies bears to the net direct written premiums
5083 of all member insurers for the preceding calendar year on [all] the kinds of insurance [in the
5084 account] for which this part applies.
5085 (4) A member insurer may not be assessed in any year [on any account] for an amount
5086 greater than 2% of that member insurer's net direct written premiums for the preceding calendar
5087 year on the kinds of insurance [in the account] for which this part applies.
5088 (5) If the maximum assessment, together with the other assets of the association in [any]
5089 the association account, do not provide in any one year [in any account] an amount sufficient to
5090 make all necessary payments [from that account], the funds available shall be prorated and the
5091 unpaid portion shall be paid as soon as funds become available.
5092 (6) The association may exempt or defer, in whole or in part, the assessment of any
5093 member insurer, if the assessment would cause the member insurer's financial statement to reflect
5094 amounts of capital or surplus less than the minimum amounts required for a certificate of authority
5095 by any jurisdiction in which the member insurer is authorized to transact insurance.
5096 (7) Each member insurer may set off against any assessment authorized payments made
5097 on covered claims and expenses incurred in the payment of the claims by the member insurer, if
5098 they are chargeable to the association account [for which the assessment is made].
5099 Section 75. Section **31A-28-222** is amended to read:
5100 **31A-28-222. Application of amendments.**
5101 (1) The amendments in [this act] Chapter 363, Laws of Utah 2001, shall become effective
5102 on April 30, 2001 and apply to the association's obligations under policies of insolvent insurers as
5103 they exist on or after April [20] 30, 2001.
5104 (2) Notwithstanding Subsection (1), the amendments to Subsections 31A-28-203(3) and
5105 31A-28-207(1)(a) in Chapter 363, Laws of Utah 2001, that add coverage for unearned premium
5106 claims shall apply only to insurers that become insolvent after [the effective date] April 30, 2001.
5107 Section 76. Section **31A-29-113** is amended to read:
5108 **31A-29-113. Benefits -- Additional types of pool insurance -- Preexisting conditions**
5109 **-- Waiver -- Maximum benefits.**
5110 (1) (a) The pool policy shall pay for eligible expenses rendered or furnished for the
5111 diagnoses or treatment of illness or injury [which] that:

5112 (i) exceed the deductible and copayment amounts applicable under Section 31A-29-114;
5113 and [which]
5114 (ii) are not otherwise limited or excluded.
5115 (b) Eligible expenses are the charges for the health care services and items rendered during
5116 times for which benefits are extended under the pool policy.
5117 (2) The coverage to be issued by the pool, its schedule of benefits, exclusions, and other
5118 limitations shall be established by the board.
5119 (3) The commissioner shall approve the benefit package developed by the board to ensure
5120 its compliance with this chapter.
5121 (4) The pool shall offer at least one benefit plan through a managed care program as
5122 authorized under Section 31A-29-106.
5123 (5) This chapter [shall] may not be construed to prohibit the pool from issuing additional
5124 types of health insurance policies with different types of benefits which in the opinion of the board
5125 may be of benefit to the citizens of Utah.
5126 (6) The board shall design and require an administrator to employ cost containment
5127 measures and requirements including preadmission certification and concurrent inpatient review
5128 for the purpose of making the pool more cost effective. The provisions of Sections 31A-22-617
5129 and 31A-22-618 of this title do not apply to coverage issued under this chapter.
5130 (7) A pool policy may contain provisions under which coverage is excluded during a
5131 six-month period following the effective date of plan coverage as to a given individual for a
5132 preexisting condition, as long as either of the following exists:
5133 (a) the condition has manifested itself within a period of six months before the effective
5134 date of coverage in such a manner as would cause an ordinary, prudent person to seek diagnosis
5135 or treatment; or
5136 (b) medical advice or treatment was recommended or received for the condition within a
5137 period of six months before the effective date of coverage.
5138 (8) A pool policy may exclude coverage for pregnancies for ten months following the
5139 effective date of coverage[.], unless the individual is eligible to receive credit for previous
5140 coverage under the Health Insurance Portability and Accountability Act, P. L. 104-91, 110 Stat.
5141 1962.
5142 (9) (a) [The] For individuals changing from individual health insurance, as defined in

5143 Subsection 31A-29-103(5), to the health insurance pool, the preexisting condition exclusion
5144 described in Subsection (7) shall be waived to the extent to which similar exclusions have been
5145 satisfied under any prior health insurance coverage:
5146 (i) which was involuntarily terminated, other than for nonpayment of premium, if the
5147 application for pool coverage is made not later than [~~31~~] 63 days following the involuntary
5148 termination; or
5149 (ii) whose premium rate exceeds the rate of the pool for equal or lesser benefits.
5150 (b) If Subsection (9)(a) applies, coverage in the pool shall be effective from the date on
5151 which the prior coverage was terminated.
5152 (10) (a) The pool may not apply any preexisting condition exclusion to an individual that
5153 is changing group health coverage to the health insurance pool if:
5154 (i) the individual applies not later than 63 days following the date of involuntary
5155 termination from group health coverage;
5156 (ii) the individual has at least 18 months of creditable coverage as of the date the
5157 individual seeks coverage from:
5158 (A) the health insurance pool; or
5159 (B) an individual health plan;
5160 (iii) the individual's most recent prior creditable coverage was under:
5161 (A) a group health plan;
5162 (B) government plan; or
5163 (C) a church plan;
5164 (iv) the individual is not eligible for coverage under:
5165 (A) a group health plan;
5166 (B) Part A or Part B of Title XVIII of the Social Security Act; or
5167 (C) a state plan under Title XIX of the Social Security Act;
5168 (v) the individual does not have other health insurance coverage;
5169 (vi) the individual's most recent coverage was not terminated because of:
5170 (A) nonpayment of premiums; or
5171 (B) fraud;
5172 (vii) the individual has been offered the option of continuing coverage under:
5173 (A) a continuation provision; or

5174 (B) a similar state extension program; and
5175 (viii) the individual's premium rate exceeds the rate of the pool for equal or lesser
5176 coverage.
5177 (b) If Subsection (10)(a) applies, coverage in the pool shall be effective from the date on
5178 which the prior coverage was terminated.
5179 [(10)] (11) The board shall establish a policy allowing for the waiver of the preexisting
5180 condition exclusion set forth in Subsection (7) for coverage of medically necessary outpatient
5181 medical care.
5182 [(11)] (12) Benefits available under the pool may not exceed $1,000,000 paid to or on
5183 behalf of any person.
5184 Section 77. Section **31A-30-101** is amended to read:
5185 **TITLE 30. INDIVIDUAL, SMALL, AND GROUP EMPLOYER HEALTH**
5186 **INSURANCE ACT**
5187 **31A-30-101. Title.**
5188 This chapter shall be known as the "Individual [and], Small, and Group Employer Health
5189 Insurance Act."
5190 Section 78. Section **31A-30-103** is amended to read:
5191 **31A-30-103. Definitions.**
5192 As used in this [part] chapter:
5193 (1) "Actuarial certification" means a written statement by a member of the American
5194 Academy of Actuaries or other individual approved by the commissioner that a covered carrier is
5195 in compliance with [the provisions of] Section 31A-30-106, based upon the examination of the
5196 covered carrier, including review of the appropriate records and of the actuarial assumptions and
5197 methods [utilized] used by the covered carrier in establishing premium rates for applicable health
5198 benefit plans.
5199 (2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through
5200 one or more intermediaries, controls or is controlled by, or is under common control with, a
5201 specified entity or person.
5202 (3) "Base premium rate" means, for each class of business as to a rating period, the lowest
5203 premium rate charged or that could have been charged under a rating system for that class of
5204 business by the covered carrier to covered insureds with similar case characteristics for health

