LEGISLATIVE GENERAL COUNSEL
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₵ 02-19-04 1:15 PM ₵

H.B. 245
1st Sub. (Buff)

Senator Thomas V. Hatch proposes the following substitute bill:

INSURANCE LAW REVISIONS

2004 GENERAL SESSION

STATE OF UTAH

Sponsor: James A. Ferrin

LONG TITLE

General Description:

This bill modifies the Insurance Code.

Highlighted Provisions:

This bill:

- modifies definition provisions;
- addresses examination costs;
- addresses confidentiality and distribution of certain records or documents;
- corrects cross references;
- addresses extension of the deadline for filing fee payments for annual statements;
- addresses use of technical experts in evaluating mergers and acquisitions;
- prohibits certain activities related to Social Security numbers;
- addresses the deposit of funds by a licensee;
- modifies trust obligations for funds collected;
- addresses grounds for probation;
- modifies trust obligations for funds collected;
- modifies the Comprehensive Health Insurance Pool Act including:
  - defining terms;
  - expanding the board;
  - addressing eligibility;

- addressing preexisting conditions;
- addressing deductibles and copayments; and
- repealing employee contribution provisions;

▸ enacts the Federal Health Care Tax Credit Program Act; **§ [~~and~~]**

▸ **PROVIDES A REPEAL DATE FOR THE FEDERAL HEALTH CARE TAX CREDIT PROGRAM ACT; AND §**

▸ makes technical changes.

Monies Appropriated in this Bill:

None

Other Special Clauses:

This bill provides an effective date.

This bill provides revisor instructions.

Utah Code Sections Affected:

AMENDS:

31A-1-301, as last amended by Chapters 131 and 298, Laws of Utah 2003

31A-2-205, as last amended by Chapter 298, Laws of Utah 2003

31A-2-207, as last amended by Chapter 259, Laws of Utah 1991

31A-2-309, as last amended by Chapter 298, Laws of Utah 2003

31A-4-113, as last amended by Chapter 116, Laws of Utah 2001

31A-8-103, as last amended by Chapter 298, Laws of Utah 2003

31A-16-103, as last amended by Chapter 1, Laws of Utah 2000

31A-23a-112, as renumbered and amended by Chapter 298, Laws of Utah 2003

31A-23a-409, as renumbered and amended by Chapter 298, Laws of Utah 2003

31A-29-103, as last amended by Chapter 168, Laws of Utah 2003

31A-29-104, as last amended by Chapter 168, Laws of Utah 2003

31A-29-111, as last amended by Chapter 168, Laws of Utah 2003

31A-29-112, as last amended by Chapter 168, Laws of Utah 2003

31A-29-113, as last amended by Chapter 168, Laws of Utah 2003

31A-29-114, as last amended by Chapter 168, Laws of Utah 2003

31A-29-115, as last amended by Chapter 168, Laws of Utah 2003

31A-30-103, as last amended by Chapters 114 and 308, Laws of Utah 2002

31A-30-108, as last amended by Chapter 308, Laws of Utah 2002

63-55b-131, as last amended by Chapter 298, Laws of Utah 2003

ENACTS:

31A-21-110, Utah Code Annotated 1953

31A-38-101, Utah Code Annotated 1953

31A-38-102, Utah Code Annotated 1953

31A-38-103, Utah Code Annotated 1953

31A-38-104, Utah Code Annotated 1953

REPEALS:

31A-29-118, as enacted by Chapter 232, Laws of Utah 1990

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

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

31A-1-301. Definitions.

As used in this title, unless otherwise specified:

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

(i) a medical condition including:

(A) medical care expenses; or

(B) the risk of disability;

(ii) accident; or

(iii) sickness.

(b) "Accident and health insurance":

(i) includes a contract with disability contingencies including:

(A) an income replacement contract;

(B) a health care contract;

(C) an expense reimbursement contract;

(D) a credit accident and health contract;

(E) a continuing care contract; and

(F) a long-term care [~~contracts~~] contract; and

(ii) may provide:

(A) hospital coverage;

(B) surgical coverage;

(C) medical coverage; or

(D) loss of income coverage.

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

(2) "Actuary" is as defined by the commissioner by rule, made in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act.

(3) "Administrator" is defined in Subsection [~~(149)~~] (150).

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

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

(6) "Agency" means:

(a) a person other than an individual, including a sole proprietorship by which a natural person does business under an assumed name; and

(b) an insurance organization licensed or required to be licensed under Section 31A-23a-301.

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

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

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

(10) "Application" means a document:

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

[~~(b)~~] (ii) that contains information that is used by the insurer to[~~: (i)~~] evaluate risk[~~;~~] and [~~(ii)~~] decide whether to:

(A) insure the risk under:

(I) the coverages as originally offered; or

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

(B) decline to insure the risk[~~.~~]; or

(b) used by the insurer to gather information from the applicant before issuance of an

annuity contract.

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

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

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

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

(15) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity.

(16) "Business of insurance" is defined in Subsection [~~(80)~~] (81).

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

(a) Section 31A-7-201;

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

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

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

(19) "Captive insurance company" means:

(a) an insurance company:

(i) owned by another organization; and

(ii) whose exclusive purpose is to insure risks of the parent organization and affiliated companies; or

(b) in the case of groups and associations, an insurance organization:

(i) owned by the insureds; and

(ii) whose exclusive purpose is to insure risks of:

(A) member organizations;

(B) group members; and

(C) affiliates of:

(I) member organizations; or

(II) group members.

(20) "Casualty insurance" means liability insurance as defined in Subsection [~~(90)~~] (91).

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

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

(b) a third party.

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

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

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

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

(b) When appropriate, the terms listed in Subsection (25)(a) apply to the equivalent supervisory official of another jurisdiction.

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

(i) provides board and lodging;

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

(A) personal services;

(B) nursing services;

(C) medical services; or

(D) other health-related services; and

(iii) provides the coverage described in Subsection (26)(a)(i) under an agreement effective:

(A) for the life of the insured; or

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

(b) Insurance is continuing care insurance regardless of whether or not the board and lodging are provided at the same location as the services described in Subsection (26)(a)(ii).

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

(i) by contract;

(ii) by common management;

(iii) through the ownership of voting securities; or

(iv) by a means other than those described in Subsections (27)(a)(i) through (iii).

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

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

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

(28) "Controlled insurer" means a licensed insurer that is either directly or indirectly controlled by a producer.

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

(30) "Controlling producer" means a producer who directly or indirectly controls an insurer.

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

(i) a corporation doing business:

(A) as:

(I) an insurance producer[~~,~~];

(II) a limited line producer[~~,~~];

(III) a consultant[~~,~~];

(IV) a managing general agent[~~,~~];

(V) a reinsurance intermediary[~~,~~];

(VI) a third party administrator[~~,~~]; or

(VII) an adjuster; and

(B) under:

[~~(A)~~] (I) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries;

[~~(B)~~] (II) Chapter 25, Third Party Administrators; [~~and~~] or

[~~(C)~~] (III) Chapter 26, Insurance Adjusters; or

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

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

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

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

(33) (a) "Credit insurance" means insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation.

(b) "Credit insurance" includes:

(i) credit accident and health insurance;

(ii) credit life insurance;

(iii) credit property insurance;

(iv) credit unemployment insurance;

(v) guaranteed automobile protection insurance;

(vi) involuntary unemployment insurance;

(vii) mortgage accident and health insurance;

(viii) mortgage guaranty insurance; and

(ix) mortgage life insurance.

(34) "Credit life insurance" means insurance on the life of a debtor in connection with an extension of credit that pays a person if the debtor dies.

(35) "Credit property insurance" means insurance:

(a) offered in connection with an extension of credit; and

(b) that protects the property until the debt is paid.

(36) "Credit unemployment insurance" means insurance:

(a) offered in connection with an extension of credit; and

(b) that provides indemnity if the debtor is unemployed for payments coming due on a:

(i) specific loan; or

(ii) credit transaction.

(37) "Creditable coverage" is as defined in 45 C.F.R. 146.113(a).

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

(a) matured;

(b) unmatured;

(c) liquidated;

(d) unliquidated;

(e) secured;

(f) unsecured;

(g) absolute;

(h) fixed; or

(i) contingent.

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

(i) for the customer service representative's:

(A) producer; or

(B) consultant employer; and

(ii) to the customer service representative's employer's:

(A) customer[-];

(B) client[-]; or

(C) organization.

(b) A customer service representative may only operate within the scope of authority of the customer service representative's producer or consultant employer.

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

(a) imposed by:

(i) statute;

(ii) rule; or

(iii) order; and

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

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

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

(43) "Department" means the Insurance Department.

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

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

(a) perform the duties of:

(i) that individual's occupation; or

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

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

(i) eating;

(ii) toileting;

(iii) transferring;

(iv) bathing; or

(v) dressing.

(46) "Disability income insurance" is defined in Subsection [~~(71)~~] (72).

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

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

(a) is incorporated;

(b) is organized; or

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

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

(i) an employee who:

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

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

(ii) a person described in Subsection (49)(b).

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

(i) a sole proprietor;

(ii) a partner in a partnership; or

(iii) an independent contractor.

(c) "Eligible employee" does not include, unless eligible under Subsection (49)(b):

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

(ii) an employer's spouse; or

(iii) a dependent of an employer.

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

(51) "Employee benefits" means one or more benefits or services provided to:

(a) employees; or

(b) dependents of employees.

(52) (a) "Employee welfare fund" means a fund:

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

(A) one or more employers;

(B) one or more labor organizations; or

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

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

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

(53) "Endorsement" means a written agreement attached to a policy or certificate to modify one or more of the provisions of the policy or certificate.

