

1 **INSURANCE LAW REVISIONS**

2 2003 GENERAL SESSION

3 STATE OF UTAH

4 **Sponsor: James A. Ferrin**

5 **This act modifies the Insurance Code and makes technical changes. This act addresses**  
6 **when orders of the commissioner or the commissioner's designee are stayed. The act**  
7 **addresses payment of tax. The act addresses certificates of authority. The act addresses**  
8 **filing requirements related to the National Association of Insurance Commissioners. The**  
9 **act addresses material transactions by insurers which are part of a holding company**  
10 **system. The act addresses qualified assets. The act addresses what constitutes insurance**  
11 **fraud. The act addresses continuance of coverage. The act increases assessments on**  
12 **insurers. This act limits the use of certain clauses in policies. The act provides for filing**  
13 **of forms procedures. The act requires exact name of insurer on group and blanket**  
14 **policies. The act clarifies provisions relating to premium increases for new or renewal**  
15 **motor vehicle coverage and household exclusion procedures as to motor vehicle coverage.**  
16 **This act clarifies right of return. The act specifies newborn enrollment procedures. The**  
17 **act specifies parameters of insurance adjustors compensation. This act provides an**  
18 **effective date.**

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

20 AMENDS:

21 **31A-3-303**, as last amended by Chapter 230, Laws of Utah 1992

22 **31A-4-103**, as last amended by Chapter 116, Laws of Utah 2001

23 **31A-4-113.5**, as enacted by Chapter 258, Laws of Utah 1992

24 **31A-8-217**, as last amended by Chapter 258, Laws of Utah 1992

25 **31A-8-402.5**, as enacted by Chapter 308, Laws of Utah 2002

26 **31A-8-407**, as last amended by Chapter 308, Laws of Utah 2002

27 **31A-17-201**, as last amended by Chapter 116, Laws of Utah 2001



28           **31A-19a-209**, as last amended by Chapter 308, Laws of Utah 2002  
29           **31A-19a-212**, as renumbered and amended by Chapter 130, Laws of Utah 1999  
30           **31A-21-201**, as last amended by Chapter 116, Laws of Utah 2001  
31           **31A-21-311**, as last amended by Chapter 308, Laws of Utah 2002  
32           **31A-22-403**, as last amended by Chapter 308, Laws of Utah 2002  
33           **31A-22-423**, as last amended by Chapter 116, Laws of Utah 2001  
34           **31A-22-517**, as last amended by Chapter 116, Laws of Utah 2001  
35           **31A-22-610**, as last amended by Chapter 116, Laws of Utah 2001  
36           **31A-23-202**, as last amended by Chapters 185 and 191, Laws of Utah 2002  
37           **31A-26-202**, as last amended by Chapters 191 and 308, Laws of Utah 2002  
38           **31A-26-310**, as enacted by Chapter 242, Laws of Utah 1985  
39           **31A-27-302**, as last amended by Chapter 204, Laws of Utah 1986  
40           **31A-27-311.5**, as last amended by Chapter 308, Laws of Utah 2002  
41           **31A-30-106**, as last amended by Chapter 308, Laws of Utah 2002  
42           **31A-30-107.1**, as enacted by Chapter 308, Laws of Utah 2002  
43           **31A-30-107.5**, as enacted by Chapter 308, Laws of Utah 2002  
44           **31A-31-103**, as enacted by Chapter 243, Laws of Utah 1994  
45           **31A-31-108**, as last amended by Chapters 185 and 375, Laws of Utah 1997  
46           **31A-33-108**, as last amended by Chapter 375, Laws of Utah 1997  
47           **49-16-301**, as renumbered and amended by Chapter 250, Laws of Utah 2002  
48           **53-7-204.2**, as last amended by Chapter 6, Laws of Utah 2002, Sixth Special Session  
49           **63-2-302 (Effective 07/01/03)**, as last amended by Chapters 63 and 191, Laws of Utah  
50           2002  
51           **63-2-302 (Superseded 07/01/03)**, as last amended by Chapter 63, Laws of Utah 2002

52           ENACTS:

53           **31A-2-306.5**, Utah Code Annotated 1953

54           **31A-23-311.1**, Utah Code Annotated 1953

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

56           Section 1. Section **31A-2-306.5** is enacted to read:

57           **31A-2-306.5.** **Stay of commissioner's decision pending administrative review or**  
58 **judicial appeal.**

59           (1) An order of the commissioner or a designee of the commissioner is not stayed by a  
60 petition for:

61           (a) administrative review;

62           (b) rehearing; or

63           (c) judicial review.

64           (2) A person seeking to stay an order of the commissioner or a designee of the  
65 commissioner shall seek a stay in accordance with:

66           (a) rules made by the commissioner in accordance with Title 63, Chapter 46a, Utah  
67 Administrative Rulemaking Act, pending a petition for:

68           (i) administrative review; or

69           (ii) rehearing; or

70           (b) Section 63-46b-18, pending judicial review.

71           Section 2. Section **31A-3-303** is amended to read:

72           **31A-3-303. Payment of tax.**

73           (1) The insurer, all brokers involved in the transaction, and the policyholder are jointly  
74 and severally liable for the payment of the taxes required under Section 31A-3-301. The  
75 policyholder's liability for payment of the premium tax under Section 31A-3-301 ends when  
76 the policyholder pays the tax to the broker or insurer. The insurer and all brokers involved in  
77 the transaction are jointly and severally liable for the payment of the additional tax required  
78 under Section 31A-3-302. Except for the tax under Section 31A-3-302, the taxes under this  
79 part shall be paid by the policyholder who shall be billed specifically for the tax when billed for  
80 the premium. Except for the tax imposed under Section 31A-3-302, absorption of the tax by  
81 the agent, broker, or insurer is an unfair method of competition under Section 31A-23-302.

82           (2) The commissioner shall by rule prescribe accounting and reporting forms and  
83 procedures for insurers, brokers, and policyholders to use in determining the amount of taxes  
84 owed under this part, and the manner and time of payment. If a tax is not paid within the time  
85 prescribed under the commissioner's rule, a penalty shall be imposed of 25% of the tax due,  
86 plus 1-1/2% per month from the time of default until full payment of the tax.

87           (3) Upon making a record of its actions, and upon reasonable cause shown, the State  
88 Tax [Commissioner] Commission may waive, reduce, or compromise any of the penalties or  
89 interest imposed under this part.

90 (4) If a policy covers risks that are only partially located in this state, for computation  
91 of tax under this part the premium shall be reasonably allocated among the states on the basis  
92 of risk locations. However, all premiums with respect to surplus lines insurance received in this  
93 state by a surplus lines broker or charged on policies written or negotiated in or from this state  
94 are taxable in full under this part, subject to a credit for any tax actually paid in another state to  
95 the extent of a reasonable allocation on the basis of risk locations.

96 (5) All premium taxes collected under this part by a broker or by an insurer are the  
97 property of this state.

98 (6) If the property of any broker is seized under any process in a court in this state, or if  
99 his business is suspended by the action of creditors or put into the hands of an assignee,  
100 receiver, or trustee, all taxes and penalties due this state under this part are preferred claims and  
101 the state is to that extent a preferred creditor.

102 Section 3. Section **31A-4-103** is amended to read:

103 **31A-4-103. Certificate of authority.**

104 (1) Each certificate of authority issued by the commissioner shall specify:

105 (a) the name of the insurer;

106 (b) the kinds of insurance [~~it~~] the insurer is authorized to transact in Utah; and

107 (c) any other information the commissioner requires.

108 (2) A certificate of authority issued under this chapter remains in force until[;];

109 (a) the certificate is not renewed; or

110 (b) under Subsection (3), the certificate of authority is:

111 [~~(a)~~] (i) revoked; or

112 [~~(b)~~] (ii) suspended[; or].

113 [~~(c) limited.]~~

114 (3) (a) After an adjudicative proceeding under Title 63, Chapter 46b, Administrative  
115 Procedures Act, if the commissioner makes a finding described in Subsection (3)(b), the  
116 commissioner may;

117 (i) revoke[;] a certificate of authority;

118 (ii) suspend[;] a certificate of authority for a period not to exceed 12 months; or

119 (iii) limit [in whole or in part the] a certificate of authority [of any insurer if].

120 [~~(i) the insurer is found to have:]~~

121 (b) The commissioner may take any action described in Subsection (3)(a) if the  
122 commissioner finds the insurer has:

123 [~~(A)~~] (i) failed to pay when due any fee due under Section 31A-3-103;

124 [~~(B)~~] (ii) violated or failed to comply with:

125 [~~(F)~~] (A) this title;

126 [~~(H)~~] (B) a rule made under Subsection 31A-2-201(3); or

127 [~~(HH)~~] (C) an order issued under Subsection 31A-2-201(4); or

128 [~~(ii) the insurer's~~] (iii) engaged in methods and practices in the conduct of business

129 that endanger the legitimate interests of customers and the public.

130 [~~(b)~~] (c) An order suspending [~~or limiting~~] a certificate of authority [~~issued under this~~  
131 ~~chapter~~] shall specify:

132 [~~(i) the period of the suspension or limitation, which in no event may be in excess of 12~~  
133 ~~months;~~]

134 [~~(ii)~~] (i) the conditions and [~~limitations~~] terms imposed on the insurer during the  
135 suspension [~~or limitation~~]; and

136 [~~(iii)~~] (ii) the conditions and procedures for reinstatement from suspension [~~or~~  
137 ~~limitation~~].

138 (d) The commissioner may place limitations on a certificate of authority at the time the  
139 certificate of authority is issued based on information contained in the application for the  
140 certificate of authority.

141 (e) An order limiting a certificate of authority that is issued under Subsection (3)(a) or  
142 (3)(d) shall specify:

143 (i) the period of the limitation;

144 (ii) the conditions of the limitation; and

145 (iii) the procedures for removing the limitation.

146 (4) Subject to the requirements of this section and in accordance with Title 63, Chapter  
147 46a, Utah Administrative Rulemaking Act, the commissioner [~~shall~~] may by rule prescribe  
148 procedures to renew or reinstate a certificate of authority.

149 (5) An insurer under this chapter whose certificate of authority is suspended or  
150 revoked, but that continues to act as an authorized insurer, is subject to the penalties for acting  
151 as an insurer without a certificate of authority.

152 (6) Any insurer holding a certificate of authority in this state shall immediately report  
153 to the commissioner a suspension or revocation of that insurer's certificate of authority in any:

- 154 (a) state;  
155 (b) the District of Columbia; or  
156 (c) a territory of the United States.

157 (7) (a) An order revoking a certificate of authority under Subsection (3) may specify a  
158 time within which the former authorized insurer may not apply for a new certificate of  
159 authority, except that the time may not exceed five years from the date on which the certificate  
160 of authority is revoked.

161 (b) If no time is specified in an order revoking a certificate of authority under  
162 Subsection (3), the former authorized insurer may not apply for a new certificate of authority  
163 for five years from the date on which the certificate of authority is revoked without express  
164 approval by the commissioner.

165 (8) (a) Subject to Subsection (8)(b), the insurer shall pay all fees under Section  
166 31A-3-103 that would have been payable if the certificate of authority had not been suspended  
167 or revoked, unless the commissioner, in accordance with rule, waives the payment of the fees  
168 by no later than the day ~~[of]~~ on which:

- 169 (i) a suspension under Subsection (3) of an insurer's certificate of authority ends; or  
170 (ii) a new certificate of authority is issued to an insurer whose certificate of authority is  
171 revoked under Subsection (3).

172 (b) If a new certificate of authority is issued more than three years after the ~~[revocation~~  
173 ~~of]~~ day on which a similar certificate of authority was revoked, this Subsection (8) applies only  
174 to the fees that would have accrued during the three years immediately following the  
175 revocation.