5205 benefit plans with the same or similar coverage.
5206 (4) "Basic coverage" means the coverage provided in the Basic Health Care Plan
5207 established by the Health Benefit Plan Committee under Subsection 31A-22-613.5(6).
5208 (5) "Carrier" means any person or entity that provides health insurance in this state
5209 including:
5210 (a) an insurance company[,];
5211 (b) a prepaid hospital or medical care plan[,];
5212 (c) a health maintenance organization[,];
5213 (d) a multiple employer welfare arrangement[,]; and
5214 (e) any other person or entity providing a health insurance plan under this title.
5215 (6) (a) Except as provided in Subsection (6)(b), "case characteristics" means demographic
5216 or other objective characteristics of a covered insured that are considered by the carrier in
5217 determining premium rates for the covered insured. [However,]
5218 (b) "Case characteristics" does not include:
5219 (i) duration of coverage since the policy was issued[,];
5220 (ii) claim experience[,]; and
5221 (iii) health status[, are not case characteristics for the purposes of this chapter].
5222 (7) "Class of business" means all or a separate grouping of covered insureds established
5223 under Section 31A-30-105.
5224 (8) "Conversion policy" means a policy providing coverage under the conversion
5225 provisions required in [Title 31A,] Chapter 22, Part VII, Group Accident and Health Insurance.
5226 (9) "Covered carrier" means any individual carrier or small employer carrier subject to this
5227 [act] chapter.
5228 (10) "Covered individual" means any individual who is covered under a health benefit plan
5229 subject to this [act] chapter.
5230 (11) "Covered insureds" means small employers and individuals who are issued a health
5231 benefit plan that is subject to this [act] chapter.
5232 (12) "Dependent" means [individuals] an individual to the extent [they are] that the
5233 individual is defined to be a dependent by:
5234 (a) the health benefit plan covering the covered individual; and
5235 (b) [the provisions of] Chapter 22, Part VI, [Disability] Accident and Health Insurance.

5236 [(13) (a) "Eligible employee" means:]
5237 [(i) an employee who works on a full-time basis and has a normal work week of 30 or
5238 more hours, and includes a sole proprietor, and a partner of a partnership, if the sole proprietor or
5239 partner is included as an employee under a health benefit plan of a small employer; or]
5240 [(ii) an independent contractor if the independent contractor is included under a health
5241 benefit plan of a small employer.]
5242 [(b) "Eligible employee" does not include:]
5243 [(i) an employee who works on a part-time, temporary, or substitute basis; or]
5244 [(ii) the spouse or dependents of the employer.]
5245 [(14)] (13) "Established geographic service area" means a geographical area approved by
5246 the commissioner within which the carrier is authorized to provide coverage.
5247 [(15) "Health benefit plan" means any certificate under a group health insurance policy,
5248 or any health insurance policy, except that health benefit plan does not include coverage only for:]
5249 [(a) accident;]
5250 [(b) dental;]
5251 [(c) vision;]
5252 [(d) Medicare supplement;]
5253 [(e) long-term care; or]
5254 [(f) the following when offered and marketed as supplemental health insurance and not
5255 as a substitute for hospital or medical expense insurance or major medical expense insurance:]
5256 [(i) specified disease;]
5257 [(ii) hospital confinement indemnity; or]
5258 [(iii) limited benefit plan.]
5259 [(16)] (14) "Index rate" means, for each class of business as to a rating period for covered
5260 insureds with similar case characteristics, the arithmetic average of the applicable base premium
5261 rate and the corresponding highest premium rate.
5262 [(17)] (15) "Individual carrier" means a carrier that [offers] provides coverage on an
5263 individual basis through a health benefit [plans covering insureds in this state under individual
5264 policies.] plan regardless of whether:
5265 (a) coverage is offered through:
5266 (i) an association;

5267 (ii) a trust;
5268 (iii) a discretionary group; or
5269 (iv) other similar groups; or
5270 (b) the policy or contract is situated out-of-state.
5271 [(18)] (16) "Individual conversion policy" means a conversion policy issued by a health
5272 benefit plan as defined in [Subsection (15)] Section 31A-1-301 to:
5273 (a) an individual; or
5274 (b) an individual with a family.
5275 [(19)] (17) "Individual coverage count" means the number of natural persons covered
5276 under a carrier's health benefit plans that are individual policies.
5277 [(20)] (18) "Individual enrollment cap" means the percentage set by the commissioner in
5278 accordance with Section 31A-30-110.
5279 [(21)] (19) "New business premium rate" means, for each class of business as to a rating
5280 period, the lowest premium rate charged or offered, or that could have been charged or offered, by
5281 the carrier to covered insureds with similar case characteristics for newly issued health benefit
5282 plans with the same or similar coverage.
5283 (20) "Preexisting condition" is as defined in Section 31A-1-301.
5284 [(22)] (21) "Premium" means all monies paid by covered insureds and covered individuals
5285 as a condition of receiving coverage from a covered carrier, including any fees or other
5286 contributions associated with the health benefit plan.
5287 [(23)] (22) (a) "Rating period" means the calendar period for which premium rates
5288 established by a covered carrier are assumed to be in effect, as determined by the carrier.
5289 [However, a]
5290 (b) A covered carrier may not have:
5291 (i) more than one rating period in any calendar month[,]; and
5292 (ii) no more than 12 rating periods in any calendar year.
5293 [(24)] (23) "Resident" means an individual who has resided in this state for at least 12
5294 consecutive months immediately preceding the date of application.
5295 [(25) "Small employer" means any person, firm, corporation, partnership, or association
5296 actively engaged in business that, on at least 50% of its working days during the preceding
5297 calendar quarter, employed at least two and no more than 50 eligible employees, the majority of

5298 whom were employed within this state. In determining the number of eligible employees,
5299 companies that are affiliated or that are eligible to file a combined tax return for purposes of state
5300 taxation are considered one employer.]
5301 (24) "Short-term limited duration insurance" means a health benefit plan that:
5302 (a) is not renewable; and
5303 (b) has an expiration date specified in the contract that is less than 364 days after the date
5304 the plan became effective.
5305 [(26)] (25) "Small employer carrier" means a carrier that [offers] provides health benefit
5306 plans covering eligible employees of one or more small employers in this state[.], regardless of
5307 whether:
5308 (a) coverage is offered through:
5309 (i) an association;
5310 (ii) trust;
5311 (iii) discretionary group; or
5312 (iv) other similar grouping; or
5313 (b) the policy or contract is situated out-of-state.
5314 [(27)] (26) "Uninsurable" means an individual who:
5315 (a) is eligible for the Comprehensive Health Insurance Pool coverage under the
5316 underwriting criteria established in Subsection 31A-29-111(4); or
5317 (b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and
5318 (ii) has a condition of health that does not meet consistently applied underwriting criteria
5319 as established by the commissioner in accordance with Subsections 31A-30-106(1)[(k)](i) and [(l)]
5320 (j) for which coverage the applicant is applying.
5321 [(28)] (27) "Uninsurable percentage" for a given calendar year equals UC/CI where, for
5322 purposes of this formula:
5323 (a) "UC" means the number of uninsurable individuals who were issued an individual
5324 policy on or after July 1, 1997; and
5325 (b) "CI" means the carrier's individual coverage count as of December 31 of the preceding
5326 year.
5327 Section 79. Section **31A-30-104** is amended to read:
5328 **31A-30-104. Applicability and scope.**

