INSURANCE LAW REVISIONS

2003 GENERAL SESSION

STATE OF UTAH

Sponsor: James A. Ferrin

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

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

AMENDS:

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

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

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

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

31A-8-402.3, as enacted by Chapter 308, Laws of Utah 2002

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

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

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

31A-19a-209, as last amended by Chapter 308, Laws of Utah 2002

31A-19a-212, as renumbered and amended by Chapter 130, Laws of Utah 1999

31A-21-106, as last amended by Chapter 308, Laws of Utah 2002

31A-21-201, as last amended by Chapter 116, Laws of Utah 2001

31A-21-311, as last amended by Chapter 308, Laws of Utah 2002

31A-22-403, as last amended by Chapter 308, Laws of Utah 2002

31A-22-423, as last amended by Chapter 116, Laws of Utah 2001

31A-22-517, as last amended by Chapter 116, Laws of Utah 2001

31A-22-610, as last amended by Chapter 116, Laws of Utah 2001

31A-22-721, as enacted by Chapter 308, Laws of Utah 2002

31A-23-202, as last amended by Chapters 185 and 191, Laws of Utah 2002

31A-26-202, as last amended by Chapters 191 and 308, Laws of Utah 2002

31A-26-310, as enacted by Chapter 242, Laws of Utah 1985

31A-27-302, as last amended by Chapter 204, Laws of Utah 1986

31A-27-311.5, as last amended by Chapter 308, Laws of Utah 2002

31A-30-106, as last amended by Chapter 308, Laws of Utah 2002

31A-30-107, as last amended by Chapter 308, Laws of Utah 2002

31A-30-107.1, as enacted by Chapter 308, Laws of Utah 2002

31A-30-107.5, as enacted by Chapter 308, Laws of Utah 2002

31A-31-103, as enacted by Chapter 243, Laws of Utah 1994

31A-31-108, as last amended by Chapters 185 and 375, Laws of Utah 1997

31A-33-108, as last amended by Chapter 375, Laws of Utah 1997

49-16-301, as renumbered and amended by Chapter 250, Laws of Utah 2002

53-7-204.2, as last amended by Chapter 6, Laws of Utah 2002, Sixth Special Session

63-2-302 (Effective 07/01/03), as last amended by Chapters 63 and 191, Laws of Utah 2002

63-2-302 (Superseded 07/01/03), as last amended by Chapter 63, Laws of Utah 2002

ENACTS:

31A-2-306.5, Utah Code Annotated 1953

31A-23-311.1, Utah Code Annotated 1953

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

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

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

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

(a) administrative review;

(b) rehearing; or

(c) judicial review.

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

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

(i) administrative review; or

(ii) rehearing; or

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

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

31A-3-303. Payment of tax.

(1) The insurer, all brokers involved in the transaction, and the policyholder are jointly and severally liable for the payment of the taxes required under Section 31A-3-301. The policyholder's liability for payment of the premium tax under Section 31A-3-301 ends when the policyholder pays the tax to the broker or insurer. The insurer and all brokers involved in the transaction are jointly and severally liable for the payment of the additional tax required under Section 31A-3-302. Except for the tax under Section 31A-3-302, the taxes under this part shall be paid by the policyholder who shall be billed specifically for the tax when billed for the premium. Except for the tax imposed under Section 31A-3-302, absorption of the tax by the

agent, broker, or insurer is an unfair method of competition under Section 31A-23-302.

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

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

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

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

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

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

31A-4-103. Certificate of authority.

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

(a) the name of the insurer;

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

(c) any other information the commissioner requires.

(2) A certificate of authority issued under this chapter remains in force until[~~,~~]:

(a) the certificate is not renewed; or

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

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

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

[~~(c) limited.~~]

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

(i) revoke[~~,~~] a certificate of authority;

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

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

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

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

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

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

[~~(I)~~] (A) this title;

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

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

[~~(ii) the insurer's~~] (iii) engaged in methods and practices in the conduct of business that endanger the legitimate interests of customers and the public.

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

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

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

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

~~limitation~~].

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

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

(i) the period of the limitation;

(ii) the conditions of the limitation; and

(iii) the procedures for removing the limitation.

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

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

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

(a) state;

(b) the District of Columbia; or

(c) a territory of the United States.

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

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

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

(i) a suspension under Subsection (3) of an insurer's certificate of authority ends; or

(ii) a new certificate of authority is issued to an insurer whose certificate of authority is revoked under Subsection (3).

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

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

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

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

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

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

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

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

(ii) include:

(A) the signed jurat page; and

(B) the actuarial certification.