(54) (a) "Escrow" means:

(i) a real estate settlement or real estate closing conducted by a third party pursuant to the requirements of a written agreement between the parties in a real estate transaction; or

(ii) a settlement or closing involving:

(A) a mobile home;

(B) a grazing right;

(C) a water right; or

(D) other personal property authorized by the commissioner.

(b) "Escrow" includes the act of conducting a:

(i) real estate settlement; or

(ii) real estate closing.

(55) "Escrow agent" means:

(a) an insurance producer with:

(i) a title insurance line of authority; and

(ii) an escrow subline of authority; or

(b) a person defined as an escrow agent in Section 7-22-101.

[~~(55)~~] (56) "Excludes" is not exhaustive and does not mean that other things are not also excluded. The items listed are representative examples for use in interpretation of this title.

[~~(56)~~] (57) "Expense reimbursement insurance" means insurance:

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

(b) written:

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

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

[~~(57)~~] (58) "Fidelity insurance" means insurance guaranteeing the fidelity of persons holding positions of public or private trust.

[~~(58)~~] (59) (a) "Filed" means that a filing is:

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

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

(iii) accompanied by the appropriate fee in accordance with:

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

(B) rule.

(b) "Filed" does not include a filing that is rejected by the department because it is not submitted in accordance with Subsection [~~(58)~~] (59)(a).

[~~(59)~~] (60) "Filing," when used as a noun, means an item required to be filed with the department including:

(a) a policy;

(b) a rate;

(c) a form;

(d) a document;

(e) a plan;

(f) a manual;

(g) an application;

(h) a report;

(i) a certificate;

(j) an endorsement;

(k) an actuarial certification;

(l) a licensee annual statement;

(m) a licensee renewal application; or

(n) an advertisement.

[~~(60)~~] (61) "First party insurance" means an insurance policy or contract in which the insurer agrees to pay claims submitted to it by the insured for the insured's losses.

[~~(61)~~] (62) "Foreign insurer" means an insurer domiciled outside of this state, including an alien insurer.

[~~(62)~~] (63) (a) "Form" means one of the following prepared for general use:

(i) a policy;

(ii) a certificate;

(iii) an application; or

(iv) an outline of coverage.

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

[~~(63)~~] (64) "Franchise insurance" means individual insurance policies provided through

a mass marketing arrangement involving a defined class of persons related in some way other than through the purchase of insurance.

[~~(64)~~] (65) "General lines of authority" include:

(a) the general lines of insurance in Subsection [~~(65)~~] (66);

(b) title insurance under one of the following sublines of authority:

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

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

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

(iv) title marketing representative only;

(c) surplus lines;

(d) workers' compensation; and

(e) any other line of insurance that the commissioner considers necessary to recognize in the public interest.

[~~(65)~~] (66) "General lines of insurance" include:

(a) accident and health;

(b) casualty;

(c) life;

(d) personal lines;

(e) property; and

(f) variable contracts, including variable life and annuity.

[~~(66)~~] (67) "Group health plan" means an employee welfare benefit plan to the extent that the plan provides medical care:

(a) (i) to employees; or

(ii) to a dependent of an employee; and

(b) (i) directly;

(ii) through insurance reimbursement; or

(iii) through any other method.

[~~(67)~~] (68) "Guaranteed automobile protection insurance" means insurance offered in connection with an extension of credit that pays the difference in amount between the insurance settlement and the balance of the loan if the insured automobile is a total loss.

[~~(68) "Health~~] (69) (a) Except as provided in Subsection (69)(b), "health benefit plan" means a policy or certificate [~~for~~] that:

(i) provides health care insurance[~~, except that health benefit plan does not include coverage:~~];

(ii) provides major medical expense insurance; or

(iii) is offered as a substitute for hospital or medical expense insurance such as:

(A) a hospital confinement indemnity; or

(B) a limited benefit plan.

(b) "Health benefit plan" does not include a policy or certificate that:

[~~(a)~~] (i) provides benefits solely for:

[~~(i)~~] (A) accident;

[~~(ii)~~] (B) dental;

(C) income replacement;

(D) long-term care;

(E) a Medicare supplement;

(F) a specified disease;

[~~(iii)~~] (G) vision; or

[~~(iv) Medicare supplement;~~]

[~~(v) long-term care; or~~]

[~~(vi) income replacement; or~~]

[~~(b) that is:~~]

(H) a short-term limited duration; or

[~~(i)~~] (ii) is offered and marketed as supplemental health insurance[~~;~~].

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

[~~(A) hospital or medical expense insurance; or~~]

[~~(B) major medical expense insurance; and~~]

[~~(iii) solely for:~~]

[~~(A) a specified disease;~~]

[~~(B) hospital confinement indemnity; or~~]

[~~(C) limited benefit plan.~~]

[~~(69)~~] (70) "Health care" means any of the following intended for use in the diagnosis,

treatment, mitigation, or prevention of a human ailment or impairment:

(a) professional services;

(b) personal services;

(c) facilities;

(d) equipment;

(e) devices;

(f) supplies; or

(g) medicine.

[~~(70)~~] (71) (a) "Health care insurance" or "health insurance" means insurance providing:

(i) health care benefits; or

(ii) payment of incurred health care expenses.

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

(i) replacement of income;

(ii) short-term accident;

(iii) fixed indemnity;

(iv) credit accident and health;

(v) supplements to liability;

(vi) workers' compensation;

(vii) automobile medical payment;

(viii) no-fault automobile;

(ix) equivalent self-insurance; or

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

[~~(71)~~] (72) "Income replacement insurance" or "disability income insurance" means insurance written to provide payments to replace income lost from accident or sickness.

[~~(72)~~] (73) "Indemnity" means the payment of an amount to offset all or part of an insured loss.

[~~(73)~~] (74) "Independent adjuster" means an insurance adjuster required to be licensed under Section 31A-26-201 who engages in insurance adjusting as a representative of insurers.

[~~(74)~~] (75) "Independently procured insurance" means insurance procured under Section 31A-15-104.

[~~(75)~~] (76) "Individual" means a natural person.

[~~(76)~~] (77) "Inland marine insurance" includes insurance covering:

(a) property in transit on or over land;

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

(c) bailee liability;

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

(e) personal and commercial property floaters.

[~~(77)~~] (78) "Insolvency" means that:

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

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

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

[~~(78)~~] (79) (a) "Insurance" means:

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

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

(b) "Insurance" includes:

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

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

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

[~~(79)~~] (80) "Insurance adjuster" means a person who directs the investigation, negotiation, or settlement of a claim under an insurance policy other than life insurance or an annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.

[~~(80)~~] (81) "Insurance business" or "business of insurance" includes:

(a) providing health care insurance, as defined in Subsection [~~(70)~~] (71), by organizations that are or should be licensed under this title;

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

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

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

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

(d) providing the characteristic services of motor clubs as outlined in Subsection [~~(106)~~] (107);

(e) providing other persons with insurance as defined in Subsection [~~(78)~~] (79);

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

(g) transacting or proposing to transact any phase of title insurance, including:

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

(ii) negotiation preliminary to execution[~~,~~];

(iii) execution of a contract of title insurance[~~,~~];

(iv) insuring[~~,~~]; and

(v) transacting matters subsequent to the execution of the contract and arising out of [~~it~~] the contract, including reinsurance; and

(h) doing, or proposing to do, any business in substance equivalent to Subsections [~~(80)~~] (81)(a) through (g) in a manner designed to evade the provisions of this title.

[~~(81)~~] (82) "Insurance consultant" or "consultant" means a person who:

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

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

(c) except as provided in Section 31A-23a-501, is not compensated directly or indirectly by an insurer or producer for advice given.

[~~(82)~~] (83) "Insurance holding company system" means a group of two or more affiliated persons, at least one of whom is an insurer.

[~~(83)~~] (84) (a) "Insurance producer" or "producer" means a person licensed or required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

(b) With regards to the selling, soliciting, or negotiating of an insurance product to an insurance customer or an insured:

(i) "producer for the insurer" means a producer who is compensated directly or indirectly by an insurer for selling, soliciting, or negotiating any product of that insurer; and

(ii) "producer for the insured" means a producer who:

(A) is compensated directly and only by an insurance customer or an insured; and

(B) receives no compensation directly or indirectly from an insurer for selling, soliciting, or negotiating any product of that insurer to an insurance customer or insured.

[~~(84)~~] (85) (a) "Insured" means a person to whom or for whose benefit an insurer makes a promise in an insurance policy and includes:

(i) policyholders;

(ii) subscribers;

(iii) members; and

(iv) beneficiaries.

(b) The definition in Subsection [~~(84)~~] (85)(a):

(i) applies only to this title; and

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

[~~(85)~~] (86) (a) (i) "Insurer" means any person doing an insurance business as a principal including:

(A) fraternal benefit societies;

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

(C) motor clubs;

(D) employee welfare plans; and

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

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

(b) "Admitted insurer" is defined in Subsection [~~(153)~~] (154)(b).

(c) "Alien insurer" is defined in Subsection (7).

(d) "Authorized insurer" is defined in Subsection [~~(153)~~] (154)(b).

(e) "Domestic insurer" is defined in Subsection (47).

(f) "Foreign insurer" is defined in Subsection [~~(61)~~] (62).

(g) "Nonadmitted insurer" is defined in Subsection [~~(153)~~] (154)(a).

(h) "Unauthorized insurer" is defined in Subsection [~~(153)~~] (154)(a).

[~~(86)~~] (87) "Interinsurance exchange" is defined in Subsection [~~(135)~~] (136).