5329 (1) This chapter applies to any:
5330 (a) health benefit plan that provides coverage to:
5331 (i) individuals;
5332 (ii) small [employer groups] employers; or
5333 (iii) both Subsections (1)(a)(i) and (ii); or
5334 (b) individual conversion policy for purposes of Sections 31A-30-106.5 and [31A-30-107]
5335 31A-30-107.5.
5336 (2) This chapter applies to a health benefit plan that provides coverage to small employers
5337 or individuals regardless of:
5338 (a) whether the contract is issued to an:
5339 (i) association;
5340 (ii) a trust;
5341 (iii) a discretionary group; or
5342 (iv) other similar grouping; or
5343 (b) the situs of delivery of the policy or contract.
5344 (3) This chapter does not apply to:
5345 (a) a large employer health benefit plan; or
5346 (b) short-term limited duration health insurance.
5347 [(2)] (4) (a) Except as provided in Subsection [(2)] (4)(b), for the purposes of this
5348 chapter[,]:
5349 (i) carriers that are affiliated companies or that are eligible to file a consolidated tax return
5350 shall be treated as one carrier; and
5351 (ii) any restrictions or limitations imposed by this chapter shall apply as if all health benefit
5352 plans delivered or issued for delivery to covered insureds in this state by the affiliated carriers were
5353 issued by one carrier.
5354 (b) [An] Upon a finding of the commissioner, an affiliated carrier that is a health
5355 maintenance organization having a certificate of authority under this title may be considered to be
5356 a separate carrier for the purposes of this chapter.
5357 (c) Unless otherwise authorized by the commissioner, a covered carrier may not enter into
5358 one or more ceding arrangements with respect to health benefit plans delivered or issued for
5359 delivery to covered insureds in this state if [such] the ceding arrangements would result in less than

5360 50% of the insurance obligation or risk for [such] the health benefit plans being retained by the
5361 ceding carrier.
5362 (d) [The provisions of] Section 31A-22-1201 [apply] applies if a covered carrier cedes or
5363 assumes all of the insurance obligation or risk with respect to one or more health benefit plans
5364 delivered or issued for delivery to covered insureds in this state.
5365 [(3)] (5) (a) A Taft Hartley trust created in accordance with Section 302(c)(5) of the
5366 Federal Labor Management Relations Act, or a carrier with the written authorization of such a
5367 trust, may make a written request to the commissioner for a waiver from the application of any of
5368 the provisions of Subsection 31A-30-106(1) with respect to a health benefit plan provided to the
5369 trust.
5370 (b) The commissioner may grant [such] a trust or carrier described in Subsection (5)(a) a
5371 waiver if the commissioner finds that application with respect to the trust would:
5372 (i) have a substantial adverse effect on the participants and beneficiaries of the trust; and
5373 (ii) require significant modifications to one or more collective bargaining arrangements
5374 under which the trust is established or maintained.
5375 (c) A waiver granted under this Subsection [(3)] (5) may not apply to an individual if the
5376 person participates in [such] a Taft Hartley trust as an associate member of any employee
5377 organization.
5378 [(4) A carrier who offers individual and small employer health benefit plans may use the
5379 small employer index rates to establish the rate limitations for individual policies, even if some
5380 individual policies are rated below the small employer base rate.]
5381 [(5)] (6) Sections 31A-30-106, 31A-30-106.5, 31A-30-106.7, 31A-30-107, 31A-30-108,
5382 and 31A-30-111 apply to:
5383 (a) any insurer engaging in the business of insurance related to the risk of a small employer
5384 for medical, surgical, hospital, or ancillary health care expenses of [its] the small employer's
5385 employees provided as an employee benefit; and
5386 (b) any contract of an insurer, other than a workers' compensation policy, related to the risk
5387 of a small employer for medical, surgical, hospital, or ancillary health care expenses of [its] the
5388 small employer's employees provided as an employee benefit.
5389 [(6)] (7) The commissioner may make rules requiring that the marketing practices be
5390 consistent with this chapter for:

5391 (a) an insurer [~~and its~~];
5392 (b) an insurer's agent;
5393 [~~(b)~~] (c) an insurance broker; and
5394 [~~(c)~~] (d) an insurance consultant.
5395 Section 80. Section **31A-30-106** is amended to read:
5396 **31A-30-106. Premiums -- Rating restrictions -- Disclosure.**
5397 (1) Premium rates for health benefit plans under this chapter are subject to the [~~following~~]
5398 provisions[~~:~~] of this Subsection (1).
5399 (a) The index rate for a rating period for any class of business [~~shall~~] may not exceed the
5400 index rate for any other class of business by more than 20%.
5401 (b) (i) For a class of business, the premium rates charged during a rating period to covered
5402 insureds with similar case characteristics for the same or similar coverage, or the rates that could
5403 be charged to such employers under the rating system for that class of business, may not vary from
5404 the index rate by more than 30% of the index rate, except as provided in Section 31A-22-625.
5405 (ii) A covered carrier who offers individual and small employer health benefit plans may
5406 use the small employer index rates to establish the rate limitations for individual policies, even if
5407 some individual policies are rated below the small employer base rate.
5408 (c) The percentage increase in the premium rate charged to a covered insured for a new
5409 rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of the
5410 following:
5411 (i) the percentage change in the new business premium rate measured from the first day
5412 of the prior rating period to the first day of the new rating period[~~. In the case of a health benefit~~
5413 ~~plan into which the covered carrier is no longer enrolling new covered insureds, the covered carrier~~
5414 ~~shall use the percentage change in the base premium rate, provided that such change does not~~
5415 ~~exceed, on a percentage basis, the change in the new business premium rate for the most similar~~
5416 ~~health benefit plan into which the covered carrier is actively enrolling new covered insureds~~];
5417 (ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods
5418 of less than one year, due to the claim experience, health status, or duration of coverage of the
5419 covered individuals as determined from the covered carrier's rate manual for the class of business,
5420 except as provided in Section 31A-22-625; and
5421 (iii) any adjustment due to change in coverage or change in the case characteristics of the

5422 covered insured as determined from the covered carrier's rate manual for the class of business.
5423 (d) (i) Adjustments in rates for claims experience, health status, and duration from issue
5424 may not be charged to individual employees or dependents.
5425 (ii) Any [~~such~~] adjustment described in Subsection (1)(d)(i) shall be applied uniformly to
5426 the rates charged for all employees and dependents of the small employer.
5427 (e) A covered carrier may [~~utilize~~] use industry as a case characteristic in establishing
5428 premium rates, provided that the highest rate factor associated with any industry classification does
5429 not exceed the lowest rate factor associated with any industry classification by more than 15%.
5430 [~~(f) In the case of health benefit plans issued prior to July 1, 1994, a premium rate for a~~
5431 ~~rating period, adjusted pro rata for rating period of less than a year, may exceed the ranges under~~
5432 ~~Subsections (1)(a) and (b) until July 1, 1996. In that case, the percentage increase in the premium~~
5433 ~~rate charged to a covered insured for a new rating period may not exceed the sum of the~~
5434 ~~following:~~]
5435 [~~(i) the percentage change in the new business premium rate measured from the first day~~
5436 ~~of the prior rating period to the first day of the new rating period. In the case where a covered~~
5437 ~~carrier is not issuing any new policies the covered carrier shall use the percentage change in the~~
5438 ~~base premium rate, provided that such change does not exceed, on a percentage basis, the change~~
5439 ~~in the new business premium rate for the most similar health benefit plan into which the covered~~
5440 ~~carrier is actively enrolling new covered insureds; and~~]
5441 [~~(ii) any adjustment due to change in coverage or change in the case characteristics of the~~
5442 ~~covered insured as determined from the carrier's rate manual for the class of business.~~]
5443 [~~(g) The commissioner may grant a one-year extension of the July 1, 1996, deadline~~
5444 ~~specified in Subsection (1)(f) if the commissioner determines that an extension is needed to avoid~~
5445 ~~significant disruption of the health insurance market subject to this chapter or to insure the~~
5446 ~~financial stability of carriers in the market.~~]
5447 [~~(h)~~] (f) (i) Covered carriers shall apply rating factors, including case characteristics,
5448 consistently with respect to all covered insureds in a class of business.
5449 (ii) Rating factors shall produce premiums for identical groups [~~which~~] that:
5450 (A) differ only by the amounts attributable to plan design; and
5451 (B) do not reflect differences due to the nature of the groups assumed to select particular
5452 health benefit plans.