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

(d) At the time an insurer makes a filing under this Subsection (1), the insurer shall pay

any filing fees assessed by the National Association of Insurance Commissioners.

[~~(b) Foreign insurers~~]

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

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

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

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

(i) the commissioner; or

(ii) the National Association of Insurance Commissioners; or

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

(i) the commissioner; or

(ii) the National Association of Insurance Commissioners.

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

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

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

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

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

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

(a) of not more than:

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

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

(b) calculated:

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

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

Section 6. Section **31A-8-402.3** is amended to read:

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

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

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

(b) at the option of the plan sponsor.

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

(a) for a network plan, if:

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

(A) the service area of the insurer; or

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

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

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

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

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

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

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

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

of the contract;

(c) the plan sponsor:

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

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

(d) the insurer:

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

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

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

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

(B) provides notice of the discontinuation in writing:

(I) to the commissioner; and

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

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

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

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

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

(I) the claims experience of a plan sponsor;

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

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

(e) the insurer:

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

(A) the small employer market;

(B) the large employer market; or

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

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

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

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

(B) provides notice of the discontinuation in writing:

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

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

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

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

(4) A large employer health benefit plan [~~for a plan sponsor~~] may be discontinued or nonrenewed:

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

(b) for noncompliance with the insurer's:

(i) minimum participation requirements; or

(ii) employer contribution requirements.

(5) A small employer health benefit plan may be discontinued or nonrenewed:

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

(b) for noncompliance with the insurer's employer contribution requirements.

(6) A small employer health benefit plan may be nonrenewed:

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

(b) for noncompliance with the insurer's minimum participation requirements.

[~~(5)~~] (7) (a) Except as provided in Subsection [~~(5)~~] (7)(d), an eligible employee may be discontinued if after issuance of coverage the eligible employee:

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

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

(b) An eligible employee that is discontinued under Subsection [~~(5)~~] (7)(a) may reenroll:

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

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

(c) At the time the eligible employee's coverage is discontinued under Subsection [~~(5)~~] (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is discontinued.

(d) An eligible employee may not be discontinued under this Subsection [~~(5)~~] (7) because of a fraud or misrepresentation that relates to health status.

[~~(6)~~] (8) For purposes of this section, a reference to "plan sponsor" includes a reference to the employer:

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

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

(i) an association;

(ii) a trust; or

(iii) a discretionary group.

[~~(7)~~] (9) An insurer may modify a health benefit plan for a plan sponsor only:

(a) at the time of coverage renewal; and

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

Section 7. Section **31A-8-402.5** is amended to read:

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

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

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

(ii) at the option of the individual.

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

(i) whether the contract is issued through:

(A) a trust;

(B) an association;

(C) a discretionary group; or

(D) other similar grouping; or

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

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

(a) for a network plan, if:

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

(A) the service area of the insurer; or

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

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

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

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

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

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

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

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

(c) the individual:

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

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

(d) the insurer:

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

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

(I) to each individual provided coverage; and

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

(B) provides notice of the discontinuation in writing:

(I) to the commissioner; and

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

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

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

(e) the insurer:

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

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

(I) to each individual provided coverage; and

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

(B) provides notice of the discontinuation in writing:

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

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

(C) discontinues and nonrenews all health benefit plans the insurer issues or delivers for [~~insurance~~] issuance in the individual market; and

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

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

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

(1) (a) Every contract between an organization and a participating provider of health care services shall be in writing and shall set forth that if the organization:

(i) fails to pay for health care services as set forth in the contract, the enrollee may not be liable to the provider for any sums owed by the organization; and

(ii) becomes insolvent, the rehabilitator or liquidator may require the participating provider of health care services to:

(A) continue to provide health care services under the contract between the participating provider and the organization until the earlier of:

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

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

(B) subject to Subsection (1)(c), reduce the fees the participating provider is otherwise entitled to receive from the organization under the contract between the participating provider and the organization during the time period described in Subsection (1)(a)(ii)(A).

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

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

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

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

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

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

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

(B) the petition for liquidation.

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

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

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

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

(i) sums owed by the organization; or

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

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

(i) a participating provider;

(ii) an agent;

(iii) a trustee; or

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

Section 9. Section **31A-17-201** is amended to read:

31A-17-201. Qualified assets.

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

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

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

(i) an investment;

(ii) a security;

(iii) property; or

(iv) a loan;

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

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

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

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

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

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

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

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

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

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

Section 10. Section **31A-19a-209** is amended to read:

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

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

(a) the maintenance of title plants; and

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

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

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

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

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

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

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

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

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

(i) the insurance business; or

(ii) the escrow business; or

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

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

(b) Each change or amendment shall:

(i) be filed with the commissioner; and

(ii) state the effective date of the change or amendment, which may not be less than 30 calendar days after the [~~date of filing~~] day on which the change or amendment is filed.