[~~(87)~~] (88) "Involuntary unemployment insurance" means insurance:

(a) offered in connection with an extension of credit;

(b) that provides indemnity if the debtor is involuntarily unemployed for payments coming due on a:

(i) specific loan; or

(ii) credit transaction.

[~~(88)~~] (89) "Large employer," in connection with a health benefit plan, means an employer who, with respect to a calendar year and to a plan year:

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

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

[~~(89)~~] (90) (a) Except for a retainer contract or legal assistance described in Section 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for specified legal expenses.

(b) "Legal expense insurance" includes arrangements that create reasonable expectations of enforceable rights.

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

[~~(90)~~] (91) (a) "Liability insurance" means insurance against liability:

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

(A) Subsection [~~(100)~~] (101) for medical malpractice insurance;

(B) Subsection [~~(127)~~] (128) for professional liability insurance; and

(C) Subsection [~~(157)~~] (158) for workers' compensation insurance;

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

(A) Subsection [~~(100)~~] (101) for medical malpractice insurance;

(B) Subsection [~~(127)~~] (128) for professional liability insurance; and

(C) Subsection [~~(157)~~] (158) for workers' compensation insurance;

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

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

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

(b) "Liability insurance" includes:

(i) vehicle liability insurance as defined in Subsection [~~(155)~~] (156);

(ii) residential dwelling liability insurance as defined in Subsection [~~(138)~~] (139); and

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

[~~(91)~~] (92) (a) "License" means the authorization issued by the commissioner to engage in some activity that is part of or related to the insurance business.

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

[~~(92)~~] (93) (a) "Life insurance" means insurance on human lives and insurances pertaining to or connected with human life.

(b) The business of life insurance includes:

(i) granting death benefits;

(ii) granting annuity benefits;

(iii) granting endowment benefits;

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

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

(vi) providing optional methods of settlement of proceeds.

[~~(93)~~] (94) "Limited license" means a license that:

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

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

[~~(94)~~] (95) "Limited line credit insurance" includes the following forms of insurance:

(a) credit life;

(b) credit accident and health;

(c) credit property;

(d) credit unemployment;

(e) involuntary unemployment;

(f) mortgage life;

(g) mortgage guaranty;

(h) mortgage accident and health;

(i) guaranteed automobile protection; and

(j) any other form of insurance offered in connection with an extension of credit that:

(i) is limited to partially or wholly extinguishing the credit obligation; and

(ii) the commissioner determines by rule should be designated as a form of limited line credit insurance.

[~~(95)~~] (96) "Limited line credit insurance producer" means a person who sells, solicits, or negotiates one or more forms of limited line credit insurance coverage to individuals through a master, corporate, group, or individual policy.

[~~(96)~~] (97) "Limited line insurance" includes:

(a) bail bond;

(b) limited line credit insurance;

(c) legal expense insurance;

(d) motor club insurance;

(e) rental car-related insurance;

(f) travel insurance; and

(g) any other form of limited insurance that the commissioner determines by rule

should be designated a form of limited line insurance.

[~~(97)~~] (98) "Limited lines authority" includes:

(a) the lines of insurance listed in Subsection [~~(96)~~] (97); and

(b) a customer service representative.

[~~(98)~~] (99) "Limited lines producer" means a person who sells, solicits, or negotiates limited lines insurance.

[~~(99)~~] (100) (a) "Long-term care insurance" means an insurance policy or rider advertised, marketed, offered, or designated to provide coverage:

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

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

(A) expenses incurred;

(B) indemnity;

(C) prepayment; or

(D) another method;

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

(A) diagnostic;

(B) preventative;

(C) therapeutic;

(D) rehabilitative;

(E) maintenance; or

(F) personal care; and

(iv) that may be issued by:

(A) an insurer;

(B) a fraternal benefit society;

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

(II) a medical service corporation;

(D) a prepaid health plan;

(E) a health maintenance organization; or

(F) an entity similar to the entities described in Subsections [~~(99)~~] (100)(a)(iv)(A) through (E) to the extent that the entity is otherwise authorized to issue life or health care insurance.

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

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

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

(B) a life insurance policy or rider;

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

(A) cognitive impairment; or

(B) functional capacity; or

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

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

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

(ii) basic hospital expense coverage;

(iii) basic medical/surgical expense coverage;

(iv) hospital confinement indemnity coverage;

(v) major medical expense coverage;

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

(vii) accident only coverage;

(viii) coverage for a specified:

(A) disease; or

(B) accident;

(ix) limited benefit health coverage; or

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

(A) if the following are not conditioned on the receipt of long-term care:

(I) benefits; or

(II) eligibility; and

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

(I) terminal illness;

(II) medical conditions requiring extraordinary medical intervention; or

(III) permanent institutional confinement.

[~~(100)~~] (101) "Medical malpractice insurance" means insurance against legal liability incident to the practice and provision of medical services other than the practice and provision

of dental services.

[~~(101)~~] (102) "Member" means a person having membership rights in an insurance corporation.

[~~(102)~~] (103) "Minimum capital" or "minimum required capital" means the capital that must be constantly maintained by a stock insurance corporation as required by statute.

[~~(103)~~] (104) "Mortgage accident and health insurance" means insurance offered in connection with an extension of credit that provides indemnity for payments coming due on a mortgage while the debtor is disabled.

[~~(104)~~] (105) "Mortgage guaranty insurance" means surety insurance under which mortgagees and other creditors are indemnified against losses caused by the default of debtors.

[~~(105)~~] (106) "Mortgage life insurance" means insurance on the life of a debtor in connection with an extension of credit that pays if the debtor dies.

[~~(106)~~] (107) "Motor club" means a person:

(a) licensed under:

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

(ii) Chapter 11, Motor Clubs; or

(iii) Chapter 14, Foreign Insurers; and

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

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

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

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

[~~(107)~~] (108) "Mutual" means a mutual insurance corporation.

[~~(108)~~] (109) "Network plan" means health care insurance:

(a) that is issued by an insurer; and

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

[~~(109)~~] (110) "Nonparticipating" means a plan of insurance under which the insured is not entitled to receive dividends representing shares of the surplus of the insurer.

[~~(110)~~] (111) "Ocean marine insurance" means insurance against loss of or damage to:

(a) ships or hulls of ships;

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

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

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

[~~(111)~~] (112) "Order" means an order of the commissioner.

[~~(112)~~] (113) "Outline of coverage" means a summary that explains an accident and health insurance policy.

[~~(113)~~] (114) "Participating" means a plan of insurance under which the insured is entitled to receive dividends representing shares of the surplus of the insurer.

[~~(114)~~] (115) "Participation," as used in a health benefit plan, means a requirement relating to the minimum percentage of eligible employees that must be enrolled in relation to the total number of eligible employees of an employer reduced by each eligible employee who voluntarily declines coverage under the plan because the employee has other group health care insurance coverage.

[~~(115)~~] (116) "Person" includes an individual, partnership, corporation, incorporated or unincorporated association, joint stock company, trust, limited liability company, reciprocal, syndicate, or any similar entity or combination of entities acting in concert.

[~~(116)~~] (117) "Personal lines insurance" means property and casualty insurance coverage sold for primarily noncommercial purposes to:

(a) individuals; and

(b) families.

[~~(117)~~] (118) "Plan sponsor" is as defined in 29 U.S.C. Sec. 1002(16)(B).

[~~(118)~~] (119) "Plan year" means:

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

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

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

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

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

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

(iii) the employer's taxable year if:

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

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

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

(c) in a case not described in Subsection [~~(118)~~] (119)(a) or (b), the calendar year.

[~~(119)~~] (120) (a) (i) "Policy" means any document, including attached endorsements and riders, purporting to be an enforceable contract, which memorializes in writing some or all of the terms of an insurance contract.

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

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

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

(C) a corporation licensed under:

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

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

(iii) "Policy" does not include:

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

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

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

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

(c) "Blanket insurance policy" means a group policy covering classes of persons without individual underwriting, where the persons insured are determined by definition of the

class with or without designating the persons covered.

[~~(120)~~] (121) "Policyholder" means the person who controls a policy, binder, or oral contract by ownership, premium payment, or otherwise.

[~~(121)~~] (122) "Policy illustration" means a presentation or depiction that includes nonguaranteed elements of a policy of life insurance over a period of years.

[~~(122)~~] (123) "Policy summary" means a synopsis describing the elements of a life insurance policy.

[~~(123)~~] (124) "Preexisting condition," in connection with a health benefit plan, means:

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

(i) the enrollment date; or

(ii) the effective date of coverage; or

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

[~~(124)~~] (125) (a) "Premium" means the monetary consideration for an insurance policy[~~, and~~].

(b) "Premium" includes, however designated:

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

(ii) membership fees[~~,~~];

(iii) required contributions[~~,~~]; or

(iv) monetary consideration[~~, however designated~~].

[~~(b)~~] (c) (i) Consideration paid to third party administrators for their services is not "premium[~~,~~]." [~~though amounts~~]

(ii) Amounts paid by third party administrators to insurers for insurance on the risks administered by the third party administrators are "premium."

[~~(125)~~] (126) "Principal officers" of a corporation means the officers designated under Subsection 31A-5-203(3).

[~~(126)~~] (127) "Proceedings" includes actions and special statutory proceedings.

[~~(127)~~] (128) "Professional liability insurance" means insurance against legal liability incident to the practice of a profession and provision of any professional services.

[~~(128)~~] (129) "Property insurance" means insurance against loss or damage to real or

personal property of every kind and any interest in that property, from all hazards or causes, and against loss consequential upon the loss or damage including vehicle comprehensive and vehicle physical damage coverages, but excluding inland marine insurance and ocean marine insurance as defined under Subsections [~~(76)~~] (77) and [~~(110)~~] (111).