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

177 **31A-4-113.5. Filing requirements -- National Association of Insurance**  
178 **Commissioners.**

179 (1) (a) Each domestic, foreign, and alien insurer who is authorized to transact insurance  
180 business in this state shall annually, on or before March 1, file with the National Association of  
181 Insurance Commissioners a copy of ~~[its]~~ the insurer's:

- 182 (i) annual statement convention blank ~~[along with]~~; and

183 (ii) any additional filings required by the commissioner for the preceding year.

184 (b) The information filed with the National Association of Insurance Commissioners  
185 under Subsection (1)(a) shall:

186 (i) be in the format and scope required by the commissioner; and ~~shall~~

187 (ii) include:

188 (A) the signed jurat page; and

189 (B) the actuarial certification.

190 (c) Any amendments and addendums to ~~the~~ an annual statement ~~subsequently~~ that  
191 are filed with the commissioner shall ~~also~~ be filed by the insurer with the National  
192 Association of Insurance Commissioners.

193 (d) At the time an insurer makes a filing under this Subsection (1), the insurer shall pay  
194 any filing fees assessed by the National Association of Insurance Commissioners.

195 ~~[(b) Foreign insurers]~~

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

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

201 (3) The commissioner may suspend, revoke, or refuse to renew the certificate of  
202 authority of any insurer failing to:

203 (a) file ~~its~~ the annual statement as required by Subsection (1)(a) when due or within  
204 any extension of time ~~which he may have~~ granted for good cause~~[-]~~ by:

205 (i) the commissioner; or

206 (ii) the National Association of Insurance Commissioners; or

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

209 (i) the commissioner; or

210 (ii) the National Association of Insurance Commissioners.

211 Section 5. Section **31A-8-217** is amended to read:

212 **31A-8-217. Material transactions by insurers which are part of holding company**  
213 **system.**

214 (1) ~~[As]~~ This section applies to ~~[insurers]~~ an insurer licensed under this chapter ~~[which~~  
215 are] that is part of a holding company system, for purposes of:

216 (a) the reporting requirements of Section 31A-16-105; and

217 (b) the material transaction standards of Section 31A-16-106~~[-and unless].~~

218 (2) Unless otherwise provided by rule, ~~[transactions are]~~ a transaction is not material  
219 under Subsection 31A-16-105(4) if ~~[they involve]~~ the transaction involves an amount:

220 (a) of not more than:

221 (i) 10% for each transaction~~[-];~~ or

222 (ii) 20% for cumulative transactions during any one calendar year~~[-];~~ and

223 (b) calculated:

224 (i) on the basis of the organization's ~~[compulsory]~~ surplus requirement, determined in  
225 accordance with Section 31A-5-211; and

226 (ii) as of December 31 ~~[next]~~ of the year immediately preceding the transaction.

227 Section 6. Section **31A-8-402.5** is amended to read:

228 **31A-8-402.5. Individual discontinuance and nonrenewal.**

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

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

232 (ii) at the option of the individual.

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

234 (i) whether the contract is issued through:

235 (A) a trust;

236 (B) an association;

237 (C) a discretionary group; or

238 (D) other similar grouping; or

239 (ii) the situs of delivery of the policy or contract.

240 (2) A health benefit plan may be discontinued or nonrenewed:

241 (a) for a network plan, if:

242 (i) the individual no longer lives, resides, or works in:

243 (A) the service area of the insurer; or

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



245 (ii) coverage is terminated uniformly without regard to any health status-related factor  
246 relating to any covered individual; or

247 (b) for coverage made available through an association, if:

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

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

251 (3) A health benefit plan may be discontinued if:

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

253 (b) the individual fails to pay premiums or contributions in accordance with the terms  
254 of the health benefit plan, including any timeliness requirements;

255 (c) the individual:

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

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

259 (d) the insurer:

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

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

263 (I) to each individual provided coverage; and

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

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

266 (I) to the commissioner; and

267 (II) at least three working days prior to the date the notice is sent to the affected  
268 individuals;

269 (C) offers to each covered individual on a guaranteed issue basis, the option to  
270 purchase all other individual health benefit products currently being offered by the insurer for  
271 individuals in that market; and

272 (D) acts uniformly without regard to any health status-related factor of covered  
273 individuals or dependents of covered individuals who may become eligible for coverage; or

274 (e) the insurer:

275 (i) elects to discontinue all of the insurer's health benefit plans in the individual market;

276 and

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

278 (I) to each individual provided coverage; and

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

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

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

282 to reside; and

283 (II) at least 30 working days prior to the date the notice is sent to the affected

284 individuals;

285 (C) discontinues and nonrenews all health benefit plans the insurer issues or delivers

286 for [~~insurance~~] issuance in the individual market; and

287 (D) acts uniformly without regard to any health status-related factor of covered

288 individuals or dependents of covered individuals who may become eligible for coverage.

289 Section 7. Section **31A-8-407** is amended to read:

290 **31A-8-407. Written contracts -- Limited liability of enrollee.**

291 (1) (a) Every contract between an organization and a participating provider of health

292 care services shall be in writing and shall set forth that if the organization:

293 (i) fails to pay for health care services as set forth in the contract, the enrollee may not

294 be liable to the provider for any sums owed by the organization; and

295 (ii) becomes insolvent, the rehabilitator or liquidator may require the participating

296 provider of health care services to:

297 (A) continue to provide health care services under the contract between the

298 participating provider and the organization until the earlier of:

299 (I) 90 days after the date of the filing of a petition for rehabilitation or the petition for

300 liquidation; or

301 (II) the date the term of the contract ends; and

302 (B) subject to Subsection (1)(c), reduce the fees the participating provider is otherwise

303 entitled to receive from the organization under the contract between the participating provider

304 and the organization during the time period described in Subsection (1)(a)(ii)(A).

305 (b) If the conditions of Subsection (1)(c) are met, the participating provider shall:

306 (i) accept the reduced payment as payment in full; and

307 (ii) relinquish the right to collect additional amounts from the insolvent organization's  
308 enrollee.

309 (c) Notwithstanding Subsection (1)(a)(ii)(B):

310 (i) the rehabilitator or liquidator may not reduce a fee to less than 75% of the regular  
311 fee set forth in the participating provider contract; and

312 (ii) the enrollee shall continue to pay the same copayments, deductibles, and other  
313 payments for services received from the participating provider that the enrollee was required to  
314 pay before the filing of:

315 (A) the petition for [~~reorganization~~] rehabilitation; or

316 (B) the petition for liquidation.

317 (2) A participating provider may not collect or attempt to collect from the enrollee sums  
318 owed by the organization or the amount of the regular fee reduction authorized under  
319 Subsection (1)(a)(ii) if the participating provider contract:

320 (a) is not in writing as required in Subsection (1); or

321 (b) fails to contain the language required by Subsection (1).

322 (3) (a) A person listed in Subsection (3)(b) may not bill or maintain any action at law  
323 against an enrollee to collect:

324 (i) sums owed by the organization; or

325 (ii) the amount of the regular fee reduction authorized under Subsection (1)(a)(ii).

326 (b) Subsection (3)(a) applies to:

327 (i) a participating provider;

328 (ii) an agent;

329 (iii) a trustee; or

330 (iv) an assignee of a person described in Subsections (3)(b)(i) through (iii).

331 Section 8. Section **31A-17-201** is amended to read:

332 **31A-17-201. Qualified assets.**

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

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

338 (a) any of the following acquired or held in accordance with Sections 31A-18-105 and  
339 31A-18-106:

340 (i) an investment;

341 (ii) a security;

342 (iii) property; or

343 (iv) a loan;

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

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

348 ~~[(b)]~~ (d) other assets authorized by the commissioner by rule.

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

352 (i) for five years after ~~[their]~~ the acquisition of the assets if ~~[they]~~ the assets are real  
353 property; and

354 (ii) for one year if ~~[they]~~ the assets are not real property.

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

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

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

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

367 Section 9. Section **31A-19a-209** is amended to read:

368 **31A-19a-209. Special provisions for title insurance.**

369 (1) In addition to the considerations in determining compliance with rate standards and  
370 rating methods as set forth in Sections 31A-19a-201 and 31A-19a-202, the commissioner shall  
371 ~~also~~ consider the costs and expenses incurred by title insurance companies, agencies, and  
372 agents peculiar to the business of title insurance including:

373 (a) the maintenance of title plants; and

374 (b) the searching and examining of public records to determine insurability of title to  
375 real redevelopment property.

376 (2) (a) Every title insurance company, agency, and title insurance agent shall file with  
377 the commissioner:

378 (i) a schedule of the escrow charges that ~~it~~ the title insurance company, agency, or  
379 title insurance agent proposes to use in this state for services performed in connection with the  
380 issuance of policies of title insurance[-]; and

381 ~~[(b) The filing required by Subsection (2)(a) shall state the effective date of this~~  
382 ~~schedule, which may not be less than 30 calendar days after the date of filing.]~~

383 (ii) any changes to the schedule of the escrow charges described in Subsection (2)(a)(i).

384 (b) (i) The schedule of escrow charges required to be filed by Subsection (2)(a)(i) takes  
385 effect on the day on which the schedule of escrow charges is filed.

386 (ii) Any changes to the schedule of the escrow charges required to be filed by  
387 Subsection (2)(a)(ii) take effect on the day specified in the change to the schedule of escrow  
388 charges except that the effective date may not be less than 30 calendar days after the day on  
389 which the change to the schedule of escrow charges is filed.

390 (3) A title insurance company, agency, or agent may not file or use any rate or other  
391 charge relating to the business of title insurance, including rates or charges filed for escrow that  
392 would cause the title insurance company, agency, or agent to:

393 (a) operate at less than the cost of doing:

394 (i) the insurance business; or

395 (ii) the escrow business; or

396 (b) fail to adequately underwrite a title insurance policy.

397 (4) (a) All or any of the schedule of rates or schedule of charges, including the schedule  
398 of escrow charges, may be changed or amended at any time, subject to the limitations in this  
399 Subsection (4).

400 (b) Each change or amendment shall:  
401 (i) be filed with the commissioner; and  
402 (ii) state the effective date of the change or amendment, which may not be less than 30  
403 calendar days after the ~~[date of filing]~~ day on which the change or amendment is filed.

404 (c) Any change or amendment remains in force for a period of at least 90 calendar days  
405 from ~~[its]~~ the change or amendment's effective date.

406 (5) While the schedule of rates and schedule of charges are effective, a copy of each  
407 shall be:

408 (a) retained in each of the offices of:

409 (i) the insurance company in this state;

410 (ii) ~~[its]~~ the insurance company's agents in this state; and

411 (b) upon request, furnished to the public.

412 (6) Except in accordance with the schedules of rates and charges filed with the  
413 commissioner, a title insurance company, agency, or agent may not make or impose any  
414 premium or other charge:

415 (a) in connection with the issuance of a policy of title insurance; or

416 (b) for escrow services performed in connection with the issuance of a policy of title  
417 insurance.

418 Section 10. Section **31A-19a-212** is amended to read:

419 **31A-19a-212. Premium increases prohibited for certain claims or inquiries.**

420 (1) Each rate, rating schedule, and rating manual filed with the commissioner for  
421 insurance covering a vehicle or the operation of a vehicle may not permit a premium increase  
422 due to:

423 (a) a telephone call or other inquiry that does not result in the payment of a claim; or

424 (b) a claim resulting from any incident, including acts of vandalism, in which the  
425 person named in the policy or any other person using the insured motor vehicle with the  
426 express or implied permission of the named insured is not at fault.

427 (2) Subsection (1) prohibits a premium increase when:

428 (a) a policy is issued; or

429 (b) a policy is renewed.

430 ~~[(2)]~~ (3) This section is an exception to Section 31A-19a-201.

431 Section 11. Section **31A-21-201** is amended to read:

432 **31A-21-201. Filing and approval of forms.**

433 (1) (a) [~~A form subject to Subsection 31A-21-101(1), except~~] Except as exempted  
434 under Subsections 31A-21-101(2) through (6), a form may not be used, sold, or offered for sale  
435 unless [~~it~~] the form has been filed with the commissioner.