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

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

(a) retained in each of the offices of:

(i) the insurance company in this state;

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

(b) upon request, furnished to the public.

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

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

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

Section 11. Section **31A-19a-212** is amended to read:

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

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

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

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

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

(a) a policy is issued; or

(b) a policy is renewed.

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

Section 12. Section **31A-21-106** is amended to read:

31A-21-106. Incorporation by reference.

(1) (a) Except as provided in Subsection (1)(b), an insurance policy may not contain any agreement or incorporate any provision not fully set forth in the policy or in an application or other document attached to and made a part of the policy at the time of its delivery, unless the policy, application, or agreement accurately reflects the terms of the incorporated agreement, provision, or attached document.

(b) (i) A policy may by reference incorporate rate schedules and classifications of risks and short-rate tables filed with the commissioner.

(ii) By rule or order, the commissioner may authorize incorporation by reference of provisions for:

(A) administrative arrangements;

(B) premium schedules; and

(C) payment procedures for complex contracts.

(c) (i) A policy of title insurance insuring the mortgage or deed of trust of an institutional lender may, if requested by an institutional lender, incorporate by reference generally applicable policy terms that are contained in a specifically identified policy that has been filed with the commissioner.

(ii) As used in Subsection (1)(c)(i), "institutional lender" means a person that regularly engages in the business of making loans secured by real estate.

(d) A policy may incorporate by reference the following by citing in the policy:

(i) a federal law or regulation;

(ii) a state law or rule; or

(iii) a public directive of a federal or state agency.

(2) A purported modification of a contract during the term of the policy may not affect the obligations of a party to the contract:

(a) unless the modification is:

(i) in writing; and

(ii) agreed to by the party against whose interest the modification operates; and

(b) except:

(i) as provided in:

(A) Subsection (3) or (4);

(B) Subsection 31A-8-402.3[~~(7)~~] (9);

(C) Subsection 31A-22-721[~~(8)~~] (10); or

(D) Subsection 31A-30-107[~~(7)~~] (8); or

(ii) as otherwise mandated by law.

(3) Subsection (2) does not prevent a change in coverage under group contracts resulting from:

(a) provisions of an employer eligibility rule;

(b) the terms of a collective bargaining agreement; or

(c) provisions in federal Employee Retirement Income Security Act plan documents.

(4) Subsection (2) does not prevent a premium increase at any renewal date that is applicable uniformly to all comparable persons.

Section 13. Section **31A-21-201** is amended to read:

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

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

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

(i) the form;

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

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

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

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

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

(A) inequitable;

(B) unfairly discriminatory;

(C) misleading;

(D) deceptive;

(E) obscure;

(F) unfair;

(G) encourages misrepresentation; or

(H) not in the public interest;

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

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

(A) the exact name of the insurer;

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

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

(iv) [~~it~~] the form violates a statute or a rule adopted by the commissioner; or

(v) [~~it~~] the form is otherwise contrary to law.

(b) Subsection (3)(a)(iii) does not apply to riders and endorsements to a basic policy.

(c) (i) Whenever the commissioner prohibits the use of a form under Subsection (3)(a), the commissioner may order that, on or before a date not less than 15 days after the order, the use of the form be discontinued.

(ii) Once a form has been prohibited, [~~it~~] the form may not be used unless appropriate changes are filed with and reviewed by the commissioner.

(iii) Whenever the commissioner prohibits the use of a form under Subsection (3)(a), the

commissioner may require the insurer to disclose contract deficiencies to existing policyholders.

(d) [~~The commissioner's prohibition~~] If the commissioner prohibits use of a form under this Subsection (3), the prohibition shall:

(i) be in writing;

(ii) constitute an order; and

(iii) state the reasons for the prohibition.

(4) (a) If, after a hearing, the commissioner determines that it is in the public interest, the commissioner may require by rule or order that certain forms be subject to the commissioner's approval prior to their use.

(b) The rule or order described in Subsection (4)(a) shall prescribe the filing procedures for the forms if the procedures are different than the procedures stated in this section.

(c) The types of forms that may be addressed under Subsection (4)(a) include:

(i) [~~forms~~] a form for a particular class of insurance;

(ii) [~~forms~~] a form for a specific line of insurance;

(iii) a specific type of form; or

(iv) [~~forms~~] a form for a specific market segment.