5453 [(ii)] (iii) A covered carrier shall treat all health benefit plans issued or renewed in the
5454 same calendar month as having the same rating period.
5455 [(i)] (g) For the purposes of this Subsection (1), a health benefit plan that [utilizes] uses
5456 a restricted network provision [shall] may not be considered similar coverage to a health benefit
5457 plan that does not [utilize] use such a network, provided that [utilization] use of the restricted
5458 network provision results in substantial difference in claims costs.
5459 [(j)] (h) The covered carrier [shall] may not, without prior approval of the commissioner,
5460 use case characteristics other than:
5461 (i) age[,];
5462 (ii) gender[,];
5463 (iii) industry[,];
5464 (iv) geographic area[,];
5465 (v) family composition[,]; and
5466 (vi) group size.
5467 [(k)] (i) (i) The commissioner may establish [regulations] rules in accordance with Title
5468 63, Chapter 46a, Utah Administrative Rulemaking Act, to:
5469 (A) implement [the provisions of] this chapter; and
5470 (B) to assure that rating practices used by covered carriers are consistent with the purposes
5471 of this chapter[, including regulations].
5472 (ii) The rules described in Subsection (1)(i)(i) may include rules that:
5473 [(i)] (A) assure that differences in rates charged for health benefit plans by covered carriers
5474 are reasonable and reflect objective differences in plan design, [(]not including differences due to
5475 the nature of the groups assumed to select particular health benefit plans[)];
5476 [(ii)] (B) prescribe the manner in which case characteristics may be used by covered
5477 carriers;
5478 [(iii) require insurers, as a condition of transacting business with regard to health care
5479 insurance policies after January 1, 1995, to reissue a health care insurance policy to any
5480 policyholder whose health care insurance policy has, after January 1, 1994, been terminated by the
5481 insurer for reasons other than those listed in Subsections 31A-30-107(1)(a) through (1)(e) or not
5482 renewed by the insurer after January 1, 1994. The commissioner may prescribe terms for the
5483 reissue of coverage that the commissioner determines are reasonable and necessary to provide

5484 continuity of coverage to insured individuals;]
5485 [(iv)] (C) implement the individual enrollment cap under Section 31A-30-110, including
5486 specifying:
5487 (I) the contents for certification[;];
5488 (II) auditing standards[;];
5489 (III) underwriting criteria for uninsurable classification[;]; and
5490 (IV) limitations on high risk enrollees under Section 31A-30-111; and
5491 [(v)] (D) establish the individual enrollment cap under Subsection 31A-30-110(1).
5492 [(l)] (j) Before implementing regulations for underwriting criteria for uninsurable
5493 classification, the commissioner shall contract with an independent consulting organization to
5494 develop industry-wide underwriting criteria for uninsurability based on an individual's expected
5495 claims under open enrollment coverage exceeding 200% of that expected for a standard insurable
5496 individual with the same case characteristics.
5497 [(m)] (k) The commissioner shall revise rules issued for Sections 31A-22-602 and
5498 31A-22-605 regarding individual accident and health policy rates to allow rating in accordance
5499 with this section.
5500 (2) For purposes of Subsection (1)(c)(i), if a health benefit plan into which the covered
5501 carrier is no longer enrolling new covered insureds, the covered carrier shall use the percentage
5502 change in the base premium rate, provided that the change does not exceed, on a percentage basis,
5503 the change in the new business premium rate for the most similar health benefit plan into which
5504 the covered carrier is actively enrolling new covered insureds.
5505 [(2)] (3) (a) A covered carrier [shall] may not transfer a covered insured involuntarily into
5506 or out of a class of business.
5507 (b) A covered carrier [shall] may not offer to transfer a covered insured into or out of a
5508 class of business unless [such] the offer is made to transfer all covered insureds in the class of
5509 business without regard:
5510 (i) to case characteristics[;];
5511 (ii) claim experience[;];
5512 (iii) health status[;]; or
5513 (iv) duration of coverage since issue.
5514 [(3) Upon offering for sale any health benefit plan to a small employer, or individual, the

5515 covered carrier shall, as part of its solicitation and sales materials, disclose or make available all
5516 of the following:]
5517 [(a) the extent to which premium rates for a specified covered insured are established or
5518 adjusted in part based on the actual or expected variation in claims costs or actual or expected
5519 variation in health status of covered individuals;]
5520 [(b) provisions concerning the covered carrier's right to change premium rates and the
5521 factors other than claim experience which affect changes in premium rates;]
5522 [(c) provisions relating to renewability of policies and contracts; and]
5523 [(d) provisions relating to any preexisting condition provision.]
5524 (4) (a) Each covered carrier shall maintain at [its] the covered carrier's principal place of
5525 business a complete and detailed description of its rating practices and renewal underwriting
5526 practices, including information and documentation that demonstrate that [its] the covered carrier's
5527 rating methods and practices are:
5528 (i) based upon commonly accepted actuarial assumptions; and [are]
5529 (ii) in accordance with sound actuarial principles.
5530 (b) (i) Each covered carrier shall file with the commissioner, on or before March 15 of
5531 each year, in a form, manner, and containing such information as prescribed by the commissioner,
5532 an actuarial certification certifying that:
5533 (A) the covered carrier is in compliance with this chapter; and [that]
5534 (B) the rating methods of the covered carrier are actuarially sound.
5535 (ii) A copy of [that] the certification required by Subsection (4)(b)(i) shall be retained by
5536 the covered carrier at [its] the covered carrier's principal place of business.
5537 (c) A covered carrier shall make the information and documentation described in this
5538 Subsection (4) available to the commissioner upon request.
5539 (d) Records submitted to the commissioner under [the provisions of] this section shall be
5540 maintained by the commissioner as protected records under Title 63, Chapter 2, Government
5541 Records Access and Management Act.
5542 Section 81. Section **31A-30-106.7** is amended to read:
5543 **31A-30-106.7. Surcharge for groups changing carriers.**
5544 [If] (1) (a) Except as provided in Subsection (1)(b), if prior notice is given, a covered
5545 carrier may impose upon a small group that changes coverage to that carrier from another carrier

5546 a one-time surcharge of up to 25% of the annualized premium that the carrier could otherwise
5547 charge under Section 31A-30-106[~~, unless the change in carriers occurs on the annual policy~~
5548 ~~renewal date of the coverage being replaced~~].
5549 (b) A covered carrier may not impose the surcharge described in Subsection (1)(a) if:
5550 (i) the change in carriers occurs on the anniversary of the plan year, as defined in Section
5551 31A-1-301;
5552 (ii) the previous coverage was involuntarily terminated under Section 31A-30-107; or
5553 (iii) employees from an existing group form a new business.
5554 (2) If a surcharge as described in Subsection (1) is imposed, payments shall be spread over
5555 the first year according to the regular group policy payment schedule.
5556 (3) A covered carrier may not impose the surcharge described in Subsection (1) if the offer
5557 to cover the group occurs at a time other than the anniversary of the plan year because:
5558 (a) (i) the application for coverage is made prior to the anniversary date in accordance with
5559 the insurer's published policies; and
5560 (ii) the offer to cover the group is not issued until after the anniversary date; or
5561 (b) (i) the application for coverage is made prior to the anniversary date in accordance with
5562 the insurer's published policies; and
5563 (ii) additional underwriting or rating information requested by the insurer is not received
5564 until after the anniversary date.
5565 (4) A covered carrier may not impose a surcharge under Subsection (1) because of
5566 gathering of underwriting information if:
5567 (a) the surcharge is based on the change being made on a date other than the anniversary
5568 or issue date;
5569 (b) the small group has been determined to be in a particular rating category; and
5570 (c) the application was filed in accordance with the insurer's written application guidelines.
5571 (5) If a covered carrier chooses to apply a surcharge under Subsection (1) based on the
5572 charge being made on a date other than the anniversary date, the application of the surcharge and
5573 the criteria for incurring or avoiding the surcharge shall be clearly stated in the:
5574 (a) written application materials provided to the applicant at the time of application, and
5575 (b) written producer guidelines.
5576 (6) All surcharges and underwriting processing shall be applied uniformly regardless of