[~~(129)~~] (130) "Qualified long-term care insurance contract" or "federally tax qualified long-term care insurance contract" means:

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

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

(i) (A) by rider; or

(B) as a part of the contract; and

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

[~~(130)~~] (131) "Qualified United States financial institution" means an institution that:

(a) is:

(i) organized under the laws of the United States or any state; or

(ii) in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or any state;

(b) is regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

(c) meets the standards of financial condition and standing that are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner as determined by:

(i) the commissioner by rule; or

(ii) the Securities Valuation Office of the National Association of Insurance Commissioners.

[~~(131)~~] (132) (a) "Rate" means:

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

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

(A) a single number; or

(B) a pure premium rate, adjusted before any application of individual risk variations

based on loss or expense considerations to account for the treatment of:

(I) expenses;

(II) profit; and

(III) individual insurer variation in loss experience.

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

[~~(132)~~] (133) (a) Except as provided in Subsection [~~(132)~~] (133)(b), "rate service organization" means any person who assists insurers in rate making or filing by:

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

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

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

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

(i) an employee of an insurer;

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

(iii) a joint underwriting group; or

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

[~~(133)~~] (134) "Rating manual" means any of the following used to determine initial and renewal policy premiums:

(a) a manual of rates;

(b) classifications;

(c) rate-related underwriting rules; and

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

[~~(134)~~] (135) "Received by the department" means:

(a) except as provided in Subsection [~~(134)~~] (135)(b), the date delivered to and stamped received by the department, whether delivered:

(i) in person; or

(ii) electronically; and

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

(i) statute;

(ii) rule; or

(iii) a specific filing order.

[~~(135)~~] (136) "Reciprocal" or "interinsurance exchange" means any unincorporated association of persons:

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

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

[~~(136)~~] (137) "Reinsurance" means an insurance transaction where an insurer, for consideration, transfers any portion of the risk it has assumed to another insurer. In referring to reinsurance transactions, this title sometimes refers to:

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

(b) the insurer assuming the risk as the:

(i) "assuming insurer"; or

(ii) "assuming reinsurer."

[~~(137)~~] (138) "Reinsurer" means any person[~~, firm, association, or corporation~~] licensed in this state as an insurer with the authority to assume reinsurance.

[~~(138)~~] (139) "Residential dwelling liability insurance" means insurance against liability resulting from or incident to the ownership, maintenance, or use of a residential dwelling that is a detached single family residence or multifamily residence up to four units.

[~~(139)~~] (140) "Retrocession" means reinsurance with another insurer of a liability assumed under a reinsurance contract. A reinsurer "retrocedes" when it reinsures with another insurer part of a liability assumed under a reinsurance contract.

[~~(140)~~] (141) "Rider" means an endorsement to:

(a) an insurance policy; or

(b) an insurance certificate.

[~~(141)~~] (142) (a) "Security" means any:

(i) note;

(ii) stock;

(iii) bond;

(iv) debenture;

(v) evidence of indebtedness;

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

(vii) collateral-trust certificate;

(viii) preorganization certificate or subscription;

(ix) transferable share;

(x) investment contract;

(xi) voting trust certificate;

(xii) certificate of deposit for a security;

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

(xiv) commodity contract or commodity option;

(xv) any certificate of interest or participation in, temporary or interim certificate for, receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed in Subsections [~~(141)~~] (142)(a)(i) through (xiv); or

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

(b) "Security" does not include:

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

(A) insurance;

(B) endowment policy; or

(C) annuity contract; or

(ii) a burial certificate or burial contract.

[~~(142)~~] (143) "Self-insurance" means any arrangement under which a person provides for spreading its own risks by a systematic plan.

(a) Except as provided in this Subsection [~~(142)~~] (143), "self-insurance" does not include an arrangement under which a number of persons spread their risks among themselves.

(b) "Self-insurance" [~~does include~~] includes:

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

~~(c) Self-insurance does include~~]; and

(ii) an arrangement by which a person with a managed program of self-insurance and risk management undertakes to indemnify its affiliates, subsidiaries, directors, officers, or

employees for liability or risk which is related to the relationship or employment.

[~~(d)~~] (c) "Self-insurance" does not include any arrangement with independent contractors.

[~~(143)~~] (144) "Sell" means to exchange a contract of insurance:

(a) by any means;

(b) for money or its equivalent; and

(c) on behalf of an insurance company.

[~~(144)~~] (145) "Short-term care insurance" means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage that is similar to long-term care insurance but that provides coverage for less than 12 consecutive months for each covered person.

[~~(145)~~] (146) "Small employer," in connection with a health benefit plan, means an employer who, with respect to a calendar year and to a plan year:

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

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

[~~(146)~~] (147) (a) "Subsidiary" of a person means an affiliate controlled by that person either directly or indirectly through one or more affiliates or intermediaries.

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

[~~(147)~~] (148) Subject to Subsection [~~(78)~~] (79)(b), "surety insurance" includes:

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

(b) bail bond insurance; and

(c) fidelity insurance.

[~~(148)~~] (149) (a) "Surplus" means the excess of assets over the sum of paid-in capital and liabilities.

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

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

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

(c) "Excess surplus" means:

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

(A) that amount of an insurer's or health organization's total adjusted capital, as defined in Subsection [~~(151)~~] (152), that exceeds the product of:

(I) 2.5; and

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

(B) that amount of an insurer's or health organization's total adjusted capital, as defined in Subsection [~~(151)~~] (152), that exceeds the product of:

(I) 3.0; and

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

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

(A) 1.5; and

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

[~~(149)~~] (150) "Third party administrator" or "administrator" means any person who collects charges or premiums from, or who, for consideration, adjusts or settles claims of residents of the state in connection with insurance coverage, annuities, or service insurance coverage, except:

(a) a union on behalf of its members;

(b) a person administering any:

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

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

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

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

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

(e) a person:

(i) licensed or exempt from licensing under:

(A) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries[~~,~~]; or

(B) Chapter 26, Insurance Adjusters[~~,~~]; and

(ii) whose activities are limited to those authorized under the license the person holds or for which the person is exempt.

[~~(150)~~] (151) "Title insurance" means the insuring, guaranteeing, or indemnifying of owners of real or personal property or the holders of liens or encumbrances on that property, or others interested in the property against loss or damage suffered by reason of liens or encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity or unenforceability of any liens or encumbrances on the property.

[~~(151)~~] (152) "Total adjusted capital" means the sum of an insurer's or health organization's statutory capital and surplus as determined in accordance with:

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

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

[~~(152)~~] (153) (a) "Trustee" means "director" when referring to the board of directors of a corporation.

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

[~~(153)~~] (154) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted insurer" means an insurer:

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

or

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

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

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

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

[~~(154)~~] (155) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

[~~(155)~~] (156) "Vehicle liability insurance" means insurance against liability resulting from or incident to ownership, maintenance, or use of any land vehicle or aircraft, exclusive of vehicle comprehensive and vehicle physical damage coverages under Subsection [~~(128)~~] (129).

[~~(156)~~] (157) "Voting security" means a security with voting rights, and includes any security convertible into a security with a voting right associated with [~~it~~] the security.

[~~(157)~~] (158) "Workers' compensation insurance" means:

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

(i) compensable accidental injuries; and

(ii) occupational disease disability;

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

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

Section 2. Section **31A-2-205** is amended to read:

31A-2-205. Examination costs.

(1) (a) Except as provided in Subsection (3), [~~examinees that are insurers~~] an examinee that is an insurer, rate service [~~organizations~~] organization, or the [~~subsidiaries~~] subsidiary of either shall reimburse the [~~Insurance Department~~] department for the reasonable costs of examinations made under Sections 31A-2-203 and 31A-2-204. The following costs shall be reimbursed:

(i) actual travel expenses;

(ii) reasonable living expense allowance;

(iii) compensation at reasonable rates for all professionals reasonably employed for the

examination under Subsection (4);

(iv) the administration and supervisory expense of:

(A) the [~~Insurance Department~~] department; and

(B) the attorney general's office; and

(v) an amount necessary to cover fringe benefits authorized by the commissioner or provided by law.

(b) In determining rates, the commissioner shall consider the rates recommended [~~by the National Association of Insurance Commissioners~~] and outlined in the examination manual sponsored by the [~~association~~] National Association of Insurance Commissioners.

[~~(b)~~] (c) This Subsection (1) applies to a surplus lines [~~producers~~] producer to the extent that the examinations are of [~~their~~] the surplus line producer's surplus lines business.

(2) An insurer requesting the examination of one of its producers shall pay the cost of the examination. Otherwise, the department shall pay the cost of examining [~~licensees~~] a licensee other than those specified under Subsection (1).

(3) (a) On the examinee's request or at the commissioner's discretion, the [~~Insurance Department~~] department may pay all or part of the costs of an examination whenever the commissioner finds that because of the frequency of examinations or the financial condition of the examinee, imposition of the costs would place an unreasonable burden on the examinee.

(b) The commissioner shall include in [~~his~~] the commissioner's annual report information about any instance in which the commissioner has applied this Subsection (3).

(4) (a) [~~Technical experts~~] A technical expert employed under Subsection 31A-2-203(3) shall present to the commissioner a statement of all expenses incurred by [~~them~~] the technical expert in conjunction with an examination.

(b) The examined insurer shall, at the commissioner's direction, pay to the technical experts or specialists the:

(i) actual travel expenses[~~,~~];

(ii) reasonable living expenses[~~,~~]; and

(iii) compensation at customary rates for expenses necessarily incurred as approved by the commissioner.

(c) The examined insurer shall reimburse:

(i) department examiners for their:

(A) actual travel expenses; and

(B) reasonable living expenses; and [~~shall reimburse~~]

(ii) the department for the compensation of department examiners involved in the examination.