(5) (a) An insurer shall maintain a complete and accurate record of the following for the time period described in Subsection (5)(b):

(i) any form:

(A) filed under this section for use; and

(B) that is in use; and

(ii) any document filed under this section with a form described in Subsection (5)(a)(i).

(b) The insurer shall maintain a record required under Subsection (5)(a) for the balance of the current year, plus three years from:

(i) the last day on which the form is used; or

(ii) the last day any policy that is issued using the form is in effect.

Section 14. Section **31A-21-311** is amended to read:

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

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

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

(A) provide the exact name of the insurer;

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

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

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

[~~(B)~~] (II) in the case of group life insurance[~~, any: (I)~~], any continuation of coverage during total disability; and

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

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

(A) a copy of the policy; or

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

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

(c) (i) A certificate shall be provided in a manner reasonably calculated to bring the certificate to the attention of the certificate holder.

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

(A) directly to the certificate holders; or

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

(iii) An affidavit by the insurer that the insurer mailed the certificates in the usual course

of business creates a rebuttable presumption that the insurer has [~~done so.~~] mailed the certificate to:

(A) a certificate holder; or

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

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

(i) booklets describing the coverage;

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

(iii) publication in a house organ.

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

Section 15. Section **31A-22-403** is amended to read:

31A-22-403. Incontestability.

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

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

(i) during the lifetime of the insured; or

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

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

(3) (a) A life insurance policy described in Subsection (2) may be contested for nonpayment of premiums.

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

(i) provisions relating to accident and health benefits allowed under Section 31A-22-609; and

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

(c) If a life insurance policy described in Subsection (2) allows the insured, after the policy's issuance and for an additional premium, to obtain a death benefit that is larger than when the policy was originally issued, the payment of the additional increment of benefit is contestable:

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

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

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

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

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

(b) Any grounds for contest available at original issuance continue to be available for contest until the policy has been in force for a total of two years:

(i) during the lifetime of the insured; and

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

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

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

(ii) do not preclude the good faith assertion at any time of defenses based upon provisions in the policy that exclude or qualify coverage, whether or not those qualifications or exclusions are specifically excepted in the policy's incontestability clause.

(b) A provision on which the contestable period would normally run may not be reformulated as a coverage exclusion or restriction to take advantage of this Subsection (5).

(6) In accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, the commissioner may make rules to implement this section.

Section 16. Section **31A-22-423** is amended to read:

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

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

insurance certificates, annuities, and annuities certificates shall contain a notice prominently printed on or attached to the cover or front page stating that the policyholder or certificate holder has the right to return the policy or certificate for any reason on or before:

(i) ten days after delivery; or

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

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

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

(ii) is:

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

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

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

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

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

(2) This section does not apply to:

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

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

(c) a noncontributory certificate;

(d) a credit life insurance certificate; and

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

Section 17. Section **31A-22-517** is amended to read:

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

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

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

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

(i) termination of employment; or

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

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

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

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

(a) term insurance[~~.~~]; or

(b) flexible premium insurance.

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

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

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

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

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

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

(5) Subject to the conditions of this section, the conversion privilege described in this

section is available:

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

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

Section 18. Section **31A-22-610** is amended to read:

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

(1) As used in this section:

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

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

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

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

(ii) an adopted child:

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

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

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

(i) is not subject to any preexisting conditions[~~,~~]; and

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

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

(B) birth abnormalities; or

(C) prematurity.

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

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

(ii) Notwithstanding Subsection (2)(c)(i), an otherwise eligible claim denied under Subsection (2)(c)(i) is eligible for payment and may be resubmitted or reprocessed once a child is enrolled pursuant to Subsection (2)(d) or (e).

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

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

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

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

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

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

(ii) the child is removed from placement.

(b) The coverage [~~requirement~~] required by Subsection (2) ends if the child is removed

from placement prior to being legally adopted.

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

Section 19. Section **31A-22-721** is amended to read:

31A-22-721. A health benefit plan for a plan sponsor -- Discontinuance and nonrenewal.

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

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

(b) at the option of the plan sponsor.

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

(a) for a network plan, if:

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

(A) the service area of the insurer; or

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

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

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

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

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

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

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

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

(c) the plan sponsor:

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

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

(d) the insurer:

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

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

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

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

(B) provides notice of the discontinuation in writing:

(I) to the commissioner; and

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

(C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase any other health benefit products currently being offered:

(I) by the insurer in the market; or

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

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

(I) the claims experience of a plan sponsor;

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

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

(e) the insurer:

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

(A) in the small employer market; or

(B) the large employer market; or

(C) both the small and large employer markets;

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

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

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

(B) provides notice of the discontinuation in writing:

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

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

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

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

(4) A large employer health benefit plan [~~for a plan sponsor~~] may be discontinued or nonrenewed:

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

(b) for noncompliance with the insurer's:

(i) minimum participation requirements; or

(ii) employer contribution requirements.