436 (b) A form is considered filed with the commissioner when the commissioner receives:

437 (i) the form;

438 (ii) the applicable filing fee as prescribed under Section 31A-3-103; and

439 (iii) the applicable transmittal forms as required by the commissioner.

440 (2) In filing a form for use in this state the insurer is responsible for assuring that the  
441 form is in compliance with this title and rules adopted by the commissioner.

442 (3) (a) The commissioner may prohibit the use of a form at any time upon a finding  
443 that:

444 (i) [~~it~~] the form is:

445 (A) inequitable;

446 (B) unfairly discriminatory;

447 (C) misleading;

448 (D) deceptive;

449 (E) obscure;

450 (F) unfair;

451 (G) encourages misrepresentation; or

452 (H) not in the public interest;

453 (ii) [~~it~~] the form provides benefits or contains other provisions that endanger the  
454 solidity of the insurer;

455 (iii) in the case of the basic policy and the application for a basic policy, [~~it~~] the basic  
456 policy or application for the basic policy fails to conspicuously, as defined by rule, provide:

457 (A) the exact name of the insurer;

458 (B) [~~its~~] the state of domicile of the insurer filing the basic policy or application for the  
459 basic policy; and

460 (C) for life insurance and annuity policies only, the address of [~~its~~] the administrative  
461 office[-] of the insurer filing the basic policy or application for the basic policy;

- 462 (iv) ~~[it]~~ the form violates a statute or a rule adopted by the commissioner; or
- 463 (v) ~~[it]~~ the form is otherwise contrary to law.
- 464 (b) Subsection (3)(a)(iii) does not apply to riders and endorsements to a basic policy.
- 465 (c) (i) Whenever the commissioner prohibits the use of a form under Subsection (3)(a),
- 466 the commissioner may order that, on or before a date not less than 15 days after the order, the
- 467 use of the form be discontinued.
- 468 (ii) Once a form has been prohibited, ~~[it]~~ the form may not be used unless appropriate
- 469 changes are filed with and reviewed by the commissioner.
- 470 (iii) Whenever the commissioner prohibits the use of a form under Subsection (3)(a),
- 471 the commissioner may require the insurer to disclose contract deficiencies to existing
- 472 policyholders.
- 473 ~~[The commissioner's prohibition]~~ If the commissioner prohibits use of a form under
- 474 this Subsection (3), the prohibition shall:
- 475 (i) be in writing;
- 476 (ii) constitute an order; and
- 477 (iii) state the reasons for the prohibition.
- 478 (4) (a) If, after a hearing, the commissioner determines that it is in the public interest,
- 479 the commissioner may require by rule or order that certain forms be subject to the
- 480 commissioner's approval prior to their use.
- 481 (b) The rule or order described in Subsection (4)(a) shall prescribe the filing
- 482 procedures for the forms if the procedures are different than the procedures stated in this
- 483 section.
- 484 (c) The types of forms that may be addressed under Subsection (4)(a) include:
- 485 (i) ~~[forms]~~ a form for a particular class of insurance;
- 486 (ii) ~~[forms]~~ a form for a specific line of insurance;
- 487 (iii) a specific type of form; or
- 488 (iv) ~~[forms]~~ a form for a specific market segment.
- 489 (5) (a) An insurer shall maintain a complete and accurate record of the following for
- 490 the time period described in Subsection (5)(b):
- 491 (i) any form:
- 492 (A) filed under this section for use; and



493 (B) that is in use; and  
494 (ii) any document filed under this section with a form described in Subsection (5)(a)(i).  
495 (b) The insurer shall maintain a record required under Subsection (5)(a) for the balance  
496 of the current year, plus three years from:

497 (i) the last day on which the form is used; or  
498 (ii) the last day any policy that is issued using the form is in effect.

499 Section 12. Section **31A-21-311** is amended to read:

500 **31A-21-311. Group and blanket insurance.**

501 (1) (a) (i) Except under Subsection (1)(d), an insurer issuing a group insurance policy  
502 other than a blanket insurance policy shall, as soon as practicable after the coverage is  
503 effective, provide a certificate for each member of the insured group, except that only one  
504 certificate need be provided for the members of a family unit.

505 (ii) The certificate required by this Subsection (1) shall:

506 (A) provide the exact name of the insurer;

507 (B) state the state of domicile of the insurer; and

508 (C) contain a summary of the essential features of the insurance coverage, including:

509 ~~[(A)]~~ (I) any rights of conversion to an individual policy; [and]

510 ~~[(B)]~~ (II) in the case of group life insurance~~[-any- (F)], any~~ continuation of coverage  
511 during total disability; and

512 ~~[(H)]~~ (III) in the case of group life insurance, the incontestability provision.

513 (iii) Upon receiving a written request, the insurer shall inform any insured how the  
514 insured may inspect, during normal business hours at a place reasonably convenient to the  
515 insured[;];

516 (A) a copy of the policy; or

517 (B) a summary of the policy containing all the details that are relevant to the certificate  
518 holder.

519 (b) The commissioner may by rule impose a requirement similar to Subsection (1)(a)  
520 on any class of blanket insurance policies for which the commissioner finds that the group of  
521 persons covered is constant enough for that type of action to be practicable and not  
522 unreasonably expensive.

523 (c) (i) A certificate shall be provided in a manner reasonably calculated to bring the

524 certificate to the attention of the certificate holder.

525 (ii) The insurer may deliver or mail a certificate:

526 (A) directly to the certificate holders; or

527 (B) in bulk to the policyholder to transmit to certificate holders.

528 (iii) An affidavit by the insurer that the insurer mailed the certificates in the usual  
529 course of business creates a rebuttable presumption that the insurer has [~~done so.~~] mailed the  
530 certificate to:

531 (A) a certificate holder; or

532 (B) a policyholder as provided in Subsection (1)(c)(ii)(B).

533 (d) The commissioner may by rule or order prescribe substitutes for delivery or mailing  
534 of certificates that are reasonably calculated to inform a certificate holder of the certificate  
535 holder's rights, including:

536 (i) booklets describing the coverage;

537 (ii) the posting of notices in the place of business; or

538 (iii) publication in a house organ.

539 (2) Unless a certificate or an authorized substitute has been made available to the  
540 certificate holder when required by this section, an act or omission forbidden to or required of  
541 the certificate holder by the certificate after the coverage has become effective as to the  
542 certificate holder, other than intentionally causing the loss insured against or failing to make  
543 required contributory premium payments, may not affect the insurer's obligations under the  
544 insurance contract.

545 Section 13. Section **31A-22-403** is amended to read:

546 **31A-22-403. Incontestability.**

547 (1) This section does not apply to group policies.

548 (2) (a) Except as provided in Subsection (3), a life insurance policy is incontestable  
549 after the policy has been in force for a period of two years from the policy's date of issue:

550 (i) during the lifetime of the insured; or

551 (ii) for a survivorship life insurance policy, during the lifetime of the surviving insured.

552 (b) A life insurance policy shall state that the life insurance policy is incontestable after  
553 the time period described in Subsection (2)(a).

554 (3) (a) A life insurance policy described in Subsection (2) may be contested for

555 nonpayment of premiums.

556 (b) A life insurance policy described in Subsection (2) may be contested as to:

557 (i) provisions relating to accident and health benefits allowed under Section

558 31A-22-609; and

559 (ii) additional benefits in the event of death by accident.

560 (c) If a life insurance policy described in Subsection (2) allows the insured, after the

561 policy's issuance and for an additional premium, to obtain a death benefit that is larger than

562 when the policy was originally issued, the payment of the additional increment of benefit is

563 contestable:

564 (i) until two years after the incremental increase of benefits; and

565 (ii) based only on a ground that may arise in connection with the incremental increase.

566 (4) (a) A reinstated life insurance policy [~~or annuity contract~~] may be contested:

567 (i) for two years following reinstatement on the same basis as at original issuance; and

568 (ii) only as to matters arising in connection with the reinstatement.

569 (b) Any grounds for contest available at original issuance continue to be available for

570 contest until the policy has been in force for a total of two years:

571 (i) during the lifetime of the insured; and

572 (ii) for a survivorship life insurance policy, during the lifetime of the surviving insured.

573 (5) (a) The limitations on incontestability under this section:

574 (i) preclude only a contest of the validity of the policy; and

575 (ii) do not preclude the good faith assertion at any time of defenses based upon

576 provisions in the policy that exclude or qualify coverage, whether or not those qualifications or

577 exclusions are specifically excepted in the policy's incontestability clause.

578 (b) A provision on which the contestable period would normally run may not be

579 reformulated as a coverage exclusion or restriction to take advantage of this Subsection (5).

580 (6) In accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, the

581 commissioner may make rules to implement this section.

582 Section 14. Section **31A-22-423** is amended to read:

583 **31A-22-423. Policy and annuity examination period.**

584 (1) (a) Except as provided under Subsection (2), all life insurance policies [~~and~~], life

585 insurance certificates, annuities, and annuities certificates shall contain a notice prominently

586 printed on or attached to the cover or front page stating that the policyholder or certificate  
587 holder has the right to return the policy or certificate for any reason on or before:

588 (i) ten days after delivery; or

589 (ii) in case of a replacement policy or certificate, 20 days after the replacement policy  
590 or certificate is delivered.

591 (b) For purposes of this section, "return" means a writing that:

592 (i) the policy or certificate is being returned for termination of coverage;

593 (ii) is:

594 (A) a written statement on the policy or certificate; or [~~an accompanying]~~

595 (B) a writing that accompanies the policy [~~is being returned for termination of coverage~~  
596 ~~that is]~~ or certificate; and

597 (iii) is delivered to or mailed first class to the insurer or [~~its]~~ the insurer's agent.

598 (c) A policy or certificate returned under this section is void from the date of issuance.

599 (d) A policyholder or certificate holder returning a policy or certificate is entitled to a  
600 refund of any premium paid.

601 (2) This section does not apply to:

602 (a) group term life insurance issued under Section 31A-22-502;

603 [~~(a)~~] (b) a group [~~policies; and]~~ master policy;

604 (c) a noncontributory certificate;

605 (d) a credit life insurance certificate; and

606 [~~(b)~~] (e) other classes of life insurance policies that the commissioner specifies by rule  
607 after finding that a right to return those policies would be impracticable or unnecessary to  
608 protect the policyholder's interests.

609 Section 15. Section **31A-22-517** is amended to read:

610 **31A-22-517. Conversion on termination of eligibility.**

611 (1) [~~If any portion of the insurance on a person covered under the policy ceases because~~  
612 ~~of termination of employment or of membership in the classes eligible for coverage, the]~~ A

613 person is entitled to be issued by the insurer, without evidence of insurability, an individual  
614 policy of life insurance without accident and health or other supplementary benefits, if:

615 (a) any portion of insurance on a person covered by a policy ceases because of:

616 (i) termination of employment; or

617 (ii) termination of membership in the classes eligible for coverage;

618 (b) an application for the individual policy is made; and

619 (c) the first premium is paid to the insurer within 31 days after the termination  
620 described in Subsection (1)(a).

621 (2) The individual policy described in Subsection (1) shall, at the option of the person  
622 entitled, be on any form then customarily [~~issued~~] provided by the insurer at the age and for the  
623 amount applied for, except that the group policy may exclude the option to elect:

624 (a) term insurance[-]; or

625 (b) flexible premium insurance.

626 (3) (a) The individual policy described in Subsection (1) shall be for an amount not in  
627 excess of the life insurance which ceases because of the termination, less the amount of any life  
628 insurance for which the person is eligible because of the termination and within 30 days after  
629 [~~it~~] the termination.

630 (b) Any amount of insurance [~~which~~] that matures on or before the termination, as an  
631 endowment payable to the person insured, whether in one sum, in installments, or in the form  
632 of an annuity, is not included in the amount [~~which~~] that is considered to cease because of the  
633 termination.