5577 the rating category or the perceived medical risks inherent in groups being submitted for
5578 consideration in the underwriting process.
5579 Section 82. Section **31A-30-107** is amended to read:
5580 **31A-30-107. Renewal -- Limitations -- Exclusions.**
5581 (1) [~~A~~] Except as otherwise provided in this section, a small employer health benefit plan
5582 [~~subject to this chapter~~] is renewable and continues in force:
5583 (a) with respect to all [~~covered individuals~~] eligible employees and dependents; and
5584 (b) at the option of the [~~covered insured except in any of the following cases~~] plan sponsor:
5585 [~~(a) nonpayment of the required premiums;~~]
5586 [~~(b) fraud or misrepresentation of:~~]
5587 [~~(i) the employer; or~~]
5588 [~~(ii) with respect to coverage of individual insureds, the insureds or their representatives;~~]
5589 [~~(c) noncompliance with the covered carrier's minimum participation requirements;~~]
5590 [~~(d) noncompliance with the covered carrier's employer contribution requirements;~~]
5591 [~~(e) repeated misuse of a provider network provision; or~~]
5592 [~~(f) an election by the covered carrier to nonrenew all of its health benefit plans issued to~~
5593 ~~covered insureds in this state, in which case the covered carrier shall:~~]
5594 [~~(i) provide advanced notice of its decision under this Subsection (1) to the commissioner~~
5595 ~~in each state in which it is licensed;~~]
5596 [~~(ii) provide notice of the decision not to renew coverage to all affected covered insureds~~
5597 ~~and to the commissioner in each state in which an affected insured individual is known to reside;~~
5598 ~~and~~]
5599 [~~(iii) provide a plan of orderly withdrawal as required by Section 31A-4-115.~~]
5600 [~~(2) Notice under Subsection (1) shall be provided:~~]
5601 [~~(a) to affected covered insureds at least 180 days prior to nonrenewal of any health benefit~~
5602 ~~plans by the covered carrier; and~~]
5603 [~~(b) to the commissioner at least three working days prior to the notice to the affected~~
5604 ~~covered insureds.~~]
5605 [~~(3) A covered carrier that elects not to renew a health benefit plan under Subsection (1)(f)~~
5606 ~~is prohibited from writing new business subject to this chapter in this state for a period of five~~
5607 ~~years from the date of notice to the commissioner.~~]

5608 [(4) When a covered carrier is doing business subject to this chapter in one service area
5609 of this state, Subsections (1) through (3) apply only to the covered carrier's operations in that
5610 service area.]
5611 [(5) Health benefit plans covering covered insureds shall comply with Subsections (5)(a)
5612 and (b).]
5613 [(a) (i) A health benefit plan may not deny, exclude, or limit benefits for a covered
5614 individual for losses incurred more than 12 months, or 18 months in the case of a late enrollee, as
5615 defined in P.L. 104-191, 110 Stat. 1940, Sec. 101, following the effective date of the individual's
5616 coverage due to a preexisting condition.]
5617 [(ii) A health benefit plan may not define a preexisting condition more restrictively than:]
5618 [(A) a condition for which medical advice, diagnosis, care, or treatment was recommended
5619 or received during the six months immediately preceding the earlier of:]
5620 [(I) the enrollment date; or]
5621 [(II) the effective date of coverage; or]
5622 [(B) for an individual insurance policy, a pregnancy existing on the effective date of
5623 coverage.]
5624 [(iii) An individual insurer shall offer a health benefit plan in compliance with Subsections
5625 (5)(a)(i) and (ii), and may, when the insurer and the insured mutually agree in writing to a
5626 condition-specific exclusion rider, offer to issue an individual policy that excludes a specific
5627 physical condition consistent with Subsections (5)(a)(iv) and (v).]
5628 [(iv) The commissioner shall establish, in rule, a list of nonlife threatening physical
5629 conditions that may be the subject of a condition-specific exclusion rider.]
5630 [(v) A condition-specific exclusion rider shall be limited to the excluded condition and
5631 may not extend to any secondary medical condition that may or may not be directly related to the
5632 excluded condition.]
5633 [(b) (i) A covered carrier shall waive any time period applicable to a preexisting condition
5634 exclusion or limitation period with respect to particular services in a health benefit plan for the
5635 period of time the individual was previously covered by public or private health insurance or by
5636 any other health benefit arrangement that provided benefits with respect to such services, provided
5637 that:]
5638 [(A) the previous coverage was continuous to a date not more than 63 full days prior to

5639 the effective date of the new coverage; and]
5640 [(B) the insured provides notification of previous coverage to the covered carrier within
5641 36 months of the coverage effective date if the insurer has previously requested such notification.]
5642 [(ii) The period of continuous coverage under Subsection (5)(b)(i)(A) may not include any
5643 waiting period for the effective date of the new coverage applied by the employer or the carrier.
5644 This Subsection (5)(b)(ii) does not preclude application of any waiting period applicable to all new
5645 enrollees under the plan.]
5646 [(iii) Credit for previous coverage as provided under Subsection (5)(b)(i)(A) need not be
5647 given for any condition which was previously excluded under a condition-specific exclusion rider.
5648 A new preexisting waiting period may be applied to any condition that was excluded by a rider
5649 under the terms of previous individual coverage.]
5650 (2) A health benefit plan may be discontinued or nonrenewed:
5651 (a) for a network plan, if:
5652 (i) there is no longer any enrollee under the group health plan who lives, resides, or works
5653 in:
5654 (A) the service area of the insurer; or
5655 (B) the area for which the insurer is authorized to do business; and
5656 (ii) in the case of the small employer market, the insurer applies the same criteria the
5657 insurer would apply in denying enrollment in the plan under Subsection 31A-30-108(6); or
5658 (b) for coverage made available in the small or large employer market only through an
5659 association, if:
5660 (i) the employer's membership in the association ceases; and
5661 (ii) the coverage is terminated uniformly without regard to any health status-related factor
5662 relating to any covered individual.
5663 (3) A small employer health benefit plan may be discontinued if:
5664 (a) a condition described in Subsection (2) exists;
5665 (b) the plan sponsor fails to pay premiums or contributions in accordance with the terms
5666 of the contract;
5667 (c) the plan sponsor:
5668 (i) performs an act or practice that constitutes fraud; or
5669 (ii) makes an intentional misrepresentation of material fact under the terms of the

5670 coverage; or

5671 (d) the insurer:

5672 (i) elects to discontinue offering a particular small employer health benefit plan delivered

5673 or issued for delivery in this state; and

5674 (ii) (A) provides notice of the discontinuation in writing:

5675 (I) to each plan sponsor, employee, or dependent of an employee or plan sponsor; and

5676 (II) at least 90 days before the date the coverage will be discontinued;

5677 (B) provides notice of the discontinuation in writing:

5678 (I) to the commissioner in each state in which an affected insured individual is known to

5679 reside;

5680 (II) at least three working days prior to the date the notice is sent to the affected plan

5681 sponsors, employees, and dependents of the plan sponsors or employees;

5682 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase:

5683 (I) all other small employer health benefit plans currently being offered by the insurer in

5684 the market; or

5685 (II) in the case of a large employer, any other small employer health benefit plan currently

5686 being offered in that market; and

5687 (D) in exercising the option to discontinue that product and in offering the option of

5688 coverage in this section, acts uniformly without regard to:

5689 (I) the claims experience of a plan sponsor;

5690 (II) any health status-related factor relating to any covered participant or beneficiary; or

5691 (III) any health status-related factor relating to any new participant or beneficiary who may

5692 become eligible for the coverage; or

5693 (e) the insurer:

5694 (i) elects to discontinue all of the insurer's small employer health benefit plans in:

5695 (A) the small employer market;

5696 (B) the large employer market; or

5697 (C) both the small employer and large employer markets; and

5698 (ii) (A) provides notice of the discontinuation in writing:

5699 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

5700 (II) at least 180 days before the date the coverage will be discontinued;

5701 (B) provides notice of the discontinuation in writing:
5702 (I) to the commissioner in each state in which an affected insured individual is known to
5703 reside; and
5704 (II) at least 30 working days prior to the date the notice is sent to the affected plan
5705 sponsors, employees, and the dependents of the plan sponsors or employees;
5706 (C) discontinues and nonrenews all plans issued or delivered for issuance in the market;
5707 and
5708 (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.
5709 (4) A small employer health benefit plan may be nonrenewed:
5710 (a) if a condition described in Subsection (2) exists; or
5711 (b) for noncompliance with the insurer's:
5712 (i) minimum participation requirements; or
5713 (ii) employer contribution requirements.
5714 (5) (a) Except as provided in Subsection (5)(d), an eligible employee may be discontinued
5715 if after issuance the eligible employee:
5716 (i) engages in an act or practice that constitutes fraud in connection with the coverage; or
5717 (ii) makes an intentional misrepresentation of material fact in connection with the
5718 coverage.
5719 (b) An eligible employee that is discontinued under Subsection (4)(a) may reenroll:
5720 (i) 12 months after the date of discontinuance; and
5721 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies to
5722 reenroll.
5723 (c) At the time the eligible employee's coverage is discontinued under Subsection (5)(a),
5724 the insurer shall notify the eligible employee of the right to reenroll when coverage is discontinued.
5725 (d) An eligible employee may not be discontinued under this Subsection (5) because of
5726 a fraud or misrepresentation that relates to health status.
5727 (6) For purposes of this section, a reference to "plan sponsor" includes a reference to the
5728 employer:
5729 (a) with respect to coverage provided to an employer member of the association; and
5730 (b) if the small employer health benefit plan is made available by an insurer in the
5731 employer market only through:

5732 (i) an association;
5733 (ii) a trust; or
5734 (iii) a discretionary group.
5735 (7) An insurer may modify a small employer health benefit plan only:
5736 (a) at the time of coverage renewal; and
5737 (b) if the modification is effective uniformly among all plans with that product.
5738 Section 83. Section **31A-30-107.1** is enacted to read:
5739 **31A-30-107.1. Individual discontinuance and nonrenewal.**
5740 (1) (a) Except as otherwise provided in this section, a health benefit plan offered on an
5741 individual basis is renewable and continues in force:
5742 (i) with respect to all individuals or dependents; and
5743 (ii) at the option of the individual.
5744 (b) Subsection (1)(a) applies regardless of:
5745 (i) whether the contract is issued through:
5746 (A) a trust;
5747 (B) an association;
5748 (C) a discretionary group; or
5749 (D) other similar grouping; or
5750 (ii) the situs of delivery of the policy or contract.
5751 (2) A health benefit plan may be discontinued or nonrenewed:
5752 (a) for a network plan, if:
5753 (i) the individual no longer lives, resides, or works in:
5754 (A) the service area of the insurer; or
5755 (B) the area for which the insurer is authorized to do business; and
5756 (C) coverage is terminated uniformly without regard to any health status-related factor
5757 relating to any covered individual; or
5758 (b) for coverage made available through an association, if:
5759 (i) the individual's membership in the association ceases; and
5760 (ii) the coverage is terminated uniformly without regard to any health status-related factor
5761 of covered individuals.
5762 (3) A health benefit plan may be discontinued if:

5763 (a) a condition described in Subsection (2) exists;
5764 (b) the individual fails to pay premiums or contributions in accordance with the terms of
5765 the health benefit plan, including any timeliness requirements;
5766 (c) the individual:
5767 (i) performs an act or practice that constitutes fraud in connection with the coverage; or
5768 (ii) makes an intentional misrepresentation of material fact under the terms of the
5769 coverage;
5770 (d) the insurer:
5771 (i) elects to discontinue offering a particular health benefit plan delivered or issued for
5772 delivery in this state; and
5773 (ii) (A) provides notice of the discontinuance in writing:
5774 (I) to each individual provided coverage; and
5775 (II) at least 180 days before the date the coverage will be discontinued;
5776 (B) provides notice of the discontinuation in writing:
5777 (I) to the commissioner in each state in which an affected insured individual is known to
5778 reside; and
5779 (II) at least three working days prior to the date the notice is sent to the affected
5780 individuals;
5781 (C) offers to each covered individual on a guaranteed issue basis, the option to purchase
5782 all other individual health insurance coverage currently being offered by the insurer for individuals
5783 in that market; and
5784 (D) acts uniformly without regard to any health status-related factor of a covered
5785 individual or dependent of a covered individual who may become eligible for coverage; or
5786 (e) the insurer:
5787 (i) elects to discontinue all of the insurer's health benefit plans in the individual market;
5788 and
5789 (ii) (A) provides notice of the discontinuation in writing:
5790 (I) to each covered individual; and
5791 (II) at least 180 days before the date the coverage will be discontinued;
5792 (B) provides notice of the discontinuation in writing:
5793 (I) to the commissioner in each state in which an affected insured individual is known to

5794 reside; and
5795 (II) at least 30 working days prior to the date the notice is sent to the affected individuals;
5796 (C) discontinues and nonrenews all health benefit plans the insurer issues or delivers for
5797 insurance in the individual market; and
5798 (D) acts uniformly without regard to any health status-related factor of a covered
5799 individual or a dependent of a covered individual who may become eligible for coverage.
5800 Section 84. Section **31A-30-107.3** is enacted to read:
5801 **31A-30-107.3. Discontinuance and nonrenewal limitations.**
5802 (1) (a) A carrier that elects to discontinue offering or to not renew a health benefit plan
5803 under Section 31A-30-107 or 31A-30-107.1 is prohibited from writing new business:
5804 (i) in the small employer and individual market in this state; and
5805 (ii) for a period of five years beginning on the date of:
5806 (A) discontinuation;
5807 (B) the last date the coverage that is not renewed is provided.
5808 (b) The prohibition described in Subsection (1)(a) may be waived if the commissioner
5809 finds that waiver is in the public interest:
5810 (i) to promote competition, or
5811 (ii) to resolve inequity in the marketplace.
5812 (2) If a carrier is doing business in one established geographic service area of the state,
5813 Sections 31A-30-107 and 31A-30-107.1 apply only to the carrier's operations in that geographic
5814 service area.
5815 (3) If a small employer employs less than two employees, a carrier may not terminate the
5816 health benefit plan until the first renewal date following the beginning of a new plan year, even if
5817 the carrier knows as of the beginning of the plan year that the employer no longer has at least two
5818 current employees.
5819 Section 85. Section **31A-30-107.5** is enacted to read:
5820 **31A-30-107.5. Limitations and exclusions.**
5821 (1) A health benefit plan may impose a preexisting condition exclusion only if:
5822 (a) the exclusion relates to a condition, regardless of the cause of the condition, for which
5823 medical advise, diagnosis, care, or treatment was recommended or received within the 6 month
5824 period ending on the enrollment date;