(5) A small employer health benefit plan may be discontinued or nonrenewed:

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

(b) for noncompliance with the insurer's employer contribution requirements.

(6) A small employer health benefit plan may be nonrenewed:

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

(b) for noncompliance with the insurer's minimum participation requirements.

[~~(5)~~] (7) (a) Except as provided in Subsection [~~(5)~~] (7)(d), an eligible employee may be discontinued if after issuance of coverage the eligible employee:

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

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

coverage.

(b) An eligible employee that is discontinued under Subsection [~~(5)~~] (7)(a) may reenroll:

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

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

(c) At the time the eligible employee's coverage is discontinued under Subsection [~~(5)~~] (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is discontinued.

(d) An eligible employee may not be discontinued under this Subsection [~~(5)~~] (7) because of a fraud or misrepresentation that relates to health status.

[~~(6)~~] (8) (a) Except as provided in Subsection [~~(6)~~] (8)(b), an insurer that elects to discontinue offering a health benefit plan under Subsection (3)(e) shall be prohibited from writing new business in such market in this state for a period of five years beginning on the date of discontinuation of the last coverage that is discontinued.

(b) The commissioner may waive the prohibition under Subsection [~~(6)~~] (8)(a) when the commissioner finds that waiver is in the public interest:

(i) to promote competition; or

(ii) to resolve inequity in the marketplace.

[~~(7)~~] (9) If an insurer is doing business in one established geographic service area of the state, this section applies only to the insurer's operations in that geographic service area.

[~~(8)~~] (10) An insurer may modify a health benefit plan for a plan sponsor only:

(a) at the time of coverage renewal; and

(b) if the modification is effective uniformly among all plans with a particular product or service.

[~~(9)~~] (11) For purposes of this section, a reference to "plan sponsor" includes a reference to the employer:

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

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

through:

(i) an association;

(ii) a trust; or

(iii) a discretionary group.

[~~(10)~~] (12) (a) A small employer that, after purchasing a health benefit plan in the small group market, employs on average more than 50 eligible employees on each business day in a calendar year may continue to renew the health benefit plan purchased in the small group market.

(b) A large employer that, after purchasing a health benefit plan in the large group market, employs on average less than 51 eligible employees on each business day in a calendar year may continue to renew the health benefit plan purchased in the large group market.

[~~(11)~~] (13) An insurer offering employer sponsored health benefit plans shall comply with the Health Insurance Portability and Accountability Act, P. L. 104-191, 110 Stat. 1962, Sec. 2701 and 2702.

Section 20. Section **31A-23-202** is amended to read:

31A-23-202. Application for license.

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

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

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

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

(i) made on the uniform application; and

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

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

(a) information about the applicant's identity;

(b) the applicant's:

(i) Social Security number; or

(ii) federal employer identification number;

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

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

(e) whether the applicant has committed an act that is a ground for denial, suspension, or revocation as set forth in Section 31A-23-216; and

(f) any other information the commissioner reasonably requires.

(3) The commissioner may require any documents reasonably necessary to verify the information contained in an application.

[~~(4) The following are private records under Subsection 63-2-302(1)(a)(vii), an applicant's :~~]

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

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

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

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

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

Section 21. Section **31A-23-311.1** is enacted to read:

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

A person commits insurance fraud as described in Subsection 31A-31-103(1)(f) if that person knowingly fails to forward to the insurer a premium:

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

(a) an applicant;

(b) a policyholder; or

(c) a certificate holder; or

(2) collected from or on behalf of an insured employee under an insured employee

benefit plan.

Section 22. Section **31A-26-202** is amended to read:

31A-26-202. Application for license.

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

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

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

(b) The application shall provide:

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

(A) the applicant's:

(I) Social Security number; or

(II) federal employer identification number;

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

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

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

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

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

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

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

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

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

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

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

Section 23. Section **31A-26-310** is amended to read:

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

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

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

(i) an employee of:

(A) the insurer; or

(B) the insured;

(ii) an independent contractor; or

(iii) a public adjuster.

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

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

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

(c) conforming to an order or rule of the commissioner [~~which deals with~~] that addresses the compensation of persons engaged in insurance adjusting on behalf of:

(i) an insurer[~~.~~]; or

(ii) an insured.