634 (4) The premium on the individual policy described in Subsection (1) shall be at the  
635 insurer's customary rate at the time of termination, which is applicable to:

636 (a) the form and amount of the individual policy[,-to];

637 (b) the class of risk to which the person belonged when terminated from the group  
638 policy[-]; and [to]

639 (c) the age attained on the effective date of the individual policy.

640 (5) Subject to the conditions of this section, the conversion privilege described in this  
641 section is available:

642 (a) to a surviving dependent, if any, at the death of the employee or member, with  
643 respect to the survivor's coverage under the group policy [~~which~~] that terminates by reason of  
644 the death; and

645 (b) to the dependent of the employee or member upon termination of coverage of the  
646 dependent, while the employee or member remains insured, because the dependent ceases to be  
647 a qualified dependent under the group policy.

648 Section 16. Section **31A-22-610** is amended to read:

649 **31A-22-610. Dependent coverage from moment of birth or adoption.**

650 (1) As used in this section:

651 (a) "Child" means, in connection with any adoption, or placement for adoption of the  
652 child, an individual who is younger than 18 years of age as of the date of the adoption or  
653 placement for adoption.

654 (b) "Placement for adoption" means the assumption and retention by a person of a legal  
655 obligation for total or partial support of a child in anticipation of the adoption of the child.

656 (2) (a) If any accident and health insurance policy provides coverage for any members  
657 of the policyholder's or certificate holder's family, the policy shall ~~also~~ provide that any health  
658 insurance benefits applicable to dependents of the insured are applicable on the same basis to:

659 (i) a newly born child from the moment of birth~~;~~; and ~~[to]~~

660 (ii) an adopted child:

661 ~~[(i)]~~ (A) beginning from the moment of birth~~,~~ if placement for adoption occurs within  
662 30 days of the child's birth; or

663 ~~[(ii)]~~ (B) beginning from the date of placement~~,~~ if placement for adoption occurs 30  
664 days or more after the child's birth.

665 (b) ~~[This]~~ The coverage described in this Subsection (2):

666 (i) is not subject to any preexisting conditions~~;~~; and

667 (ii) includes any injury or sickness, including the necessary care and treatment of  
668 medically diagnosed:

669 (A) congenital defects ~~[and]~~;

670 (B) birth abnormalities; or

671 (C) prematurity.

672 ~~[(c) If the payment of a specific premium is required to provide coverage for a child of  
673 the policyholder or certificate holder, the policy may require that the insurer be notified of the  
674 birth or placement for the purpose of adoption, and that the required premium be paid within  
675 30 days after the date of birth or placement for the purpose of adoption, in order to have the  
676 coverage extend beyond that 30-day period.]~~

677 (c) (i) Subject to Subsection (2)(c)(ii), a claim for services for a newly born child or an  
678 adopted child may be denied until the child is enrolled.

679 (ii) Notwithstanding Subsection (2)(c)(i), ~~it~~ **AN OTHERWISE ELIGIBLE** ~~it~~ claim denied  
 679a under Subsection (2)(c)(i) ~~it~~ **IS ELIGIBLE FOR PAYMENT AND** ~~it~~  
 680 may be resubmitted or reprocessed ~~it~~ **[for payment]** ~~it~~ once a child is enrolled ~~it~~ **PURSUANT TO**  
 680a **SUBSECTION (2)(d) OR (e)** ~~it~~ .

681 (d) If the payment of a specific premium is required to provide coverage for a child of a  
 682 policyholder or certificate holder, for there to be coverage for the child, the policyholder or  
 683 certificate holder shall enroll:

684 (i) a newly born child within 30 days after the date of birth of the child; or

685 (ii) an adopted child within 30 days after the day of placement of adoption.

686 (e) If the payment of a specific premium is not required to provide coverage for a child  
 687 of a policyholder or certificate holder, for the child to receive coverage the policyholder or  
 688 certificate holder shall enroll a newly born child or an adopted child no later than 30 days after  
 689 the first notification of denial of a claim for services for that child.

690 (3) (a) The coverage required by Subsection (2) as to children placed for the purpose of  
 691 adoption with a policyholder or certificate holder continues in the same manner as it would  
 692 with respect to a child of the policyholder or certificate holder unless;

693 (i) the placement is disrupted prior to legal adoption; and

694 (ii) the child is removed from placement.

695 (b) The coverage ~~requirement~~ required by Subsection (2) ends if the child is removed  
 696 from placement prior to being legally adopted.

697 (4) The provisions of this section apply to employee welfare benefit plans as defined in  
 698 Section 26-19-2.

699 Section 17. Section **31A-23-202** is amended to read:

700 **31A-23-202. Application for license.**

701 (1) (a) Subject to Subsection (2) the application for a resident license as an agent, a  
 702 broker, or a consultant shall be:

703 (i) made to the commissioner on forms and in a manner the commissioner prescribes;

704 and

705 (ii) accompanied by an applicable fee that is not refunded if the application is denied;

706 and

707 (b) the application for a nonresident license as an agent, a broker, or a consultant shall  
 708 be:

709 (i) made on the uniform application; and

710 (ii) accompanied by an applicable fee that is not refunded if the application is denied.

711 (2) An application described in Subsection (1) shall provide:

712 (a) information about the applicant's identity;

713 (b) the applicant's:

714 (i) Social Security number; or

715 (ii) federal employer identification number;

716 (c) the applicant's personal history, experience, education, and business record;

717 (d) if the applicant is a natural person, whether the applicant is 18 years of age or older;

718 (e) whether the applicant has committed an act that is a ground for denial, suspension,

719 or revocation as set forth in Section 31A-23-216; and

720 (f) any other information the commissioner reasonably requires.

721 (3) The commissioner may require any documents reasonably necessary to verify the

722 information contained in an application.

723 [~~(4) The following are private records under Subsection 63-2-302(1)(a)(vii), an~~

724 ~~applicant's-:]~~

725 [~~(a) Social Security number ; or]~~

726 [~~(b) federal employer identification number.]~~

727 (4) The following information contained in an application filed under this section is a

728 private record under Title 63, Chapter 2, Government Records Access and Management Act:

729 (a) an applicant's Social Security number; or

730 (b) an applicant's federal employer identification number.

731 Section 18. Section **31A-23-311.1** is enacted to read:

732 **31A-23-311.1. Person's liability if premium received is not forwarded to the**

733 **insurer.**

734 A person commits insurance fraud as described in Subsection 31A-31-103(1)(f) if that

735 person knowingly fails to forward to the insurer a premium:

736 (1) received from one of the following in partial or total payment of the premium due

737 from:

738 (a) an applicant;

739 (b) a policyholder; or

740 (c) a certificate holder; or



741 (2) collected from or on behalf of an insured employee under an insured employee  
742 benefit plan.

743 Section 19. Section **31A-26-202** is amended to read:

744 **31A-26-202. Application for license.**

745 (1) (a) The application for a license as an independent adjuster or public adjuster shall  
746 be:

747 (i) made to the commissioner on forms and in a manner the commissioner prescribes;

748 and

749 (ii) accompanied by the applicable fee, which is not refunded if the application is  
750 denied.

751 (b) The application shall provide:

752 (i) information about the applicant's identity, including:

753 (A) the applicant's:

754 (I) Social Security number; or

755 (II) federal employer identification number;

756 (B) the applicant's personal history, experience, education, and business record;

757 (C) if the applicant is a natural person, whether the applicant is 18 years of age or  
758 older; and

759 (D) whether the applicant has committed an act that is a ground for denial, suspension,  
760 or revocation as set forth in Section 31A-25-208; and

761 (ii) any other information as the commissioner reasonably requires.

762 (2) The commissioner may require documents reasonably necessary to verify the  
763 information contained in the application.

764 [~~(3) The following are private records under Subsection 63-2-302(1)(a)(vii):~~]

765 [~~(a) the applicant's Social Security number; and~~]

766 [~~(b) the applicant's federal employer identification number.~~]

767 (3) The following information contained in an application filed under this section is a  
768 private record under Title 63, Chapter 2, Government Records Access and Management Act:

769 (a) an applicant's Social Security number; or

770 (b) an applicant's federal employer identification number.

771 Section 20. Section **31A-26-310** is amended to read:

772 **31A-26-310. Compensation of insurers' claims adjusters.**

773 (1) (a) Except as provided in Subsection (2), ~~[insurers]~~ an insurer or an insured may  
774 not pay a person~~[-, whether an employee or independent contractor,]~~ who is representing [it] the  
775 insurer or insured in connection with an insurance claim ~~[adjustments]~~ adjustment on ~~[a]~~ any  
776 basis that is dependent, in whole or in part, upon the amounts paid ~~[insureds]~~ an insured or  
777 ~~[claimants]~~ claimant under an insurance ~~[policies]~~ policy.

778 (b) Subsection (1)(a) includes payments to:

779 (i) an employee of:

780 (A) the insurer; or

781 (B) the insured;

782 (ii) an independent contractor; or

783 (iii) a public adjuster.

784 (2) Subsection (1) does not prohibit a compensation arrangement:

785 (a) based upon the overall profitability of the insurer;

786 (b) based upon the discovery or proof of fraudulent insurance claims; or

787 (c) conforming to an order or rule of the commissioner ~~[which deals with]~~ that

788 addresses the compensation of persons engaged in insurance adjusting on behalf of:

789 (i) an insurer[-]; or

790 (ii) an insured.

791 Section 21. Section **31A-27-302** is amended to read:

792 **31A-27-302. Answering the petition -- Hearing -- Appeal.**

793 (1) (a) The insurer shall answer the petition described in Section 31A-27-301 within  
794 five working days after receiving ~~[the]~~ notice.

795 (b) If the insurer does not answer within ~~[this]~~ the time described in Subsection (1)(a),  
796 the court shall issue a rehabilitation order under Section 31A-27-303.

797 (2) If the insurer answers and objects to the petition described in Section 31A-27-301,  
798 the court shall:

799 (a) hear the case as soon as it is convenient[-]; and [shall]

800 (b) proceed expeditiously to grant or deny the petition.

801 (3) (a) The judgment of the court granting or denying the petition may be appealed  
802 under the Utah Rules of Civil Procedure.

803 (b) If the court's judgment is to grant a petition for rehabilitation, the judgment remains  
804 in effect pending the decision on appeal.

805 (c) The Supreme Court shall give expeditious review of appeals made under this  
806 Subsection (3).