(d) (i) The examined insurer shall certify the consolidated account of all charges and expenses for the examination. [~~One~~]

(ii) The insurer shall:

(A) retain a copy [~~shall be retained by the insurer and the other shall be filed~~] of the consolidated account; and

(B) file a copy of the consolidated account with the department as a public record.

(e) (i) An annual report of examination charges paid by examined insurers directly to persons employed under Subsection 31A-2-203(3) or to department examiners shall be included with the department's budget request[~~, but amounts~~].

(f) Amounts paid directly by examined insurers to persons employed under Subsection 31A-2-203(3) or to department examiners may not be deducted from the department's appropriation.

(5) (a) The amount payable under Subsection (1) is due ten days after the examinee has been served with a detailed account of the costs.

(b) Payments received by the department under this Subsection (5) shall be handled as provided by [~~Subsection~~] Section 31A-3-101.

(6) (a) The commissioner may require an examinee under Subsection (1), or an insurer requesting an examination under Subsection (2), either before or during an examination, to make deposits with the state treasurer to pay the costs of examination.

(b) Any deposit made under this Subsection (6) shall be held in trust by the state treasurer until applied to pay the [~~Insurance Department~~] department the costs payable under this section.

(c) If a deposit made under this Subsection (6) exceeds examination costs, the state treasurer shall refund the surplus.

(7) [~~Domestic insurers~~] A domestic insurer may offset the examination expenses paid under this section against premium taxes under Subsection 59-9-102(2).

Section 3. Section **31A-2-207** is amended to read:

31A-2-207. Commissioner's records and reports.

(1) The commissioner shall maintain all [~~Insurance Department~~] department records [~~which~~] that are:

(a) required by law;

(b) necessary for the effective operation of the department; or

(c) necessary to maintain a full record of department activities.

(2) The records of the department may be preserved, managed, stored, and made available for review consistent with:

(a) another Utah statute;

(b) the rules made under Section 63-2-904;

(c) the decisions of the State Records Committee made under Title 63, Chapter 2, Government Records Access and Management Act; or

(d) the needs of the public.

(3) [~~No Insurance Department~~] A department record may not be destroyed, damaged, or disposed of without:

(a) authorization of the commissioner; and

(b) compliance with all other applicable laws.

(4) The commissioner shall maintain a permanent record of [~~his~~] the commissioner's proceedings and important activities, including:

(a) a concise statement of the condition of each insurer examined by [~~him,~~] the commissioner; and

(b) a record of all certificates of authority and licenses issued by [~~him~~] the commissioner.

(5) (a) Prior to October 1 of each year, the commissioner shall prepare an annual report to the governor which shall include, for the preceding calendar year, the information concerning the department and the insurance industry which the commissioner believes will be useful to the governor and the public. [~~This~~]

(b) The report required by this Subsection (5) shall include the information required under Chapter 27 and Subsections 31A-2-106(2), 31A-2-205(3), and 31A-2-208(3).

(c) The commissioner shall [~~have this~~] make the report [~~printed in sufficient numbers to meet the expected~~] required by this Subsection (5) available to the public and industry

[~~demand for the document~~] in electronic format.

(6) All department records and reports are open to public inspection unless specifically provided otherwise by statute or by Title 63, Chapter 2, Government Records Access and Management Act.

(7) On request, the commissioner shall provide to any person certified or uncertified copies of any record in the department that is open to public inspection.

(8) Notwithstanding Subsection (6) and Title 63, Chapter 2, Government Records Access and Management Act, the commissioner shall protect from disclosure any record, as defined in Section 63-2-103, or other document received from an insurance regulator of another jurisdiction:

(a) at least to the same extent the record or document is protected from disclosure under the laws applicable to the insurance regulator providing the record or document; or

(b) under the same terms and conditions of confidentiality as the National Association of Insurance Commissioners requires as a condition of participating in any of the National Association of Insurance Commissioners' programs.

Section 4. Section **31A-2-309** is amended to read:

31A-2-309. Service of process through state officer.

(1) The commissioner, or the lieutenant governor when the subject proceeding is brought by the state, is the agent for receipt of service of any summons, notice, order, pleading, or any other legal process relating to a Utah court or administrative agency upon the following:

(a) all insurers authorized to do business in this state, while authorized to do business in this state, and thereafter in any proceeding arising from or related to any transaction having a connection with this state;

(b) all surplus lines insurers for any proceeding arising out of a contract of insurance that is subject to the surplus lines law, or out of a certificate, cover note, or other confirmation of that type of insurance;

(c) all unauthorized insurers or other persons assisting unauthorized insurers under Subsection 31A-15-102(1) by doing an act specified in Subsection 31A-15-102(2), for a proceeding arising out of the transaction that is subject to the unauthorized insurance law;

(d) any nonresident producer, consultant, adjuster, and third party administrator, while authorized to do business in this state, and thereafter in any proceeding arising from or related

to any transaction having a connection with this state; and

(e) any reinsurer submitting to the commissioner's jurisdiction under Subsection 31A-17-404(7).

(2) [~~Each~~] The following is considered to have irrevocably appointed the commissioner and lieutenant governor as that person's agents in accordance with Subsection (1):

(a) each licensed insurer by applying for and receiving a certificate of authority[~~,~~];

(b) each surplus lines insurer by entering into a contract subject to the surplus lines law[~~,~~];

(c) each unauthorized insurer by doing in this state any of the acts prohibited by Section [~~31A-15-101,~~] 31A-15-103; and

(d) each nonresident producer, consultant, adjuster, and third party administrator [~~is considered to have irrevocably appointed the commissioner and lieutenant governor as his agents in accordance with Subsection (1)~~].

(3) The commissioner and lieutenant governor are also agents for the executors, administrators or personal representatives, receivers, trustees, or other successors in interest of the persons specified under Subsection (1).

(4) Litigants serving process on the commissioner or lieutenant governor under this section shall pay the fee applicable under Section 31A-3-103.

(5) The right to substituted service under this section does not limit the right to serve a summons, notice, order, pleading, demand, or other process upon a person in any other manner provided by law.

Section 5. Section **31A-4-113** is amended to read:

31A-4-113. Annual statements.

(1) (a) Each authorized insurer shall annually, on or before March 1, file with the commissioner a true statement of [~~its~~] the authorized insurer's financial condition, transactions, and affairs as of December 31 of the preceding year.

(b) The statement required by Subsection (1)(a) shall be:

(i) verified by the oaths of at least two of the insurer's principal officers; and

(ii) in the general form and provide the information as prescribed by the commissioner by rule.

(c) The commissioner may, for good cause shown, extend the date for filing the

statement required by Subsection (1)(a)[~~, except that the deadline for filing fee payment may not be extended~~].

(2) The annual statement of an alien insurer shall:

(a) relate only to [~~its~~] the alien insurer's transactions and affairs in the United States unless the commissioner requires otherwise; and

(b) be verified by:

(i) the insurer's United States manager; or

(ii) the insurer's authorized officers.

Section 6. Section **31A-8-103** is amended to read:

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

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

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

(i) is wholly exempt from:

(A) Chapter 7, Nonprofit Health Service Insurance Corporations;

(B) Chapter 9, Insurance Fraternals;

(C) Chapter 10, Annuities;

(D) Chapter 11, Motor Clubs;

(E) Chapter 12, State Risk Management Fund;

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

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

(H) Chapter 28, Guaranty Associations; and

(ii) is not subject to:

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

(B) Section 31A-4-107;

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

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

(E) Chapter 17, Determination of Financial Condition, except:

(I) Parts II and VI; or

(II) as made applicable by the commissioner by rule consistent with this chapter;

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

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

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

(a) enrollees;

(b) investors; or

(c) the public.

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

(a) this chapter;

(b) a provision referenced under this chapter; or

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

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

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

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

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

(5) Solicitation of enrollees by an organization is not a violation of any provision of law relating to solicitation or advertising by health professionals if that solicitation is made in accordance with:

(a) this chapter; and

(b) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries.

(6) This title does not prohibit any health maintenance organization from meeting the requirements of any federal law that enables the health maintenance organization to:

(a) receive federal funds; or

(b) obtain or maintain federal qualification status.

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

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

Section 7. Section **31A-16-103** is amended to read:

31A-16-103. Acquisition of control of or merger with domestic insurer -- Required filings -- Content of statement -- Alternative filing materials -- Criminal background information -- Approval by commissioner -- Dissenting shareholders -- Violations -- Jurisdiction, consent to service of process.

(1) (a) A person may not take the actions described in Subsections (1)(b) or (c) unless, at the time any offer, request, or invitation is made or any such agreement is entered into, or prior to the acquisition of securities if no offer or agreement is involved:

(i) the person files with the commissioner a statement containing the information required by this section;

(ii) the person provides a copy of the statement described in Subsection (1)(a)(i) to the insurer; and

(iii) the commissioner approves the offer, request, invitation, agreement, or acquisition.

(b) Unless the person complies with Subsection (1)(a), a person other than the issuer may not make a tender offer for, a request or invitation for tenders of, or enter into any agreement to exchange securities, or seek to acquire or acquire in the open market or otherwise, any voting security of a domestic insurer if after the acquisition, the person would directly, indirectly, by conversion, or by exercise of any right to acquire be in control of the insurer.

(c) Unless the person complies with Subsection (1)(a), a person may not enter into an agreement to merge with or otherwise to acquire control of:

(i) a domestic insurer; or

(ii) any person controlling a domestic insurer.

(d) (i) For purposes of this section, a domestic insurer includes any person controlling a domestic insurer unless the person as determined by the commissioner is either directly or through its affiliates primarily engaged in business other than the business of insurance.