Section 24. Section **31A-27-302** is amended to read:

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

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

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

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

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

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

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

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

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

Section 25. Section **31A-27-311.5** is amended to read:

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

(1) As used in this section:

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

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

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

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

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

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

(ii) "managed care organization" includes:

(A) a limited health plan;

(B) a health maintenance organization;

(C) a preferred provider organization;

(D) a fraternal benefit society; or

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

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

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

(B) a mandatory state pooling plan;

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

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

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

(h) "participating provider contract" means the agreement between a participating provider and a managed care organization authorized under Section 31A-8-407;

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

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

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

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

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

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

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

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

(B) an individual who contracts to render professional or personal services that the individual performs[~~.~~];

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

(m) "uncovered expenditure" means the costs of health care services that are covered by

an organization for which an enrollee is liable in the event of the managed care organization's insolvency.

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

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

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

(I) a petition for rehabilitation; or

(II) a petition for liquidation; or

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

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

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

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

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

(A) the petition for rehabilitation; or

(B) the petition for liquidation.

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

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

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

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

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

(i) Subject to Subsections (2)(d)(ii), (iii), and (v), upon notification from and subject to the direction of the rehabilitator or liquidator of a health maintenance organization licensed under Chapter 8, Health Maintenance Organizations and Limited Health Plans, a solvent health maintenance organization licensed under Chapter 8, Health Maintenance Organizations and Limited Health Plans, and operating within a portion of the insolvent health maintenance organization's service area shall extend to the enrollees all rights, privileges, and obligations of being an enrollee in the accepting health maintenance organization.

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

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

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

(v) (A) The rehabilitator or liquidator of an insolvent health maintenance organization

shall take those measures that are possible to ensure that no health maintenance organization is required to accept more than its pro rata share of the adverse risk represented by the enrollees of the insolvent health maintenance organization.

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

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

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

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

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

(C) If the rehabilitator or liquidator makes an assessment under this Subsection (2)(d)(vi), the rehabilitator or liquidator shall assess each solvent health maintenance organization its pro rata share of the total assessment based upon its premiums from the previous calendar year.

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

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

(e) (i) A rehabilitator or liquidator may transfer, through sale, or otherwise, the group and individual health care obligations of the insolvent managed care organization to other managed care organizations or other insurers, if those other managed care organizations and other insurers

are licensed or have a certificate of authority to provide the same health care services in this state that is held by the insolvent managed care organization.

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

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

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

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

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

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

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

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

(B) from one category of managed care organization to another managed care organization, regardless of the category of the transferee managed care organization; and

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

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

Section 26. Section **31A-30-106** is amended to read:

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

(1) Premium rates for health benefit plans under this chapter are subject to the provisions

of this Subsection (1).

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

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

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

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

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

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

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

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

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

(e) A covered carrier may use industry as a case characteristic in establishing premium rates, provided that the highest rate factor associated with any industry classification does not

exceed the lowest rate factor associated with any industry classification by more than 15%.

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

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

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

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

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

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

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

(i) age;

(ii) gender;

(iii) industry;

(iv) geographic area;

(v) family composition; and

(vi) group size.

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

(A) implement this chapter; and

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

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

(A) assure that differences in rates charged for health benefit products by covered carriers

are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit products;

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

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

(I) the contents for certification;

(II) auditing standards;

(III) underwriting criteria for uninsurable classification; and

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

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

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

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

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

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

(b) A covered carrier may not offer to transfer a covered insured into or out of a class of business unless the offer is made to transfer all covered insureds in the class of business without

regard:

(i) to case characteristics;

(ii) claim experience;

(iii) health status; or

(iv) duration of coverage since issue.

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

(i) based upon commonly accepted actuarial assumptions; and

(ii) in accordance with sound actuarial principles.

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

(A) the covered carrier is in compliance with this chapter; and

(B) the rating methods of the covered carrier are actuarially sound.

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

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

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

Section 27. Section **31A-30-107** is amended to read:

31A-30-107. Renewal -- Limitations -- Exclusions -- Discontinuance and nonrenewal.

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

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

(b) at the option of the plan sponsor.

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

(a) for a network plan, if:

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

(A) the service area of the covered carrier; or

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

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

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

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

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

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

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

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

(c) the plan sponsor:

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

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

(d) the covered carrier:

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

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

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

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

(B) provides notice of the discontinuation in writing:

(I) to the commissioner; and

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

(C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all other small employer health benefit products currently being offered by the small employer carrier in the market; and

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

(I) the claims experience of a plan sponsor;

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

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

(e) the covered carrier:

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

(A) the small employer market;

(B) the large employer market; or

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

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

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

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

(B) provides notice of the discontinuation in writing:

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

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

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

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

(4) A small employer health benefit plan may be discontinued or nonrenewed:

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

(b) for noncompliance with the [~~covered carrier's: (i) minimum participation requirements; or (ii)~~] insurer's employer contribution requirements.