807 Section 22. Section **31A-27-311.5** is amended to read:

808 **31A-27-311.5. Continuance of coverage -- Health maintenance organizations.**

809 (1) As used in this section:

810 (a) "basic health care services" is as defined in Section 31A-8-101;

811 (b) "enrollee" is as defined in Section 31A-8-101;

812 (c) "health care" is as defined in Section 31A-1-301;

813 (d) "health maintenance organization" is as defined in Section 31A-8-101;

814 (e) "limited health plan" is as defined in Section 31A-8-101;

815 (f) (i) "managed care organization" means any entity licensed by, or holding a  
816 certificate of authority from, the department to furnish health care services or health insurance;

817 (ii) "managed care organization" includes:

818 (A) a limited health plan;

819 (B) a health maintenance organization;

820 (C) a preferred provider organization;

821 (D) a fraternal benefit society; or

822 (E) any entity similar to an entity described in Subsections (1)(f)(ii)(A) through (D);

823 (iii) "managed care organization" does not include:

824 (A) an insurer or other person that is eligible for membership in a guaranty association  
825 under Chapter 28, Guaranty Associations;

826 (B) a mandatory state pooling plan;

827 (C) a mutual assessment company or any entity that operates on an assessment basis; or

828 (D) any entity similar to an entity described in Subsections (1)(f)(iii)(A) through (C);

829 (g) "participating provider" means a provider who, under a contract with a managed  
830 care organization authorized under Section 31A-8-407, agrees to provide health care services to  
831 enrollees with an expectation of receiving payment, directly or indirectly, from the managed  
832 care organization, other than copayment;

833 (h) "participating provider contract" means the agreement between a participating

834 provider and a managed care organization authorized under Section 31A-8-407;

835 (i) "preferred provider" means a provider who agrees to provide health care services  
836 under an agreement authorized under Subsection 31A-22-617(1);

837 (j) "preferred provider contract" means the written agreement between a preferred  
838 provider and a managed care organization authorized under Subsection 31A-22-617(1);

839 (k) (i) except as provided in Subsection (1)(k)(ii), "preferred provider organization"  
840 means any person that:

841 (A) furnishes at a minimum, through preferred providers, basic health care services to  
842 an enrollee in return for prepaid periodic payments in an amount agreed to prior to the time  
843 during which the health care may be furnished;

844 (B) is obligated to the enrollee to arrange for the services described in Subsection  
845 (1)(k)(i)(A); and

846 (C) permits the enrollee to obtain health care services from providers who are not  
847 preferred providers; and

848 (ii) "preferred provider organization" does not include:

849 (A) an insurer licensed under Chapter 7, Nonprofit Health Service Insurance  
850 [~~Corporation~~] Corporations; or

851 (B) an individual who contracts to render professional or personal services that the  
852 individual performs[-];

853 (l) "provider" is as defined in Section 31A-8-101; and

854 (m) "uncovered expenditure" means the costs of health care services that are covered  
855 by an organization for which an enrollee is liable in the event of the managed care  
856 organization's insolvency.

857 (2) The rehabilitator or liquidator may take one or more of the actions described in  
858 Subsections (2)(a) through (f) to assure continuation of health care coverage for enrollees of an  
859 insolvent managed care organization.

860 (a) (i) Subject to Subsection (2)(a)(ii), a rehabilitator or liquidator may require a  
861 participating provider and preferred provider of health care services to continue to provide the  
862 health care services the provider is required to provide under the provider's participating  
863 provider contract or preferred provider contract until the earlier of:

864 (A) 90 days after the date of the filing of:

865 (I) a petition for rehabilitation; or

866 (II) a petition for liquidation; or

867 (B) the date the term of the contract ends.

868 (ii) A requirement by the rehabilitator or liquidator under Subsection (2)(a)(i) that a  
869 participating provider or preferred provider continue to provide health care services under a  
870 provider's participating provider contract or preferred providers contract expires when health  
871 care coverage for all enrollees of the insolvent managed care organization is obtained from  
872 another managed care organization or insurer.

873 (b) (i) Subject to Subsection (2)(b)(ii), a rehabilitator or liquidator may reduce the fees  
874 a participating provider or preferred provider is otherwise entitled to receive from the managed  
875 care organization under its participating provider contract or preferred provider contract during  
876 the time period in Subsection (2)(a)(i).

877 (ii) Notwithstanding Subsection (2)(b)(i) a rehabilitator or liquidator may not reduce a  
878 fee to less than 75% of the regular fee set forth in the respective participating provider contract  
879 or preferred provider contract.

880 (iii) An enrollee shall continue to pay the same copayments, deductibles, and other  
881 payments for services received from the participating provider or preferred provider that the  
882 enrollee was required to pay before the date of filing of:

883 (A) the petition for rehabilitation; or

884 (B) the petition for liquidation.

885 (c) (i) A participating provider or preferred provider shall:

886 (A) accept the amounts specified in Subsection (2)(b) as payment in full; and

887 (B) relinquish the right to collect additional amounts from the insolvent managed care  
888 organization's enrollee.

889 (ii) Subsections (2)(b) and (2)(c)(i) shall apply to the fees paid to a provider who agrees  
890 to provide health care services to an enrollee but is not a preferred or participating provider.

891 (d) If the managed care organization is a health maintenance organization, Subsections  
892 (2)(d)(i) through (vi) apply.

893 (i) Subject to Subsections (2)(d)(ii), (iii), and (v), upon notification from and subject to  
894 the direction of the rehabilitator or liquidator of a health maintenance organization licensed  
895 under Chapter 8, Health Maintenance Organizations and Limited Health Plans, a solvent health

896 maintenance organization licensed under Chapter 8, Health Maintenance Organizations and  
897 Limited Health Plans, and operating within a portion of the insolvent health maintenance  
898 organization's service area shall extend to the enrollees all rights, privileges, and obligations of  
899 being an enrollee in the accepting health maintenance organization.

900 (ii) Notwithstanding Subsection (2)(d)(i), the accepting health maintenance  
901 organization shall give credit to an enrollee for any waiting period already satisfied under the  
902 provisions of the enrollee's contract with the insolvent health maintenance organization.

903 (iii) A health maintenance organization accepting an enrollee of an insolvent health  
904 maintenance organization under Subsection (2)(d)(i) shall charge the enrollee the premiums  
905 applicable to the existing business of the accepting health maintenance organization.

906 (iv) A health maintenance organization's obligation to accept an enrollee under  
907 Subsection (2)(d)(i) is limited in number to the accepting health maintenance organization's pro  
908 rata share of all health maintenance organization enrollees in this state, as determined after  
909 excluding the enrollees of the insolvent insurer.

910 (v) (A) The rehabilitator or liquidator of an insolvent health maintenance organization  
911 shall take those measures that are possible to ensure that no health maintenance organization is  
912 required to accept more than its pro rata share of the adverse risk represented by the enrollees  
913 of the insolvent health maintenance organization.

914 (B) If the methodology used by the rehabilitator or liquidator to assign an enrollee is  
915 one that can be expected to produce a reasonably equitable distribution of adverse risk, that  
916 methodology and its results are acceptable under this Subsection (2)(d)(v).

917 (vi) (A) Notwithstanding Section 31A-27-311, the rehabilitator or liquidator may  
918 require all solvent health maintenance organizations to pay for the covered claims incurred by  
919 the enrollees of the insolvent health maintenance organization.

920 (B) As determined by the rehabilitator or liquidator, payments required under this  
921 Subsection (2)(d)(vi) may:

922 (I) begin as of the filing of the petition for ~~[reorganization]~~ rehabilitation or the petition  
923 for liquidation; and

924 (II) continue for a maximum period through the time all enrollees are assigned pursuant  
925 to this section.

926 (C) If the rehabilitator or liquidator makes an assessment under this Subsection

927 (2)(d)(vi), the rehabilitator or liquidator shall assess each solvent health maintenance  
928 organization its pro rata share of the total assessment based upon its premiums from the  
929 previous calendar year.

930 (D) (I) A solvent health maintenance organization required to pay for covered claims  
931 under this Subsection (2)(d)(vi) shall be entitled to file a claim against the estate of the  
932 insolvent health maintenance organization.

933 (II) Any claim described in Subsection (2)(a)(vi)(D)(I), if allowed by the rehabilitator  
934 or liquidator, shall share in any distributions from the estate of the insolvent health  
935 maintenance organization as a Class 3 claim.

936 (e) (i) A rehabilitator or liquidator may transfer, through sale, or otherwise, the group  
937 and individual health care obligations of the insolvent managed care organization to other  
938 managed care organizations or other insurers, if those other managed care organizations and  
939 other insurers are licensed or have a certificate of authority to provide the same health care  
940 services in this state that is held by the insolvent managed care organization.

941 (ii) The rehabilitator or liquidator may combine group and individual health care  
942 obligations of the insolvent managed care organization in any manner the rehabilitator or  
943 liquidator considers best to provide for continuous health care coverage for the maximum  
944 number of enrollees of the insolvent managed care organization.

945 (iii) If the terms of a proposed transfer of the same combination of group and  
946 individual policy obligations to more than one other managed care organization or insurer are  
947 otherwise equal, the rehabilitator or liquidator shall give preference to the transfer of the group  
948 and individual policy obligations of an insolvent managed care organization as follows:

949 (A) from one category of managed care organization to another managed care  
950 organization of the same category, as follows:

951 (I) from a limited health plan to a limited health plan;

952 (II) from a health maintenance organization to a health maintenance organization;

953 (III) from a preferred provider organization to a preferred provider organization;

954 (IV) from a fraternal benefit society to a fraternal benefit society; and

955 (V) from any entity similar to any of the above to a category that is similar;

956 (B) from one category of managed care organization to another managed care

957 organization, regardless of the category of the transferee managed care organization; and

958 (C) from a managed care organization to a nonmanaged care provider of health care  
959 coverage, including insurers.

960 (f) [~~A~~] If an insolvent managed care organization has required surplus, a rehabilitator  
961 or liquidator may use the insolvent managed care organization's required [~~capital or permanent~~  
962 ~~surplus, and compulsory~~] surplus[;] to continue to provide coverage for the insolvent managed  
963 care organization's enrollees, including paying uncovered expenditures.

964 Section 23. Section **31A-30-106** is amended to read:

965 **31A-30-106. Premiums -- Rating restrictions -- Disclosure.**

966 (1) Premium rates for health benefit plans under this chapter are subject to the  
967 provisions of this Subsection (1).

968 (a) The index rate for a rating period for any class of business may not exceed the  
969 index rate for any other class of business by more than 20%.

970 (b) (i) For a class of business, the premium rates charged during a rating period to  
971 covered insureds with similar case characteristics for the same or similar coverage, or the rates  
972 that could be charged to such employers under the rating system for that class of business, may  
973 not vary from the index rate by more than 30% of the index rate, except as provided in Section  
974 31A-22-625.

975 (ii) A covered carrier that offers individual and small employer health benefit plans  
976 may use the small employer index rates to establish the rate limitations for individual policies,  
977 even if some individual policies are rated below the small employer base rate.

978 (c) The percentage increase in the premium rate charged to a covered insured for a new  
979 rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of  
980 the following:

981 (i) the percentage change in the new business premium rate measured from the first day  
982 of the prior rating period to the first day of the new rating period;

983 (ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods  
984 of less than one year, due to the claim experience, health status, or duration of coverage of the  
985 covered individuals as determined from the covered carrier's rate manual for the class of  
986 business, except as provided in Section 31A-22-625; and

987 (iii) any adjustment due to change in coverage or change in the case characteristics of  
988 the covered insured as determined from the covered carrier's rate manual for the class of



989 business.

990 (d) (i) Adjustments in rates for claims experience, health status, and duration from  
991 issue may not be charged to individual employees or dependents.

992 (ii) Any adjustment described in Subsection (1)(d)(i) shall be applied uniformly to the  
993 rates charged for all employees and dependents of the small employer.

994 (e) A covered carrier may use industry as a case characteristic in establishing premium  
995 rates, provided that the highest rate factor associated with any industry classification does not  
996 exceed the lowest rate factor associated with any industry classification by more than 15%.

997 (f) (i) Covered carriers shall apply rating factors, including case characteristics,  
998 consistently with respect to all covered insureds in a class of business.

999 (ii) Rating factors shall produce premiums for identical groups that:

1000 (A) differ only by the amounts attributable to plan design; and

1001 (B) do not reflect differences due to the nature of the groups assumed to select  
1002 particular health benefit products.

1003 (iii) A covered carrier shall treat all health benefit plans issued or renewed in the same  
1004 calendar month as having the same rating period.

1005 (g) For the purposes of this Subsection (1), a health benefit plan that uses a restricted  
1006 network provision may not be considered similar coverage to a health benefit plan that does not  
1007 use such a network, provided that use of the restricted network provision results in substantial  
1008 difference in claims costs.

1009 (h) The covered carrier may not, without prior approval of the commissioner, use case  
1010 characteristics other than:

1011 (i) age;

1012 (ii) gender;

1013 (iii) industry;

1014 (iv) geographic area;

1015 (v) family composition; and

1016 (vi) group size.

1017 (i) (i) The commissioner may establish rules in accordance with Title 63, Chapter 46a,  
1018 Utah Administrative Rulemaking Act, to:

1019 (A) implement this chapter; and

1020 (B) assure that rating practices used by covered carriers are consistent with the  
1021 purposes of this chapter.