(ii) The controlling person described in Subsection (1)(d)(i) shall file with the commissioner a preacquisition notification containing the information required in Subsection (2) 30 calendar days before the proposed effective date of the acquisition.

(iii) For the purposes of this section, "person" does not include any securities broker [~~holding~~] that in the usual and customary brokers function holds less than 20% of:

(A) the voting securities of an insurance company; or [~~of~~]

(B) any person that controls an insurance company [~~in the usual and customary brokers function~~].

(iv) This section applies to all domestic insurers and other entities licensed under Chapters 5, 7, 8, 9, and 11.

(e) (i) An agreement for acquisition of control or merger as contemplated by this Subsection (1) is not valid or enforceable unless the agreement:

(A) is in writing; and

(B) includes a provision that the agreement is subject to the approval of the commissioner upon the filing of any applicable statement required under this chapter.

(ii) A written agreement for acquisition or control that includes the provision described in Subsection (1)(e)(i) satisfies the requirements of this Subsection (1).

(2) The statement to be filed with the commissioner under Subsection (1) shall be made under oath or affirmation and shall contain the following information:

(a) the name and address of the "acquiring party," which means each person by whom or on whose behalf the merger or other acquisition of control referred to in Subsection (1) is to be effected; and

(i) if the person is an individual:

(A) the person's principal occupation;

(B) a listing of all offices and positions held by the person during the past five years; and

(C) any conviction of crimes other than minor traffic violations during the past ten years; and

(ii) if the person is not an individual:

(A) a report of the nature of its business operations during:

(I) the past five years; or

(II) for any lesser period as the person and any of its predecessors has been in existence;

(B) an informative description of the business intended to be done by the person and the person's subsidiaries;

(C) a list of all individuals who are or who have been selected to become directors or executive officers of the person, or individuals who perform, or who will perform functions appropriate to such positions; and

(D) for each individual described in Subsection (2)(a)(ii)(C), the information required by Subsection (2)(a)(i)[~~(A)~~] for each individual;

(b) (i) the source, nature, and amount of the consideration used or to be used in effecting the merger or acquisition of control;

(ii) a description of any transaction in which funds were or are to be obtained for [~~that~~] the purpose of effecting the merger or acquisition of control, including any pledge of:

(A) the insurer's stock; or

(B) the stock of any of [~~its~~] the insurer's subsidiaries or controlling affiliates; and

(iii) the identity of persons furnishing the consideration;

(c) (i) fully audited financial information, or other financial information considered acceptable by the commissioner, of the earnings and financial condition of each acquiring party for:

(A) the preceding five fiscal years of each acquiring party[~~,~~]; or [~~for~~]

(B) any lesser period the acquiring party and any of its predecessors shall have been in existence[~~,~~]; and [~~similar~~]

(ii) unaudited information:

(A) similar to the information described in Subsection (2)(c)(i); and

(B) prepared within the 90 days prior to the filing of the statement;

(d) any plans or proposals which each acquiring party may have to:

(i) liquidate the insurer;

(ii) sell its assets;

(iii) merge or consolidate the insurer with any person; or

(iv) make any other material change in the insurer's:

(A) business[,];

(B) corporate structure[,]; or

(C) management;

(e) (i) the number of shares of any security referred to in Subsection (1) that each acquiring party proposes to acquire;

(ii) the terms of the offer, request, invitation, agreement, or acquisition referred to in Subsection (1); and

(iii) a statement as to the method by which the fairness of the proposal was arrived at;

(f) the amount of each class of any security referred to in Subsection (1) that:

(i) is beneficially owned; or

(ii) concerning which there is a right to acquire beneficial ownership by each acquiring party;

(g) a full description of any contract, arrangement, or understanding with respect to any security referred to in Subsection (1) in which any acquiring party is involved, including:

(i) the transfer of any of the securities;

(ii) joint ventures;

(iii) loan or option arrangements;

(iv) puts or calls;

(v) guarantees of loans;

(vi) guarantees against loss or guarantees of profits;

(vii) division of losses or profits; or

(viii) the giving or withholding of proxies;

(h) a description of the purchase by any acquiring party of any security referred to in Subsection (1) during the 12 calendar months preceding the filing of the statement including:

(i) the dates of purchase;

(ii) the names of the purchasers; and

(iii) the consideration paid or agreed to be paid for the purchase;

(i) a description of:

(i) any recommendations to purchase by any acquiring party any security referred to in

Subsection (1) made during the 12 calendar months preceding the filing of the statement; or

(ii) any recommendations made by anyone based upon interviews or at the suggestion of the acquiring party;

(j) (i) copies of all tender offers for, requests for, or invitations for tenders of, exchange offers for, and agreements to acquire or exchange any securities referred to in Subsection (1); and

(ii) if distributed, copies of additional soliciting material relating to the transactions described in Subsection (2)(j)(i);

(k) (i) the term of any agreement, contract, or understanding made with, or proposed to be made with, any broker-dealer as to solicitation of securities referred to in Subsection (1) for tender; and

(ii) the amount of any fees, commissions, or other compensation to be paid to broker-dealers with regard to any agreement, contract, or understanding described in Subsection (2)(k)(i); and

(l) any additional information the commissioner requires by rule, which the commissioner determines to be:

(i) necessary or appropriate for the protection of policyholders of the insurer; or

(ii) in the public interest.

(3) The department may request:

(a) (i) criminal background information maintained pursuant to Title 53, Chapter 10, Part 2, from the Bureau of Criminal Identification; and

(ii) complete Federal Bureau of Investigation criminal background checks through the national criminal history system.

(b) Information obtained by the department from the review of criminal history records received under Subsection (3)(a) shall be used by the department for the purpose of:

(i) verifying the information in Subsection (2)(a)(i);

(ii) determining the integrity of persons who would control the operation of an insurer; and

(iii) preventing persons who violate 18 U.S.C. Sections 1033 and 1034 from engaging in the business of insurance in the state.

(c) If the department requests the criminal background information, the department

shall:

(i) pay to the Department of Public Safety the costs incurred by the Department of Public Safety in providing the department criminal background information under Subsection (3)(a)(i);

(ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau of Investigation in providing the department criminal background information under Subsection (3)(a)(ii); and

(iii) charge the person required to file the statement referred to in Subsection (1) a fee equal to the aggregate of Subsections (3)(c)(i) and (ii).

(4) (a) If the source of the consideration under Subsection (2)(b)(i) is a loan made in the lender's ordinary course of business, the identity of the lender shall remain confidential, if the person filing the statement so requests.

(b) (i) Under Subsection (2)(e), the commissioner may require a statement of the adjusted book value assigned by the acquiring party to each security in arriving at the terms of the offer[~~, with~~].

(ii) For purposes of this Subsection (4)(b), "adjusted book value" [~~meaning~~] means each security's proportional interest in the capital and surplus of the insurer with adjustments that reflect:

[~~(i)~~] (A) market conditions;

[~~(ii)~~] (B) business in force; and

[~~(iii)~~] (C) other intangible assets or liabilities of the insurer.

(c) The description required by Subsection (2)(g) shall identify the persons with whom the contracts, arrangements, or understandings have been entered into.

(5) (a) If the person required to file the statement referred to in Subsection (1) is a partnership, limited partnership, syndicate, or other group, the commissioner may require that all the information called for by Subsections (2), (3), or (4) shall be given with respect to each:

(i) partner of the partnership or limited partnership;

(ii) member of the syndicate or group; and

(iii) person who controls the partner or member.

(b) If any partner, member, or person referred to in Subsection (5)(a) is a corporation, or if the person required to file the statement referred to in Subsection (1) is a corporation, the

commissioner may require that the information called for by Subsection (2) shall be given with respect to:

(i) the corporation;

(ii) each officer and director of the corporation; and

(iii) each person who is directly or indirectly the beneficial owner of more than 10% of the outstanding voting securities of the corporation.

(6) If any material change occurs in the facts set forth in the statement filed with the commissioner and sent to the insurer pursuant to Subsection (2), an amendment setting forth the change, together with copies of all documents and other material relevant to the change, shall be filed with the commissioner and sent to the insurer within two business days after the filing person learns of such change.

(7) If any offer, request, invitation, agreement, or acquisition referred to in Subsection (1) is proposed to be made by means of a registration statement under the Securities Act of 1933, or under circumstances requiring the disclosure of similar information under the Securities Exchange Act of 1934, or under a state law requiring similar registration or disclosure, a person required to file the statement referred to in Subsection (1) may use copies of any registration or disclosure documents in furnishing the information called for by the statement.

(8) (a) The commissioner shall approve any merger or other acquisition of control referred to in Subsection (1) unless, after a public hearing on the merger or acquisition, the commissioner finds that:

(i) after the change of control, the domestic insurer referred to in Subsection (1) would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed;

(ii) the effect of the merger or other acquisition of control would:

(A) substantially lessen competition in insurance in this state; or

(B) tend to create a monopoly in insurance;

(iii) the financial condition of any acquiring party might:

(A) jeopardize the financial stability of the insurer; or

(B) prejudice the interest of:

(I) its policyholders; or

(II) any remaining securityholders who are unaffiliated with the acquiring party;

(iv) the terms of the offer, request, invitation, agreement, or acquisition referred to in Subsection (1) are unfair and unreasonable to the securityholders of the insurer;

(v) the plans or proposals which the acquiring party has to liquidate the insurer, sell its assets, or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are:

(A) unfair and unreasonable to policyholders of the insurer; and

(B) not in the public interest; or

(vi) the competence, experience, and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of the policyholders of the insurer and the public to permit the merger or other acquisition of control.