(5) A small employer health benefit plan may be nonrenewed:

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

(b) for noncompliance with the insurer's minimum participation requirements.

[~~(5)~~] (6) (a) Except as provided in Subsection [~~(5)~~] (6)(d), an eligible employee may be discontinued if after issuance of coverage the eligible employee:

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

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

(b) An eligible employee that is discontinued under Subsection [~~(5)~~] (6)(a) may reenroll:

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

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

(c) At the time the eligible employee's coverage is discontinued under Subsection [~~(5)~~] (6)(a), the covered carrier shall notify the eligible employee of the right to reenroll when coverage is discontinued.

(d) An eligible employee may not be discontinued under this Subsection [~~(5)~~] (6) because of a fraud or misrepresentation that relates to health status.

[~~(6)~~] (7) For purposes of this section, a reference to "plan sponsor" includes a reference to the employer:

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

(b) if the small employer health benefit plan is made available by a covered carrier in the

employer market only through:

(i) an association;

(ii) a trust; or

(iii) a discretionary group.

[~~(7)~~] (8) A covered carrier may modify a small employer health benefit plan only:

(a) at the time of coverage renewal; and

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

Section 28. Section **31A-30-107.1** is amended to read:

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

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

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

(ii) at the option of the individual.

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

(i) whether the contract is issued through:

(A) a trust;

(B) an association;

(C) a discretionary group; or

(D) other similar grouping; or

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

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

(a) for a network plan, if:

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

(A) the service area of the covered carrier; or

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

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

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

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

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

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

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

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

(c) the individual:

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

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

(d) the covered carrier:

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

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

(I) to each individual provided coverage; and

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

(B) provides notice of the discontinuation in writing:

(I) to the commissioner; and

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

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

(D) acts uniformly without regard to any health status-related factor of a covered individual or dependent of a covered individual who may become eligible for coverage; or

(e) the covered carrier:

(i) elects to discontinue all of the covered carrier's health benefit plans in the individual

market; and

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

(I) to each covered individual; and

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

(B) provides notice of the discontinuation in writing:

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

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

(C) discontinues and nonrenews all health benefit plans the covered carrier issues or delivers for [~~insurance~~] issuance in the individual market; and

(D) acts uniformly without regard to any health status-related factor of a covered individual or a dependent of a covered individual who may become eligible for coverage.

Section 29. Section **31A-30-107.5** is amended to read:

31A-30-107.5. Limitations and exclusions.

(1) A health benefit plan may impose a preexisting condition exclusion only if:

(a) the exclusion relates to a condition, regardless of the cause of the condition, for which medical advise, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date;

(b) the exclusion extends for a period of:

(i) not more than 12 months after the enrollment date; or

(ii) in the case of a late enrollee, 18 months after the enrollment date; and

(c) the period [~~of the preexisting condition exclusion~~] described in Subsection (1)(b) is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date.

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

(a) public or private health insurance; or

(b) any other group health plan as defined in 42 U.S.C. Section 300gg-91.

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

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

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

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

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

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

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

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

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

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

(i) shall offer a health benefit plan in compliance with Subsection (1); and

(ii) may, when the individual carrier and the insured mutually agree in writing to a condition-specific exclusion rider, offer to issue an individual policy that excludes a specific physical condition consistent with Subsection [~~(5)~~] (6)(b).

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

(ii) A condition-specific exclusion rider:

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

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

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

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

(b) the limitation period does not exceed 12 months;

(c) the limitation period is applied uniformly; and

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

Section 30. Section **31A-31-103** is amended to read:

31A-31-103. Insurance fraud.

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

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

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

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

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

[~~or~~]

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

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

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

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

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

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

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

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

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

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

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

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

(4) An insurer or service provider is not liable for any fraudulent insurance act committed by an employee without the authority of the insurer or service provider unless the

insurer or service provider knew or should have known of the fraudulent insurance act.

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

31A-31-108. Assessment of insurers.

(1) For purposes of this section:

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

(i) "annuity consideration";

(ii) "membership fees";

(iii) "other fees";

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

(v) "other considerations in Utah."

(b) "Utah consideration" means:

(i) the total premiums written for Utah risks;

(ii) annuity consideration;

(iii) membership fees collected by the insurer;

(iv) other fees collected by the insurer;

(v) deposit-type contract funds; and

(vi) other considerations in Utah.