1022 (ii) The rules described in Subsection (1)(i)(i) may include rules that:

1023 (A) assure that differences in rates charged for health benefit products by covered  
1024 carriers are reasonable and reflect objective differences in plan design, not including  
1025 differences due to the nature of the groups assumed to select particular health benefit products;

1026 (B) prescribe the manner in which case characteristics may be used by covered carriers;

1027 (C) implement the individual enrollment cap under Section 31A-30-110, including  
1028 specifying:

1029 (I) the contents for certification;

1030 (II) auditing standards;

1031 (III) underwriting criteria for uninsurable classification; and

1032 (IV) limitations on high risk enrollees under Section 31A-30-111; and

1033 (D) establish the individual enrollment cap under Subsection 31A-30-110(1).

1034 (j) Before implementing regulations for underwriting criteria for uninsurable  
1035 classification, the commissioner shall contract with an independent consulting organization to  
1036 develop industry-wide underwriting criteria for uninsurability based on an individual's expected  
1037 claims under open enrollment coverage exceeding 200% of that expected for a standard  
1038 insurable individual with the same case characteristics.

1039 (k) The commissioner shall revise rules issued for Sections 31A-22-602 and  
1040 31A-22-605 regarding individual accident and health policy rates to allow rating in accordance  
1041 with this section.

1042 (2) For purposes of Subsection (1)(c)(i), if a health benefit product is a health benefit  
1043 product into which the covered carrier is no longer enrolling new covered insureds, the covered  
1044 carrier shall use the percentage change in the base premium rate, provided that the change does  
1045 not exceed, on a percentage basis, the change in the new business premium rate for the most  
1046 similar health benefit product into which the covered carrier is actively enrolling new covered  
1047 insureds.

1048 (3) (a) A covered carrier may not transfer a covered insured involuntarily into or out of  
1049 a class of business.

1050 (b) A covered carrier may not offer to transfer a covered insured into or out of a class

1051 of business unless the offer is made to transfer all covered insureds in the class of business  
1052 without regard:

- 1053 (i) to case characteristics;
- 1054 (ii) claim experience;
- 1055 (iii) health status; or
- 1056 (iv) duration of coverage since issue.

1057 (4) (a) Each covered carrier shall maintain at the covered carrier's principal place of  
1058 business a complete and detailed description of its rating practices and renewal underwriting  
1059 practices, including information and documentation that demonstrate that the covered carrier's  
1060 rating methods and practices are:

- 1061 (i) based upon commonly accepted actuarial assumptions; and
- 1062 (ii) in accordance with sound actuarial principles.

1063 (b) (i) Each covered carrier shall file with the commissioner, on or before March 15 of  
1064 each year, in a form, manner, and containing such information as prescribed by the  
1065 commissioner, an actuarial certification certifying that:

- 1066 (A) the covered carrier is in compliance with this chapter; and
- 1067 (B) the rating methods of the covered carrier are actuarially sound.

1068 (ii) A copy of the certification required by Subsection (4)(b)(i) shall be retained by the  
1069 covered carrier at the covered carrier's principal place of business.

1070 (c) A covered carrier shall make the information and documentation described in this  
1071 Subsection (4) available to the commissioner upon request.

1072 (d) Records submitted to the commissioner under this section shall be maintained by  
1073 the commissioner as protected records under Title 63, Chapter 2, Government Records Access  
1074 and Management Act.

1075 Section 24. Section **31A-30-107.1** is amended to read:

1076 **31A-30-107.1. Individual discontinuance and nonrenewal.**

1077 (1) (a) Except as otherwise provided in this section, a health benefit plan offered on an  
1078 individual basis is renewable and continues in force:

- 1079 (i) with respect to all individuals or dependents; and
- 1080 (ii) at the option of the individual.

1081 (b) Subsection (1)(a) applies regardless of:

- 1082 (i) whether the contract is issued through:
- 1083 (A) a trust;
- 1084 (B) an association;
- 1085 (C) a discretionary group; or
- 1086 (D) other similar grouping; or
- 1087 (ii) the situs of delivery of the policy or contract.
- 1088 (2) A health benefit plan may be discontinued or nonrenewed:
- 1089 (a) for a network plan, if:
- 1090 (i) the individual no longer lives, resides, or works in:
- 1091 (A) the service area of the covered carrier; or
- 1092 (B) the area for which the covered carrier is authorized to do business; and
- 1093 (ii) coverage is terminated uniformly without regard to any health status-related factor
- 1094 relating to any covered individual; or
- 1095 (b) for coverage made available through an association, if:
- 1096 (i) the individual's membership in the association ceases; and
- 1097 (ii) the coverage is terminated uniformly without regard to any health status-related
- 1098 factor of covered individuals.
- 1099 (3) A health benefit plan may be discontinued if:
- 1100 (a) a condition described in Subsection (2) exists;
- 1101 (b) the individual fails to pay premiums or contributions in accordance with the terms
- 1102 of the health benefit plan, including any timeliness requirements;
- 1103 (c) the individual:
- 1104 (i) performs an act or practice that constitutes fraud in connection with the coverage; or
- 1105 (ii) makes an intentional misrepresentation of material fact under the terms of the
- 1106 coverage;
- 1107 (d) the covered carrier:
- 1108 (i) elects to discontinue offering a particular health benefit product delivered or issued
- 1109 for delivery in this state; and
- 1110 (ii) (A) provides notice of the discontinuance in writing:
- 1111 (I) to each individual provided coverage; and
- 1112 (II) at least 90 days before the date the coverage will be discontinued;

- 1113 (B) provides notice of the discontinuation in writing:  
1114 (I) to the commissioner; and  
1115 (II) at least three working days prior to the date the notice is sent to the affected  
1116 individuals;
- 1117 (C) offers to each covered individual on a guaranteed issue basis the option to purchase  
1118 all other individual health benefit products currently being offered by the covered carrier for  
1119 individuals in that market; and
- 1120 (D) acts uniformly without regard to any health status-related factor of a covered  
1121 individual or dependent of a covered individual who may become eligible for coverage; or  
1122 (e) the covered carrier:
- 1123 (i) elects to discontinue all of the covered carrier's health benefit plans in the individual  
1124 market; and
- 1125 (ii) (A) provides notice of the discontinuation in writing:  
1126 (I) to each covered individual; and  
1127 (II) at least 180 days before the date the coverage will be discontinued;
- 1128 (B) provides notice of the discontinuation in writing:  
1129 (I) to the commissioner in each state in which an affected insured individual is known  
1130 to reside; and  
1131 (II) at least 30 working days prior to the date the notice is sent to the affected  
1132 individuals;
- 1133 (C) discontinues and nonrenews all health benefit plans the covered carrier issues or  
1134 delivers for ~~[insurance]~~ issuance in the individual market; and
- 1135 (D) acts uniformly without regard to any health status-related factor of a covered  
1136 individual or a dependent of a covered individual who may become eligible for coverage.
- 1137 Section 25. Section **31A-30-107.5** is amended to read:  
1138 **31A-30-107.5. Limitations and exclusions.**
- 1139 (1) A health benefit plan may impose a preexisting condition exclusion only if:  
1140 (a) the exclusion relates to a condition, regardless of the cause of the condition, for  
1141 which medical advise, diagnosis, care, or treatment was recommended or received within the  
1142 six-month period ending on the enrollment date;
- 1143 (b) the exclusion extends for a period of:

1144 (i) not more than 12 months after the enrollment date; or  
 1145 (ii) in the case of a late enrollee, 18 months after the enrollment date; and  
 1146 (c) the period [~~of the preexisting condition exclusion~~] described in Subsection (1)(b) is  
 1147 reduced by the aggregate of the periods of creditable coverage applicable to the participant or  
 1148 beneficiary as of the enrollment date.

1149 (2) Creditable coverage shall be provided for the period of time the individual was  
 1150 previously covered by:

1151 (a) public or private health insurance; or

1152 (b) any other **GROUP** health **[benefit arrangement] PLAN AS DEFINED IN 42 U.S.C.**

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1153 [~~(2)~~] (3) (a) The period of continuous coverage under Subsection (1)(c) may not  
 1154 include any waiting period for the effective date of the new coverage applied by the employer  
 1155 or the carrier.

1156 (b) This Subsection [~~(2)~~] (3) does not preclude application of any waiting period  
 1157 applicable to all new enrollees under the plan.

1158 [~~(3)~~] (4) (a) Credit for previous coverage as provided under Subsection (1)(c) need not  
 1159 be given for any condition that was previously excluded under a condition-specific exclusion  
 1160 rider issued pursuant to Subsection [~~(5)~~] (6).

1161 (b) A new preexisting waiting period may be applied to any condition that was  
 1162 excluded by a rider under the terms of previous individual coverage.

1163 [~~(4)~~] (5) (a) For purposes of Subsection (1)(c), a period of creditable coverage may not  
 1164 be counted with respect to enrollment of an individual under a health benefit plan, if:

1165 (i) after the period and before the enrollment date, there was a 63-day period during all  
 1166 of which the individual was not covered under any creditable coverage; or

1167 (ii) the insured fails to provide notification of previous coverage to the covered carrier  
 1168 within 36 months of the coverage effective date if the covered carrier has previously requested  
 1169 the notification.

1170 (b) (i) Credit for previous coverage as provided under Subsection (1)(c) need not be  
 1171 given for any condition that was previously excluded in compliance with Subsection [~~(5)~~] (6).

1172 (ii) A new preexisting waiting period may be applied to any condition that was  
 1173 excluded under the terms of previous individual coverage.

1174 [~~(5)~~] (6) (a) An individual carrier:

1175 (i) shall offer a health benefit plan in compliance with Subsection (1); and  
1176 (ii) may, when the individual carrier and the insured mutually agree in writing to a  
1177 condition-specific exclusion rider, offer to issue an individual policy that excludes a specific  
1178 physical condition consistent with Subsection [~~(5)~~] (6)(b).

1179 (b) (i) The commissioner shall establish by rule a list of life threatening physical  
1180 conditions that may not be the subject of a condition-specific exclusion rider.

1181 (ii) A condition-specific exclusion rider:

1182 (A) shall be limited to the excluded condition; and

1183 (B) may not extend to any secondary medical condition that may or may not be directly  
1184 related to the excluded condition.

1185 (7) Notwithstanding the other provisions of this section, a health benefit plan may  
1186 impose a limitation period if:

1187 (a) each policy that imposes a limitation period under the health benefit plan specifies  
1188 the physical condition that is excluded from coverage during the limitation period;

1189 (b) the limitation period does not exceed six months;

1190 (c) the limitation period is applied uniformly; and

1191 (d) the limitation period is reduced in compliance with Subsection (1)(c).

1192 Section 26. Section **31A-31-103** is amended to read:

1193 **31A-31-103. Insurance fraud.**

1194 (1) A person commits a fraudulent insurance act if that person with intent to deceive or  
1195 defraud:

1196 (a) knowingly presents or causes to be presented to an insurer any oral or written  
1197 statement or representation knowing that the statement or representation contains false,  
1198 incomplete, or misleading information concerning any fact material to an application for the  
1199 issuance or renewal of an insurance policy, certificate, or contract;

1200 (b) knowingly presents or causes to be presented to an insurer any oral or written  
1201 statement or representation as part of, or in support of, a claim for payment or other benefit  
1202 pursuant to an insurance policy, certificate, or contract, or in connection with any civil claim  
1203 asserted for recovery of damages for personal or bodily injuries or property damage, knowing  
1204 that the statement or representation contains false, incomplete, or misleading information  
1205 concerning any fact or thing material to the claim;

1206 (c) knowingly accepts a benefit from the proceeds derived from a fraudulent insurance  
1207 act;

1208 (d) assists, abets, solicits, or conspires with another to commit a fraudulent insurance  
1209 act; ~~or~~

1210 (e) knowingly supplies false or fraudulent material information in any document or  
1211 statement required by the department~~[-]; or~~

1212 (f) knowingly fails to forward a premium to an insurer in violation of Section  
1213 31A-23-311.1.