(b) For purposes of Subsection (8)(a)(iv), the offering price for each security may not be considered unfair if the adjusted book values under Subsection (2)(e):

(i) are disclosed to the securityholders; and

(ii) determined by the commissioner to be reasonable.

(9) (a) The public hearing referred to in Subsection (8) shall be held within 30 days after the statement required by Subsection (1) is filed.

(b) (i) At least 20 days notice of the hearing shall be given by the commissioner to the person filing the statement.

(ii) Affected parties may waive the notice required by this Subsection (9)(b).

(iii) Not less than seven days notice of the public hearing shall be given by the person filing the statement to:

(A) the insurer; and

(B) any person designated by the commissioner.

(c) The commissioner shall make a determination within 30 days after the conclusion of the hearing.

(d) At the hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interest may be affected by the hearing may:

(i) present evidence;

(ii) examine and cross-examine witnesses; and

(iii) offer oral and written arguments.

(e) (i) A person or insurer described in Subsection (9)(d) may conduct discovery proceedings in the same manner as is presently allowed in the district courts of this state.

(ii) All discovery proceedings shall be concluded not later than three days before the commencement of the public hearing.

[~~(10) At the acquiring person's expense and consent, the commissioner may retain any attorneys, actuaries, accountants, and other experts not otherwise a part of the commissioner's staff, which are reasonably necessary to assist the commissioner in reviewing the proposed acquisition of control.~~]

(10) (a) The commissioner may retain technical experts to assist in reviewing all, or a portion of, information filed in connection with a proposed merger or other acquisition of control referred to in Subsection (1).

(b) In determining whether any of the conditions in Subsection (8) exist, the commissioner may consider the findings of technical experts employed to review applicable filings.

(c) (i) A technical expert employed under Subsection (10)(a) shall present to the commissioner a statement of all expenses incurred by the technical expert in conjunction with the technical expert's review of a proposed merger or other acquisition of control.

(ii) At the commissioner's direction the acquiring person shall compensate the technical expert at customary rates for time and expenses:

(A) necessarily incurred; and

(B) approved by the commissioner.

(iii) The acquiring person shall:

(A) certify the consolidated account of all charges and expenses incurred for the review by technical experts;

(B) retain a copy of the consolidated account described in Subsection (10)(c)(iii)(A); and

(C) file with the department as a public record a copy of the consolidated account described in Subsection (10)(c)(iii)(A).

(11) (a) (i) If a domestic insurer proposes to merge into another insurer, any securityholder electing to exercise a right of dissent may file with the insurer a written request

for payment of the adjusted book value given in the statement required by Subsection (1) and approved under Subsection (8), in return for the surrender of the security holder's securities.

(ii) The request described in Subsection (11)(a)(i) shall be filed not later than ten days after the day of the securityholders' meeting where the corporate action is approved.

(b) The dissenting securityholder is entitled to and the insurer is required to pay to the dissenting securityholder the specified value within 60 days of receipt of the dissenting security holder's security.

(c) Persons electing under this Subsection (11) to receive cash for their securities waive the dissenting shareholder and appraisal rights otherwise applicable under Title 16, Chapter 10a, Part 13, Dissenters' Rights.

(d) (i) This Subsection (11) provides an elective procedure for dissenting securityholders to resolve their objections to the plan of merger.

(ii) This section does not restrict the rights of dissenting securityholders under Title 16, Chapter 10a, Utah Revised Business Corporation Act, unless this election is made under this Subsection (11).

(12) (a) All statements, amendments, or other material filed under Subsection (1), and all notices of public hearings held under Subsection (8), shall be mailed by the insurer to its securityholders within five business days after the insurer has received the statements, amendments, other material, or notices.

(b) (i) Mailing expenses shall be paid by the person making the filing.

(ii) As security for the payment of [~~these~~] mailing expenses, that person shall file with the commissioner an acceptable bond or other deposit in an amount determined by the commissioner.

(13) This section does not apply to any offer, request, invitation, agreement, or acquisition that the commissioner by order exempts from the requirements of this section as:

(a) not having been made or entered into for the purpose of, and not having the effect of, changing or influencing the control of a domestic insurer; or

(b) as otherwise not comprehended within the purposes of this section.

(14) The following are violations of this section:

(a) the failure to file any statement, amendment, or other material required to be filed pursuant to Subsections (1), (2), and (5); or

(b) the effectuation, or any attempt to effectuate, an acquisition of control of or merger with a domestic insurer unless the commissioner has given the commissioner's approval to the acquisition or merger.

(15) (a) The courts of this state are vested with jurisdiction over:

(i) a person who:

(A) files a statement with the commissioner under this section; and

(B) is not resident, domiciled, or authorized to do business in this state; and

(ii) overall actions involving persons described in Subsection (15)(a)(i) arising out of a violation of this section.

(b) A person described in Subsection (15)(a) is considered to have performed acts equivalent to and constituting an appointment of the commissioner by that person, to be that person's lawful [~~attorney~~] agent upon whom may be served all lawful process in any action, suit, or proceeding arising out of a violation of this section.

(c) A copy of a lawful process described in Subsection (15)(b) shall be:

(i) served on the commissioner; and

(ii) transmitted by registered or certified mail by the commissioner to the person at that person's last-known address.

Section 8. Section **31A-21-110** is enacted to read:

31A-21-110. Prohibition against certain use of Social Security number -- Exceptions -- Applicability of section.

(1) As used in this section "publicly display or publicly post" means to intentionally communicate or otherwise make available to the general public.

(2) An insurer not subject to Section 31A-22-634 may not do any of the following:

(a) publicly display or publicly post in any manner an individual's Social Security number; or

(b) print an individual's Social Security number on any card required for the individual to access products or services provided or covered by the insurer.

(3) This section does not prevent:

(a) the collection, use, or release of a Social Security number as required by state or federal law;

(b) the use of a Social Security number for internal verification or administrative

purposes; or

(c) the release of a Social Security number:

(i) for claims administration purposes; or

(ii) as part of the verification, eligibility, or payment process.

(4) (a) An insurer shall comply with this section by July 1, 2005.

(b) An insurer may obtain an extension for compliance with this section in accordance with this Subsection (4)(b).

(i) The request for extension shall:

(A) be in writing to the department prior to July 1, 2005; and

(B) provide an explanation as to why the insurer cannot comply.

(ii) The commissioner shall grant a request for extension:

(A) for a period of time not to exceed March 1, 2006; and

(B) if the commissioner finds that the explanation provided under Subsection (4)(b)(i) is a reasonable explanation.

Section 9. Section **31A-23a-112** is amended to read:

31A-23a-112. Probation -- Grounds for revocation.

(1) The commissioner may place a licensee on probation for a period not to exceed 24 months as follows:

(a) after an adjudicative proceeding under Title 63, Chapter 46b, Administrative Procedures Act, for any circumstances that would justify a suspension under Section 31A-23a-111; or

(b) at the issuance of a new license:

(i) with an admitted violation under 18 U.S.C. Sections 1033 and 1034; or

(ii) with a response to background information questions on any new license application indicating that:

(A) the person has been convicted of a crime, [~~as defined~~] that is listed by rule made in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, as a crime that is grounds for probation;

(B) the person is currently charged with a crime, [~~as defined~~] that is listed by rule made in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, as a crime that is grounds for probation regardless of whether adjudication was withheld;

(C) the person has been involved in an administrative proceeding regarding any professional or occupational license; or

(D) any business in which the person is or was an owner, partner, officer, or director has been involved in an administrative proceeding regarding any professional or occupational license.

(2) The commissioner may put a new licensee on probation for a specified period no longer than 12 months if the licensee has admitted to violations under 18 U.S.C. Sections 1033 and 1034.

(3) The probation order shall state the conditions for retention of the license, which shall be reasonable.

(4) Any violation of the probation is grounds for revocation pursuant to any proceeding authorized under Title 63, Chapter 46b, Administrative Procedures Act.

Section 10. Section **31A-23a-409** is amended to read:

31A-23a-409. Trust obligation for funds collected.

(1) (a) Every licensee is a trustee for all funds received or collected for forwarding to insurers or to insureds.

(b) Except for amounts necessary to pay bank charges, and except for funds paid by insureds and belonging in part to the licensee as fees or commissions, a licensee may not commingle trust funds with:

(i) the licensee's own funds; or [~~with~~]

(ii) funds held in any other capacity.

(c) Except as provided under Subsection (4), every licensee owes to insureds and insurers the fiduciary duties of a trustee with respect to money to be forwarded to insurers or insureds through the licensee.

(d) (i) Unless the funds are sent to the appropriate payee by the close of the next business day after their receipt, the licensee shall deposit them in an account authorized under Subsection (2).

(ii) Funds [~~so~~] deposited under this Subsection (1)(d) shall remain in an account authorized under Subsection (2) until sent to the appropriate payee.

(2) Funds required to be deposited under Subsection (1) shall be deposited:

(a) in a federally insured trust account [~~with a financial institution located in this state~~]

in a depository institution, as defined in Section 7-1-103, which:

(i) has an office in this state;

(ii) has federal deposit insurance; and

(iii) is authorized by its primary regulator to engage in the trust business, as defined by Section 7-5-1, in this state; or

(b) in some other account, approved by the commissioner by rule or order, providing safety comparable to federally insured trust accounts.

(3) It is not a violation of Subsection (2)(a) if the amounts in the accounts exceed the amount of the federal insurance on the accounts.

(4) A trust account into which funds are deposited may be interest bearing. The interest accrued on the account may be paid to the licensee, so long as the licensee otherwise complies with this section and with the contract with the insurer.

(5) A financial institution or other organization holding trust funds under this section may not offset or impound trust account funds against debts and obligations incurred by the licensee.