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

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

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

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

[~~(c) $563 for an insurer with total premiums for Utah risks of less than $5,000,000 but~~

~~more than $2,500,000;~~]

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

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

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

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

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

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

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

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

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

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

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

Section 32. Section **31A-33-108** is amended to read:

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

(1) The chief executive officer shall:

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

(b) recommend to the board any necessary or desirable changes in the workers' compensation law;

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

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

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

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

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

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

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

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

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

(l) maintain contacts with governmental and other public or private groups having an

interest in workers' compensation insurance;

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

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

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

(2) The chief executive officer may:

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

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

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

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

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

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

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

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

Section 33. Section **49-16-301** is amended to read:

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

(1) In addition to the monies paid to this system under Subsection (6), participating employers and firefighter service employees shall jointly pay the certified contribution rates to the office to maintain this system on a financially and actuarially sound basis.

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

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

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

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

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

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

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

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

(c) All member contributions are vested and nonforfeitable.

(5) (a) Each member is considered to consent to payroll deductions of member

contributions.

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

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

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

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

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

Section 34. Section **53-7-204.2** is amended to read:

53-7-204.2. Fire Academy -- Establishment -- Fire Academy Support Fund -- Funding.

(1) In this section:

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

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

(2) The board shall:

(a) establish a fire academy that:

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

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

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

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

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

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

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

(c) request funding for the academy.

(3) The board may:

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

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

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

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

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

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

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

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

(v) appropriations made by the Legislature.

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

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

Section 35. Section **63-2-302 (Effective 07/01/03)** is amended to read:

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

(1) The following records are private:

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

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

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

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

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

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

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

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

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

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

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

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

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

(j) a record that:

(i) contains information about an individual;

(ii) is voluntarily provided by the individual; and

(iii) goes into an electronic database that:

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

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

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

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

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

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

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

(iii) records that must be disclosed in accordance with another statute;

(c) records of independent state agencies if the disclosure of those records would conflict with the fiduciary obligations of the agency;

(d) other records containing data on individuals the disclosure of which constitutes a clearly unwarranted invasion of personal privacy; and

(e) records provided by the United States or by a government entity outside the state that are given with the requirement that the records be managed as private records, if the providing entity states in writing that the record would not be subject to public disclosure if retained by it.

(3) (a) As used in this Subsection (3), "medical records" means medical reports, records, statements, history, diagnosis, condition, treatment, and evaluation.

(b) Medical records in the possession of the University of Utah Hospital, its clinics, doctors, or affiliated entities are not private records or controlled records under Section 63-2-303 when the records are sought:

(i) in connection with any legal or administrative proceeding in which the patient's physical, mental, or emotional condition is an element of any claim or defense; or

(ii) after a patient's death, in any legal or administrative proceeding in which any party relies upon the condition as an element of the claim or defense.

(c) Medical records are subject to production in a legal or administrative proceeding according to state or federal statutes or rules of procedure and evidence as if the medical records were in the possession of a nongovernmental medical care provider.

Section 36. Section **63-2-302 (Superseded 07/01/03)** is amended to read:

63-2-302 (Superseded 07/01/03). Private records.

(1) The following records are private:

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

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

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

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

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

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

(A) reasonably could be expected to interfere with the investigation undertaken by the

committee; or

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

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

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

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

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

(i) a record that:

(i) contains information about an individual;

(ii) is voluntarily provided by the individual; and

(iii) goes into an electronic database that:

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

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

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

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

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

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

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

(iii) records that must be disclosed in accordance with another statute;

(c) records of independent state agencies if the disclosure of those records would conflict with the fiduciary obligations of the agency;

(d) other records containing data on individuals the disclosure of which constitutes a clearly unwarranted invasion of personal privacy; and

(e) records provided by the United States or by a government entity outside the state that are given with the requirement that the records be managed as private records, if the providing entity states in writing that the record would not be subject to public disclosure if retained by it.

(3) (a) As used in this Subsection (3), "medical records" means medical reports, records, statements, history, diagnosis, condition, treatment, and evaluation.

(b) Medical records in the possession of the University of Utah Hospital, its clinics, doctors, or affiliated entities are not private records or controlled records under Section 63-2-303 when the records are sought:

(i) in connection with any legal or administrative proceeding in which the patient's physical, mental, or emotional condition is an element of any claim or defense; or

(ii) after a patient's death, in any legal or administrative proceeding in which any party relies upon the condition as an element of the claim or defense.

(c) Medical records are subject to production in a legal or administrative proceeding according to state or federal statutes or rules of procedure and evidence as if the medical records were in the possession of a nongovernmental medical care provider.

Section 37. **Effective date.**

The amendments in this act to Section 63-2-302 (Effective 07/01/03) take effect on July 1, 2003.