1214 (2) A service provider commits a fraudulent insurance act if that service provider with  
1215 intent to deceive or defraud:

1216 (a) knowingly submits or causes to be submitted a bill or request for payment  
1217 containing charges or costs for an item or service that are substantially in excess of customary  
1218 charges or costs for the item or service or containing itemized or delineated fees for what  
1219 would customarily be considered a single procedure or service;

1220 (b) knowingly furnishes or causes to be furnished an item or service to a person  
1221 substantially in excess of the needs of the person or of a quality that fails to meet professionally  
1222 recognized standards;

1223 (c) knowingly accepts a benefit from the proceeds derived from a fraudulent insurance  
1224 act; or

1225 (d) assists, abets, solicits, or conspires with another to commit a fraudulent insurance  
1226 act.

1227 (3) An insurer commits a fraudulent insurance act if that insurer with intent to deceive  
1228 or defraud:

1229 (a) knowingly withholds information or provides false or misleading information with  
1230 respect to an application, coverage, benefits, or claims under a policy or certificate;

1231 (b) assists, abets, solicits, or conspires with another to commit a fraudulent insurance  
1232 act;

1233 (c) knowingly accepts a benefit from the proceeds derived from a fraudulent insurance  
1234 act; or

1235 (d) knowingly supplies false or fraudulent material information in any document or  
1236 statement required by the department.



1237 (4) An insurer or service provider is not liable for any fraudulent insurance act  
1238 committed by an employee without the authority of the insurer or service provider unless the  
1239 insurer or service provider knew or should have known of the fraudulent insurance act.

1240 Section 27. Section **31A-31-108** is amended to read:

1241 **31A-31-108. Assessment of insurers.**

1242 (1) For purposes of this section:

1243 (a) The commission shall by rule made in accordance with Title 63, Chapter 46a, Utah  
1244 Administrative Rulemaking Act, define:

1245 (i) "annuity consideration";

1246 (ii) "membership fees";

1247 (iii) "other fees";

1248 (iv) "deposit-type contract funds"; and

1249 (v) "other considerations in Utah."

1250 (b) "Utah consideration" means:

1251 (i) the total premiums written for Utah risks;

1252 (ii) annuity consideration;

1253 (iii) membership fees collected by the insurer;

1254 (iv) other fees collected by the insurer;

1255 (v) deposit-type contract funds; and

1256 (vi) other considerations in Utah;

1257 (c) "Utah risks" means insurance coverage on the lives, health, or against the liability  
1258 of persons residing in Utah, or on property located in Utah, other than property temporarily in  
1259 transit through Utah.

1260 [(H)] (2) To implement this chapter, Section 34A-2-110, and Section 76-6-521, the  
1261 commissioner may assess each admitted insurer and each nonadmitted insurer transacting  
1262 insurance under Chapter 15, Parts 1 and 2, an annual fee as follows:

1263 [~~(a) \$75 for an insurer with total premiums for Utah risks of \$1,000,000 or less;~~]

1264 [~~(b) \$263 for an insurer with total premiums for Utah risks of less than \$2,500,000 but~~  
1265 ~~more than \$1,000,000;~~]

1266 [~~(c) \$563 for an insurer with total premiums for Utah risks of less than \$5,000,000 but~~  
1267 ~~more than \$2,500,000;~~]

1268 ~~[(d) \$1,125 for an insurer with total premiums for Utah risks of less than \$10,000,000~~  
1269 ~~but more than \$5,000,000;]~~

1270 ~~[(e) \$4,500 for an insurer with total premiums for Utah risks of less than \$50,000,000~~  
1271 ~~but more than \$10,000,000; and]~~

1272 ~~[(f) \$11,250 for an insurer with total premiums for Utah risks of \$50,000,000 or more.]~~

1273 (a) \$150 for an insurer if the sum of the Utah consideration for that insurer is less than  
1274 or equal to \$1,000,000;

1275 (b) \$400 for an insurer if the sum of the Utah consideration for that insurer is greater  
1276 than \$1,000,000 but is less than or equal to \$2,500,000;

1277 (c) \$700 for an insurer if the sum of the Utah consideration for that insurer is greater  
1278 than \$2,500,000 but is less than or equal to \$5,000,000;

1279 (d) \$1,350 for an insurer if the sum of the Utah consideration for that insurer is greater  
1280 than \$5,000,000 but less than or equal to \$10,000,000;

1281 (e) \$5,150 for an insurer if the sum of the Utah consideration for that insurer is greater  
1282 than \$10,000,000 but less than \$50,000,000; and

1283 (f) \$12,350 for an insurer if the sum of the Utah consideration for that insurer equals or  
1284 exceeds \$50,000,000.

1285 ~~[(2)]~~ (3) All money received by the state under this section shall be deposited in the  
1286 General Fund as a nonlapsing dedicated credit of the Insurance Department for the purpose of  
1287 providing funds to pay for any costs and expenses incurred by the Insurance Department in the  
1288 administration, investigation, and enforcement of this chapter, Section 34A-2-110, and Section  
1289 76-6-521.

1290 ~~[(3) As used in this section, "Utah risks" means insurance coverage on the lives, health,~~  
1291 ~~or against the liability of persons residing in Utah, or on property located in Utah, other than~~  
1292 ~~property temporarily in transit through Utah.]~~

1293 Section 28. Section **31A-33-108** is amended to read:

1294 **31A-33-108. Powers and duties of chief executive officer.**

1295 (1) The chief executive officer shall:

1296 (a) administer all operations of the Workers' Compensation Fund under the direction of  
1297 the board;

1298 (b) recommend to the board any necessary or desirable changes in the workers'

1299 compensation law;

1300 (c) recommend to the board an annual administrative budget covering the operations of  
1301 the Workers' Compensation Fund and, upon approval, submit the administrative budget,  
1302 financial status, and actuarial condition of the fund to the governor and the Legislature for their  
1303 examination;

1304 (d) direct and control all expenditures of the approved budget;

1305 (e) from time to time, upon the recommendation of a consulting actuary, recommend to  
1306 the board rating plans, the amount of deviation, if any, from standard rates, and the amount of  
1307 dividends, if any, to be returned to policyholders;

1308 (f) invest the Injury Fund's assets under the guidance of the board and in accordance  
1309 with Chapter 18;

1310 (g) recommend general policies and procedures to the board to guide the operations of  
1311 the fund;

1312 (h) formulate and administer a system of personnel administration and employee  
1313 compensation that uses merit principles of personnel management, includes employee benefits  
1314 and grievance procedures consistent with those applicable to state agencies, and includes  
1315 inservice training programs;

1316 (i) prepare and administer fiscal, payroll, accounting, data processing, and procurement  
1317 procedures for the operation of the Workers' Compensation Fund;

1318 (j) conduct studies of the workers' compensation insurance business, including the  
1319 preparation of recommendations and reports;

1320 (k) develop uniform procedures for the management of the Workers' Compensation  
1321 Fund;

1322 (l) maintain contacts with governmental and other public or private groups having an  
1323 interest in workers' compensation insurance;

1324 (m) within the limitations of the budget, employ necessary staff personnel and  
1325 consultants, including actuaries, attorneys, medical examiners, adjusters, investment  
1326 counselors, accountants, and clerical and other assistants to accomplish the purpose of the  
1327 Workers' Compensation Fund;

1328 (n) maintain appropriate levels of property, casualty, and liability insurance as  
1329 approved by the board to protect the fund, its directors, officers, employees, and assets; and

1330 (o) develop self-insurance programs as approved by the board to protect the fund, its  
1331 directors, officers, employees, and assets to supersede or supplement insurance maintained  
1332 under Subsection (1)(n).

1333 (2) The chief executive officer may:

1334 (a) enter into contracts of workers' compensation and occupational disease insurance,  
1335 which may include employer's liability insurance to cover the exposure of a policyholder to his  
1336 Utah employees and their dependents for liability claims, including the cost of defense in the  
1337 event of suit, for claims based upon bodily injury to the policyholder's Utah employees;

1338 (b) reinsure any risk or part of any risk;

1339 (c) cause to be inspected and audited the payrolls of policyholders or employers  
1340 applying to the Workers' Compensation Fund for insurance;

1341 (d) establish procedures for adjusting claims against the Workers' Compensation Fund  
1342 that comply with Title 34A, Chapters 2 and 3, and determine the persons to whom and through  
1343 whom the payments of compensation are to be made;

1344 (e) contract with physicians, surgeons, hospitals, and other health care providers for  
1345 medical and surgical treatment and the care and nursing of injured persons entitled to benefits  
1346 from the Workers' Compensation Fund;

1347 (f) require policyholders to maintain an adequate deposit to provide security for periods  
1348 of coverage for which premiums have not been paid;

1349 (g) contract with self-insured entities for the administration of workers' compensation  
1350 claims and safety consultation services; and

1351 (h) with the approval of the board, adopt the calendar year or any other reporting period  
1352 to report claims and payments made or reserves established on claims that are necessary to  
1353 accommodate the reporting requirements of the Labor Commission, [~~Insurance Commission~~]  
1354 department, State Tax Commission, or National Council on Compensation Insurance.

1355 Section 29. Section **49-16-301** is amended to read:

1356 **49-16-301. Contributions -- Two divisions -- Election by employer to pay**  
1357 **employee contributions -- Accounting for and vesting of worker contributions --**  
1358 **Deductions.**

1359 (1) In addition to the monies paid to this system under Subsection (6), participating  
1360 employers and firefighter service employees shall jointly pay the certified contribution rates to

1361 the office to maintain this system on a financially and actuarially sound basis.

1362 (2) For purposes of determining contribution rates, this system is divided into two  
1363 divisions according to Social Security coverage as follows:

1364 (a) members of this system with on-the-job Social Security coverage are in Division A;  
1365 and

1366 (b) members of this system without on-the-job Social Security coverage are in Division  
1367 B.

1368 (3) (a) A participating employer may elect to pay all or part of the required member  
1369 contributions, in addition to the required participating employer contributions.

1370 (b) Any amount contributed by a participating employer under this section shall vest to  
1371 the member's benefit as though the member had made the contribution.

1372 (c) The required member contributions shall be reduced by the amount that is paid by  
1373 the participating employer.

1374 (4) (a) All member contributions are credited by the office to the account of the  
1375 individual member.

1376 (b) This amount is held in trust for the payment of benefits to the member or the  
1377 member's beneficiaries.

1378 (c) All member contributions are vested and nonforfeitable.

1379 (5) (a) Each member is considered to consent to payroll deductions of member  
1380 contributions.

1381 (b) The payment of compensation less these payroll deductions is considered to be full  
1382 payment for services rendered by the member.

1383 (6) (a) In addition to contribution rates described under this section, there shall be paid  
1384 to the Firefighters' Retirement Trust Fund created under Section 49-16-104:

1385 (i) 50% of the annual tax levied, assessed, and collected under Title 59, Chapter 9,  
1386 Taxation of Admitted Insurers, upon premiums for property insurance [premiums], as defined  
1387 under Section 31A-1-301, and as applied to fire and allied lines insurance collected by  
1388 insurance companies within the state; and

1389 (ii) 10% of all money assessed and collected under Title 59, Chapter 9, Taxation of  
1390 Admitted Insurers, upon premiums for life insurance [premiums], as defined in Section  
1391 31A-1-301, within the state.

1392 (b) Payments to the fund shall be made annually until the service liability is liquidated,  
1393 after which the tax revenue provided in this Subsection (6) for the Firefighters' Retirement  
1394 Trust Fund ceases.

1395 Section 30. Section **53-7-204.2** is amended to read:

1396 **53-7-204.2. Fire Academy -- Establishment -- Fire Academy Support Fund --**  
1397 **Funding.**

1398 (1) In this section:

1399 (a) "Account" means the Fire Academy Support Account created in Subsection (4).