5825 (b) the exclusion extends for a period of:
5826 (i) not more than 12 months after the enrollment date; or
5827 (ii) in the case of a late enrollee, 18 months after the enrollment date; and
5828 (c) the period of the preexisting condition exclusion is reduced by the aggregate of the
5829 periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date.
5830 (2) (a) The period of continuous coverage under Subsection (1)(c) may not include any
5831 waiting period for the effective date of the new coverage applied by the employer or the carrier.
5832 (b) This Subsection (2) does not preclude application of any waiting period applicable to
5833 all new enrollees under the plan.
5834 (3) (a) (i) Credit for previous coverage as provided under Subsection (1)(c) need not be
5835 given for any condition that was previously excluded under a condition-specific exclusion rider
5836 issued pursuant to Subsection (5).
5837 (ii) A new preexisting waiting period may be applied to any condition that was excluded
5838 by a rider under the terms of previous individual coverage.
5839 (4) (a) For purposes of Subsection (1)(c), a period of creditable coverage may not be
5840 counted with respect to enrollment of an individual under a health benefit plan, if:
5841 (i) after the period and before the enrollment date, there was a 63 day period during all of
5842 which the individual was not covered under any creditable coverage; or
5843 (ii) the insured fails to provide notification of previous coverage to the covered carrier
5844 within 36 months of the coverage effective date if the insurer has previously requested the
5845 notification.
5846 (b) (i) Credit for previous coverage as provided under Subsection (1)(c) need not be given
5847 for any condition that was previously excluded in compliance with Subsection (5).
5848 (ii) A new preexisting waiting period may be applied to any condition that was excluded
5849 under the terms of previous individual coverage.
5850 (5) (a) An individual carrier:
5851 (i) shall offer a health benefit plan in compliance with Subsection (1); and
5852 (ii) may, when the insurer and the insured mutually agree in writing to a condition-specific
5853 exclusion rider, offer to issue an individual policy that excludes a specific physical condition
5854 consistent with Subsections (5)(b).
5855 (b) (i) The commissioner shall establish by rule a list of life threatening physical conditions

5856 that may not be the subject of a condition-specific exclusion rider.
5857 (ii) A condition-specific exclusion rider:
5858 (A) shall be limited to the excluded condition; and
5859 (B) may not extend to any secondary medical condition that may or may not be directly
5860 related to the excluded condition.
5861 Section 86. Section **31A-30-108** is amended to read:
5862 **31A-30-108. Eligibility for small employer and individual market.**
5863 (1) (a) Small employer carriers shall accept residents for small group coverage as set forth
5864 in the Health Insurance Portability and Accountability Act, P.L. 104-191, 110 Stat. 1962, Sec.
5865 1701(f) and 2711(a).
5866 (b) Individual carriers shall accept residents for individual coverage pursuant:
5867 (i) to P.L. 104-191, 110 Stat. 1979, Sec. 2741(a)-(b); and
5868 (ii) Subsection (3).
5869 (2) (a) Small employer carriers shall offer to accept all eligible employees and their
5870 dependents at the same level of benefits under any health benefit plan provided to a small
5871 employer.
5872 (b) Small employer carriers may:
5873 (i) request a small employer to submit a copy of [~~its~~] the small employer's quarterly income
5874 tax withholdings to determine whether the employees for whom coverage is provided or requested
5875 are bona fide employees of the small employer; and
5876 (ii) deny or terminate coverage if the small employer refuses to provide documentation
5877 requested under Subsection (2)(b)(i).
5878 (3) Except as provided in Subsection (5) and Section 31A-30-110, individual carriers shall
5879 accept for coverage individuals to whom all of the following conditions apply:
5880 (a) the individual is not covered or eligible for coverage[~~,~~]:
5881 (i) (A) as an employee of an employer[~~,~~];
5882 (B) as a member of an association[~~,~~]; or
5883 (C) as a member of any other group; and
5884 (ii) under:
5885 [~~(i)~~] (A) a health benefit plan; or
5886 [~~(ii)~~] (B) a self-insured arrangement that provides coverage similar to that provided by a

5887 health benefit plan as defined in Section [31A-30-103] 31A-1-301;
5888 (b) the individual is not covered and is not eligible for coverage under any public health
5889 benefits arrangement including:
5890 (i) the Medicare program established under Title XVIII [or];
5891 (ii) the Medicaid program established under Title XIX of the Social Security Act[, or];
5892 (iii) any other act of [congress or] law of this or any other state that provides benefits
5893 comparable to the benefits provided under this [part, including] chapter; or
5894 (iv) coverage under the Comprehensive Health Insurance Pool Act created in Chapter 29,
5895 Comprehensive Health Insurance Pool Act;
5896 (c) unless the maximum benefit has been reached the individual is not covered or eligible
5897 for coverage under any:
5898 (i) Medicare supplement policy[,];
5899 (ii) conversion option[,];
5900 (iii) continuation or extension under COBRA[,]; or
5901 (iv) state extension [unless the maximum benefit has been reached];
5902 (d) the individual has not terminated or declined coverage described in Subsection (3)(a),
5903 (b), or (c) within 93 days of application for coverage, unless the individual is eligible for individual
5904 coverage under P.L. 104-191, 110 Stat. 1979, Sec. 2741(b), in which case, the requirement of this
5905 Subsection (3)(d) does not apply; and
5906 (e) the individual is certified as ineligible for the Health Insurance Pool if:
5907 (i) the individual applies for coverage with the Comprehensive Health Insurance Pool
5908 within 30 days after being rejected or refused coverage by the covered carrier and reapplies for
5909 coverage with that covered carrier within 30 days after the date of issuance of a certificate under
5910 Subsection 31A-29-111(4)(c); or
5911 (ii) the individual applies for coverage with any individual carrier within 45 days after:
5912 (A) notice of cancellation of coverage under Subsection 31A-29-115(1); or
5913 (B) the date of issuance of a certificate under Subsection 31A-29-111(4)(c) if the
5914 individual applied first for coverage with the Comprehensive Health Insurance Pool.
5915 (4) (a) If coverage is obtained under Subsection (3)(e)(i) and the required premium is paid,
5916 the effective date of coverage shall be the first day of the month following the individual's
5917 submission of a completed insurance application to that covered carrier.

5918 (b) If coverage is obtained under Subsection (3)(e)(ii) and the required premium is paid,
5919 the effective date of coverage shall be the day following the:
5920 (i) cancellation of coverage under Subsection 31A-29-115(1); or
5921 (ii) submission of a completed insurance application to the Comprehensive Health
5922 Insurance Pool.
5923 (5) (a) An individual carrier is not required to accept individuals for coverage under
5924 Subsection (3) if the carrier issues no new individual policies in the state after July 1, 1997.
5925 (b) A carrier described in Subsection (5)(a) may not issue new individual policies in the
5926 state for five years from July 1, 1997.
5927 (c) Notwithstanding Subsection (5)(b), a carrier may request permission to issue new
5928 policies after July 1, 1999, which may only be granted if:
5929 (i) the carrier accepts uninsurables as is required of a carrier entering the market under
5930 Subsection 31A-30-110; and
5931 (ii) the commissioner finds that the carrier's issuance of new individual policies:
5932 (A) is in the best interests of the state; and
5933 (B) does not provide an unfair advantage to the carrier.
5934 (6) (a) If a small employer carrier offers health benefit plans to small employers through
5935 a network plan, the small employer carrier may:
5936 (i) limit the employers that may apply for the coverage to those employers with eligible
5937 employees who live, reside, or work in the service area for the network plan; and
5938 (ii) within the service area of the network plan, deny coverage to an employer if the insurer
5939 has demonstrated to the commissioner that the small employer carrier:
5940 (A) will not have the capacity to deliver services adequately to enrollees of any additional
5941 groups because of the small employer carrier's obligations to existing group contract holders and
5942 enrollees; and
5943 (B) applies this section uniformly to all employers without regard to:
5944 (I) the claims experience of a employer, an employer's employee, or a dependent of an
5945 employee; or
5946 (II) any health status-related factor relating to an employee or dependent of an employee.
5947 (b) (i) An insurer that denies health insurance coverage to an employer in any service area
5948 in accordance with this section may not offer coverage in the small employer market within the