1400 (b) "Property insurance premium" [~~has the same meaning as provided~~] means premium  
1401 paid as consideration for property insurance as defined in Section 31A-1-301.

1402 (2) The board shall:

1403 (a) establish a fire academy that:

1404 (i) provides instruction and training for paid, volunteer, institutional, and industrial  
1405 firefighters;

1406 (ii) develops new methods of firefighting and fire prevention;

1407 (iii) provides training for fire and arson detection and investigation;

1408 (iv) provides public education programs to promote fire safety;

1409 (v) provides for certification of firefighters, pump operators, instructors, and officers;

1410 and

1411 (vi) provides facilities for teaching fire-fighting skills;

1412 (b) establish a cost recovery fee in accordance with Section 63-38-3.2 for training  
1413 commercially employed firefighters; and

1414 (c) request funding for the academy.

1415 (3) The board may:

1416 (a) accept gifts, donations, and grants of property and services on behalf of the fire  
1417 academy; and

1418 (b) enter into contractual agreements necessary to facilitate establishment of the school.

1419 (4) (a) To provide a funding source for the academy and for the general operation of  
1420 the State Fire Marshal Division, there is created in the General Fund a restricted account  
1421 known as the Fire Academy Support Account.

1422 (b) The following revenue shall be deposited in the account to implement this section:

1423 (i) the percentage specified in Subsection (5) of the annual tax for each year that is  
1424 levied, assessed, and collected under Title 59, Chapter 9, Taxation of Admitted Insurers, upon  
1425 property insurance premiums and as applied to fire and allied lines insurance collected by  
1426 insurance companies within the state;

1427 (ii) the percentage specified in Subsection (6) of all money assessed and collected upon  
1428 life insurance premiums within the state;

1429 (iii) the cost recovery fees established by the board;

1430 (iv) gifts, donations, and grants of property on behalf of the fire academy; and

1431 (v) appropriations made by the Legislature.

1432 (5) The percentage of the tax specified in Subsection (4)(b)(i) to be deposited in the  
1433 account each fiscal year is 25%.

1434 (6) The percentage of the money specified in Subsection (4)(b)(ii) to be deposited in  
1435 the account each fiscal year is 5%.

1436 Section 31. Section **63-2-302 (Effective 07/01/03)** is amended to read:

1437 **63-2-302 (Effective 07/01/03). Private records.**

1438 (1) The following records are private:

1439 (a) records concerning an individual's eligibility for unemployment insurance benefits,  
1440 social services, welfare benefits, or the determination of benefit levels;

1441 (b) records containing data on individuals describing medical history, diagnosis,  
1442 condition, treatment, evaluation, or similar medical data;

1443 (c) records of publicly funded libraries that when examined alone or with other records  
1444 identify a patron;

1445 (d) records received or generated for a Senate or House Ethics Committee concerning  
1446 any alleged violation of the rules on legislative ethics, prior to the meeting, and after the  
1447 meeting, if the ethics committee meeting was closed to the public;

1448 (e) records received or generated for a Senate confirmation committee concerning  
1449 character, professional competence, or physical or mental health of an individual:

1450 (i) if prior to the meeting, the chair of the committee determines release of the records:

1451 (A) reasonably could be expected to interfere with the investigation undertaken by the  
1452 committee; or

1453 (B) would create a danger of depriving a person of a right to a fair proceeding or

1454 impartial hearing;

1455 (ii) after the meeting, if the meeting was closed to the public;

1456 (f) employment records concerning a current or former employee of, or applicant for  
1457 employment with, a governmental entity that would disclose that individual's home address,  
1458 home telephone number, Social Security number, insurance coverage, marital status, or payroll  
1459 deductions;

1460 (g) records or parts of records under Section 63-2-302.5 that a current or former  
1461 employee identifies as private according to the requirements of that section;

1462 (h) that part of a record indicating a person's Social Security number or federal  
1463 employer identification number if provided under Section 31A-23-202, 31A-26-202, 58-1-301,  
1464 61-1-4, or 61-2-6;

1465 (i) that part of a voter registration record identifying a voter's driver license or  
1466 identification card number, Social Security number, or last four digits of the Social Security  
1467 number; and

1468 (j) a record that:

1469 (i) contains information about an individual;

1470 (ii) is voluntarily provided by the individual; and

1471 (iii) goes into an electronic database that:

1472 (A) is designated by and administered under the authority of the Chief Information  
1473 Officer; and

1474 (B) acts as a repository of information about the individual that can be electronically  
1475 retrieved and used to facilitate the individual's online interaction with a state agency.

1476 (2) The following records are private if properly classified by a governmental entity:

1477 (a) records concerning a current or former employee of, or applicant for employment  
1478 with a governmental entity, including performance evaluations and personal status information  
1479 such as race, religion, or disabilities, but not including records that are public under Subsection  
1480 63-2-301(1)(b) or 63-2-301(2)(o), or private under Subsection 63-2-302(1)(b);

1481 (b) records describing an individual's finances, except that the following are public:

1482 (i) records described in Subsection 63-2-301(1);

1483 (ii) information provided to the governmental entity for the purpose of complying with  
1484 a financial assurance requirement; or



- 1485 (iii) records that must be disclosed in accordance with another statute;
- 1486 (c) records of independent state agencies if the disclosure of those records would  
1487 conflict with the fiduciary obligations of the agency;
- 1488 (d) other records containing data on individuals the disclosure of which constitutes a  
1489 clearly unwarranted invasion of personal privacy; and
- 1490 (e) records provided by the United States or by a government entity outside the state  
1491 that are given with the requirement that the records be managed as private records, if the  
1492 providing entity states in writing that the record would not be subject to public disclosure if  
1493 retained by it.
- 1494 (3) (a) As used in this Subsection (3), "medical records" means medical reports,  
1495 records, statements, history, diagnosis, condition, treatment, and evaluation.
- 1496 (b) Medical records in the possession of the University of Utah Hospital, its clinics,  
1497 doctors, or affiliated entities are not private records or controlled records under Section  
1498 63-2-303 when the records are sought:
- 1499 (i) in connection with any legal or administrative proceeding in which the patient's  
1500 physical, mental, or emotional condition is an element of any claim or defense; or
- 1501 (ii) after a patient's death, in any legal or administrative proceeding in which any party  
1502 relies upon the condition as an element of the claim or defense.
- 1503 (c) Medical records are subject to production in a legal or administrative proceeding  
1504 according to state or federal statutes or rules of procedure and evidence as if the medical  
1505 records were in the possession of a nongovernmental medical care provider.
- 1506 Section 32. Section **63-2-302 (Superseded 07/01/03)** is amended to read:
- 1507 **63-2-302 (Superseded 07/01/03). Private records.**
- 1508 (1) The following records are private:
- 1509 (a) records concerning an individual's eligibility for unemployment insurance benefits,  
1510 social services, welfare benefits, or the determination of benefit levels;
- 1511 (b) records containing data on individuals describing medical history, diagnosis,  
1512 condition, treatment, evaluation, or similar medical data;
- 1513 (c) records of publicly funded libraries that when examined alone or with other records  
1514 identify a patron;
- 1515 (d) records received or generated for a Senate or House Ethics Committee concerning

1516 any alleged violation of the rules on legislative ethics, prior to the meeting, and after the  
1517 meeting, if the ethics committee meeting was closed to the public;

1518 (e) records received or generated for a Senate confirmation committee concerning  
1519 character, professional competence, or physical or mental health of an individual:

1520 (i) if prior to the meeting, the chair of the committee determines release of the records:

1521 (A) reasonably could be expected to interfere with the investigation undertaken by the  
1522 committee; or

1523 (B) would create a danger of depriving a person of a right to a fair proceeding or  
1524 impartial hearing;

1525 (ii) after the meeting, if the meeting was closed to the public;

1526 (f) records concerning a current or former employee of, or applicant for employment  
1527 with, a governmental entity that would disclose that individual's home address, home telephone  
1528 number, Social Security number, insurance coverage, marital status, or payroll deductions;

1529 (g) that part of a record indicating a person's Social Security number or federal  
1530 employer identification number if provided under Section 31A-23-202, 31A-26-202, 58-1-301,  
1531 61-1-4, or 61-2-6;

1532 (h) that part of a voter registration record identifying a voter's driver license or  
1533 identification card number, Social Security number, or last four digits of the Social Security  
1534 number; and

1535 (i) a record that:

1536 (i) contains information about an individual;

1537 (ii) is voluntarily provided by the individual; and

1538 (iii) goes into an electronic database that:

1539 (A) is designated by and administered under the authority of the Chief Information  
1540 Officer; and

1541 (B) acts as a repository of information about the individual that can be electronically  
1542 retrieved and used to facilitate the individual's online interaction with a state agency.

1543 (2) The following records are private if properly classified by a governmental entity:

1544 (a) records concerning a current or former employee of, or applicant for employment  
1545 with a governmental entity, including performance evaluations and personal status information  
1546 such as race, religion, or disabilities, but not including records that are public under Subsection

- 1547 63-2-301(1)(b) or 63-2-301(2)(o), or private under Subsection 63-2-302(1)(b);
- 1548 (b) records describing an individual's finances, except that the following are public:
- 1549 (i) records described in Subsection 63-2-301(1);
- 1550 (ii) information provided to the governmental entity for the purpose of complying with
- 1551 a financial assurance requirement; or
- 1552 (iii) records that must be disclosed in accordance with another statute;
- 1553 (c) records of independent state agencies if the disclosure of those records would
- 1554 conflict with the fiduciary obligations of the agency;
- 1555 (d) other records containing data on individuals the disclosure of which constitutes a
- 1556 clearly unwarranted invasion of personal privacy; and
- 1557 (e) records provided by the United States or by a government entity outside the state
- 1558 that are given with the requirement that the records be managed as private records, if the
- 1559 providing entity states in writing that the record would not be subject to public disclosure if
- 1560 retained by it.
- 1561 (3) (a) As used in this Subsection (3), "medical records" means medical reports,
- 1562 records, statements, history, diagnosis, condition, treatment, and evaluation.
- 1563 (b) Medical records in the possession of the University of Utah Hospital, its clinics,
- 1564 doctors, or affiliated entities are not private records or controlled records under Section
- 1565 63-2-303 when the records are sought:
- 1566 (i) in connection with any legal or administrative proceeding in which the patient's
- 1567 physical, mental, or emotional condition is an element of any claim or defense; or
- 1568 (ii) after a patient's death, in any legal or administrative proceeding in which any party
- 1569 relies upon the condition as an element of the claim or defense.
- 1570 (c) Medical records are subject to production in a legal or administrative proceeding
- 1571 according to state or federal statutes or rules of procedure and evidence as if the medical
- 1572 records were in the possession of a nongovernmental medical care provider.

1573 **Section 33. Effective date.**

1574 The amendments in this act to Section 63-2-302 (Effective 07/01/03) take effect on July

1575 1, 2003.

**Legislative Review Note**

**as of 2-18-03 8:39 AM**

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

**Office of Legislative Research and General Counsel**

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**Fiscal Note**  
**Bill Number HB0373**

**Insurance Law Revisions**

21-Feb-03

2:47 PM

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**State Impact**

This bill will generate about \$215,000 in Dedicated Credits.

	<u>FY 04 Approp.</u>	<u>FY 05 Approp.</u>	<u>FY 04 Revenue</u>	<u>FY 05 Revenue</u>
Dedicated Credits Revenue	\$215,000	\$215,000	\$215,000	\$215,000
<b>TOTAL</b>	<b>\$215,000</b>	<b>\$215,000</b>	<b>\$215,000</b>	<b>\$215,000</b>

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**Individual and Business Impact**

This bill will increase fees to most insurers for fraud by \$75 with a few as high as \$1,100.

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**Office of the Legislative Fiscal Analyst**