5949 service area to any employer for a period of 180 days after the date the coverage is denied.
5950 (ii) Subsection (6)(b) does not:
5951 (A) limit the insurer's ability to renew coverage that is in force; or
5952 (B) relieve the insurer of the responsibility to renew coverage that is in force.
5953 (c) Coverage offered within a service area after the 180 day period specified in Subsection
5954 (6)(b) is subject to the requirements of this section.
5955 Section 87. Section **31A-30-110** is amended to read:
5956 **31A-30-110. Individual enrollment cap.**
5957 (1) The commissioner shall set the individual enrollment cap at .5% on July 1, 1997.
5958 (2) The commissioner shall raise the individual enrollment cap by .5% at the later of the
5959 following dates:
5960 (a) six months from the last increase in the individual enrollment cap; or
5961 (b) the date when CCI/TI is greater than .90, where:
5962 (i) "CCI" is the total individual coverage count for all carriers certifying that their
5963 uninsurable percentage has reached the individual enrollment cap; and
5964 (ii) "TI" is the total individual coverage count for all carriers.
5965 (3) The commissioner may establish a minimum number of uninsurable individuals that
5966 a carrier entering the market who is subject to this chapter must accept under the individual
5967 enrollment provisions of this chapter.
5968 (4) Beginning July 1, 1997, an individual carrier may decline to accept individuals
5969 applying for individual enrollment under Subsection 31A-30-108(3), other than individuals
5970 applying for coverage as set forth in P.L. 104-191, 110 Stat. 1979, Sec. 2741 (a)-(b), if:
5971 (a) the uninsurable percentage for that carrier equals or exceeds the cap established in
5972 Subsection (1); and
5973 (b) the covered carrier has certified on forms provided by the commissioner that its
5974 uninsurable percentage equals or exceeds the individual enrollment cap.
5975 (5) The department may audit a carrier's records to verify whether the carrier's uninsurable
5976 classification meets industry standards for underwriting criteria as established by the commissioner
5977 in accordance with Subsection 31A-30-106(1)[~~(k)~~](i).
5978 (6) (a) If the commissioner determines that individual enrollment is causing a substantial
5979 adverse effect on premiums, enrollment, or experience, the commissioner may suspend, limit, or

5980 delay further individual enrollment for up to 12 months.
5981 (b) The commissioner shall adopt rules to establish a uniform methodology for calculating
5982 and reporting loss ratios for individual policies for determining whether the individual enrollment
5983 provisions of Section 31A-30-108 should be waived for an individual carrier experiencing
5984 significant and adverse financial impact as a result of complying with those provisions.
5985 Section 88. Section **31A-30-111** is amended to read:
5986 **31A-30-111. Limitations on high risk enrollees.**
5987 (1) (a) The requirements of this chapter do not apply to any carrier that is currently in a
5988 state of supervision, insolvency, or liquidation.
5989 (b) If a carrier demonstrates to the satisfaction of the commissioner that the requirements
5990 of this chapter would place the carrier in a state of supervision, insolvency, or liquidation the
5991 commissioner may waive or modify the requirements of Sections 31A-30-108 and 31A-30-110.
5992 (2) (a) A modification or waiver by the commissioner under this section shall be effective
5993 for period of not more than one year.
5994 (b) At the end of [~~the~~] any one year period described in Subsection (2)(a), a carrier [~~must~~
5995 ~~demonstrate new~~] is subject to Sections 31A-30-108 and 31A-30-110 unless the carrier
5996 demonstrates to the satisfaction of the commissioner the need for [~~the~~] a modification or waiver
5997 in accordance with Subsection (1)(b).
5998 (3) Notwithstanding the requirements of this chapter, a carrier may deny health insurance
5999 coverage in the small employer and individual market if the carrier demonstrates to the satisfaction
6000 of the commissioner that the carrier:
6001 (a) does not have the financial reserves necessary to underwrite additional coverage;
6002 (b) is applying this section uniformly to all small employers and individuals without regard
6003 to:
6004 (i) any health status-related factor of the individuals; or
6005 (ii) whether the individuals are eligible individuals.
6006 Section 89. Section **31A-30-114** is enacted to read:
6007 **31A-30-114. Disclosure.**
6008 (1) A covered carrier shall make the information described in Subsection (2) available:
6009 (a) to:
6010 (i) a small employer; or

6011 (ii) an individual; and
6012 (b) (i) at the time of solicitation; or
6013 (ii) upon the request of:
6014 (A) a small employer; or
6015 (B) an individual;
6016 (c) as part of the covered carrier's solicitation and sales materials.
6017 (2) The following information is required to be disclosed or made available under
6018 Subsection (1):
6019 (a) the provisions of the coverage concerning the insurer's right to change premium rates;
6020 and
6021 (b) the factors that may effect changes in premium rates;
6022 (c) the provisions of the coverage relating to renewability of coverage;
6023 (d) the provisions of the coverage relating to any preexisting condition exclusion; and
6024 (e) the benefits and premiums available under all health insurance coverage for which the
6025 small employer or individual is qualified.
6026 Section 90. Section **59-9-105** is amended to read:
6027 **59-9-105. Tax on certain insurers to pay for relative value study and other**
6028 **publications.**
6029 (1) Each insurer providing coverage for motor vehicle liability, uninsured motorist, and
6030 personal injury protection shall pay to the State Tax Commission on or before March 31 of each
6031 year, a tax of .01% on the total premiums received for these coverages during the preceding
6032 calendar year from policies covering motor vehicle risks in this state.
6033 (2) The taxable premium under this section shall be reduced by all premiums returned or
6034 credited to policyholders on direct business subject to tax in this state.
6035 (3) All money received by the state under this section shall be deposited in the General
6036 Fund as a dedicated credit for the purpose of providing funds to pay for any costs and expenses
6037 incurred by the Insurance Department:
6038 (a) in conducting, maintaining, and administering the relative value study referred to in
6039 Section 31A-22-307; [~~and~~]
6040 (b) to prepare, publish, and distribute publications relating to insurance and consumers of
6041 insurance as provided in Section 31A-2-208[~~.~~]; and

6042 (c) in providing the services of the Insurance Department through the use of:
6043 (i) electronic commerce; and
6044 (ii) other information technology.
6045 Section 91. Section **63-55-231** is amended to read:
6046 **63-55-231. Repeal dates, Title 31A.**
6047 (1) Section 31A-1-104, Electronic Commerce Dedicated Fee, is repealed July 1, 2006.
6048 [(1)] (2) Section 31A-2-208.5, Comparison tables, is repealed July 1, 2005.
6049 [(2)] (3) Section 31A-2-217, Coordination with other states, is repealed July 1, 2003.
6050 [(3)] (4) Section 31A-22-315, Motor Vehicle Insurance Reporting, is repealed July 1,
6051 2010.
6052 [(4)] (5) Section 31A-22-625, Catastrophic Coverage of Mental Health Conditions, is
6053 repealed July 1, 2011.
6054 [(5)] (6) Title 31A, Chapter 31, Insurance Fraud Act, is repealed July 1, 2007.
6055 Section 92. **Repealer.**
6056 This act repeals:
6057 Section **31A-8-402, Contract cancellation or nonrenewal.**
6058 Section **31A-15-206, Countersignatures not required.**
6059 Section **31A-22-720, Mental health parity.**
6060 Section 93. **Effective date.**
6061 This act takes effect on May 6, 2002, except that the amendments to Section 31A-26-202
6062 (Effective 07/01/02) take effect on July 1, 2002.

Legislative Review Note
as of 1-17-02 3:16 PM

A limited legal review of this legislation raises no obvious constitutional or statutory concerns.

Office of Legislative Research and General Counsel