(6) Any licensee who, not being lawfully entitled thereto, diverts or appropriates any portion of the funds held under Subsection (1) to the licensee's own use, is guilty of theft under Title 76, Chapter 6, Part 4. Section 76-6-412 applies in determining the classification of the offense. Sanctions under Section 31A-2-308 also apply.

Section 11. Section **31A-29-103** is amended to read:

31A-29-103. Definitions.

As used in this chapter:

(1) "Board" means the board of directors of the pool created in Section 31A-29-104.

(2) (a) "Creditable coverage" has the same meaning as provided in the Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat.1956, Sec. 2701(c)(1) and 45 C.F.R. Sec. 146.11(a)(1)[;].

(b) "Creditable coverage" does not include a period of time in which there is a significant break in coverage as described in the Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat. 1956, Sec. 2701(c)(2).

(3) "Domicile" means the place where an individual has a fixed and permanent home and principal establishment:

(a) to which the individual, if absent, intends to return; and

(b) in which the individual, and the individual's family voluntarily reside, not for a special or temporary purpose, but with the intention of making a permanent home.

[~~(3)~~] (4) "Enrollee" means an individual who has met the eligibility requirements of the pool and is covered by a pool policy under this chapter.

[~~(4)~~] (5) "Health care facility" means any entity providing health care services which is licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act.

[~~(5)~~] (6) "Health care provider" has the same meaning as provided in Section 78-14-3.

[~~(6)~~] (7) "Health care services" means:

(a) any service or product:

(i) used in furnishing to any individual medical care or hospitalization[~~,~~]; or

(ii) incidental to furnishing medical care or hospitalization[~~,~~]; and

(b) any other service or product furnished for the purpose of preventing, alleviating, curing, or healing human illness or injury.

[~~(7)~~] (8) (a) "Health insurance" means any:

(i) hospital and medical expense-incurred policy;

(ii) nonprofit health care service plan contract; or

(iii) health maintenance organization subscriber contract.

(b) "Health insurance" does not mean:

(i) any insurance arising out of [~~the Workers' Compensation Act~~] Title 34A, Chapter 2 or 3, or similar law;

(ii) automobile medical payment insurance; or

(iii) insurance under which benefits are payable with or without regard to fault and which is required by law to be contained in any liability insurance policy.

[~~(8)~~] (9) "Health maintenance organization" has the same meaning as provided in Section 31A-8-101.

[~~(9)~~] (10) (a) "Health plan" means any arrangement by which an individual, including a dependent or spouse, covered or making application to be covered under the pool has:

(i) access to hospital and medical benefits or reimbursement including group or individual insurance or subscriber contract;

(ii) coverage through:

(A) a health maintenance organization[~~,~~];

(B) a preferred provider prepayment[~~,~~];

(C) group practice[~~,~~]; or

(D) individual practice plan;

(iii) coverage under an uninsured arrangement of group or group-type contracts including employer self-insured, cost-plus, or other benefits methodologies not involving insurance;

(iv) coverage under a group type contract which is not available to the general public and can be obtained only because of connection with a particular organization or group; and

(v) coverage by Medicare or other governmental benefit. [~~The term~~]

(b) "Health plan" includes coverage through health insurance.

[~~(10)~~] (11) "HIPAA" means the Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat.1962.

[~~(11)~~] (12) "HIPAA eligible" means an individual who is eligible under the provisions of the Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat. 1979, Sec. 2741(b).

[~~(12)~~] (13) "Insurer" means:

(a) an insurance company authorized to transact accident and health insurance business in this state[~~,~~];

(b) a health maintenance organization[~~,~~]; and

(c) a self-insurer not subject to federal preemption.

[~~(13)~~] (14) "Medicaid" means coverage under Title XIX of the Social Security Act, 42 U.S.C. Sec. 1396 et seq., as amended.

[~~(14)~~] (15) "Medicare" means coverage under both Part A and B of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq., as amended.

[~~(15)~~] (16) "Plan of operation" means the plan developed by the board in accordance with Section 31A-29-105 and includes the articles, bylaws, and operating rules adopted by the board under Section 31A-29-106.

[~~(16)~~] (17) "Pool" means the Utah Comprehensive Health Insurance Pool created in Section 31A-29-104.

[~~(17)~~] (18) "Pool fund" means the Comprehensive Health Insurance Pool Enterprise

Fund created in Section 31A-29-120.

[~~(18)~~] (19) "Pool policy" means a health insurance policy issued under this chapter.

[~~(19)~~] (20) "Preexisting condition" means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period immediately prior to the enrollment date.

[~~(20)~~] (21) (a) "Resident" or "residency" means [~~an individual~~] a person who is domiciled in this state [~~as defined in Section 23-13-2~~].

(b) A resident retains residency if that resident leaves this state:

(i) to serve in the armed forces of the United States; or

(ii) for religious or educational purposes.

[~~(21)~~] (22) "Third-party administrator" has the same meaning as provided in Section 31A-1-301.

Section 12. Section **31A-29-104** is amended to read:

31A-29-104. Creation of pool -- Board of directors -- Appointment -- Terms -- Quorum -- Plan preparation.

(1) There is created the "Utah Comprehensive Health Insurance Pool," a nonprofit entity within the Insurance Department.

(2) The pool shall be under the direction of a board of directors composed of [~~11~~] 12 members.

(a) The governor shall appoint ten of the directors with the consent of the Senate as follows:

(i) two representatives of health insurance companies or health service organizations;

(ii) one representative of a health maintenance organization;

(iii) one physician;

(iv) one representative of hospitals;

(v) one representative of the general public who is reasonably expected to qualify for coverage under the pool;

(vi) one parent or spouse of such an individual;

(vii) one representative of the general public; [~~and~~]

(viii) one representative of employers[~~.~~]; and

(ix) one licensed producer with an accident and health line of authority.

(b) The board shall also include:

(i) the commissioner or [~~his~~] the commissioner's designee; and

(ii) the executive director of the Department of Health or [~~his~~] the executive director's designee.

(3) (a) Except as required by Subsection (3)(b), as terms of current board members expire, the governor shall appoint each new member or reappointed member to a four-year term.

(b) Notwithstanding the requirements of Subsection (3)(a), the governor shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of board members are staggered so that approximately half of the board is appointed every two years.

(4) When a vacancy occurs in the membership for any reason, the replacement shall be appointed for the unexpired term in the same manner as the original appointment was made.

(5) (a) (i) Members who are not government employees shall receive no compensation or benefits for their services, but may receive per diem and expenses incurred in the performance of the member’s official duties at the rates established by the Division of Finance under Sections 63A-3-106 and 63A-3-107 from the Pool Fund.

(ii) Members may decline to receive per diem and expenses for their service.

(b) (i) State government officer and employee members who do not receive salary, per diem, or expenses from their agency for their service may receive per diem and expenses incurred in the performance of their official duties from the pool at the rates established by the Division of Finance under Sections 63A-3-106 and 63A-3-107.

(ii) A state government member who is a member because of their state government position may not receive per diem or expenses for their service.

(iii) State government officer and employee members may decline to receive per diem and expenses for their service.

(6) The board shall elect annually a chair and vice chair from its membership.

(7) Six board members are a quorum for the transaction of business.

(8) The action of a majority of the members of the quorum is the action of the board.

(9) The board shall submit a plan of operation to the commissioner no later than January 1, 1991.

(10) The sale of policies under this chapter shall commence on July 1, 1991, or as soon thereafter as adequate funding for the coverage is available as determined by the commissioner.

Section 13. Section **31A-29-111** is amended to read:

31A-29-111. Eligibility -- Limitations.

(1) (a) Except as provided in [~~Subsection~~] Subsections (1)(b) and (2), an individual who is not HIPAA eligible is eligible for pool coverage if the individual:

(i) pays the established premium;

(ii) is a resident of this state; and

(iii) meets the health underwriting criteria under Subsection [~~(4)~~] (5)(a).

(b) Notwithstanding Subsection (1)(a), an individual who is not HIPAA eligible is not eligible for pool coverage if one or more of the following conditions apply:

(i) [~~at the time of application,~~] the individual is eligible for health care benefits under Medicaid or Medicare, except as provided in Section 31A-29-112;

(ii) the individual has terminated coverage in the pool, unless:

(A) 12 months have elapsed since the termination date; or

(B) the individual demonstrates that creditable coverage has been involuntarily terminated for any reason other than nonpayment of premium;

(iii) the pool has paid the maximum lifetime benefit to or on behalf of the individual;

(iv) the individual is an inmate of a public institution;

(v) the individual is eligible for other public programs for which medical care is provided;

(vi) the individual's health condition does not meet the criteria established under Subsection [~~(4)~~] (5);

(vii) the individual is [~~an eligible employee, a dependent of an eligible employee, or a member of~~] eligible for coverage under an employer group that offers health insurance or a self-insurance arrangement to [~~all~~] its eligible employees, dependents, or members[~~;~~] as:

(A) an eligible employee;

(B) a dependent of an eligible employee; or

(C) a member;

(viii) [~~at the time the pool coverage is applied for,~~] the individual:

(A) has coverage substantially equivalent to a pool policy, as established by the board

in administrative rule, either as an insured or a covered dependent[~~,~~]; or [~~the individual~~]

(B) would be eligible for the substantially equivalent coverage if the individual elected to obtain the coverage; or

(ix) at the time of application, the individual[~~: (A) is not HIPAA eligible; and (B)~~] has not resided in Utah for at least 12 consecutive months preceding the date of application.

(2) (a) Except as provided in Subsections (1) and (2)(b), an individual who is HIPAA eligible is eligible for pool coverage if the individual:

(i) pays the established premium; and

(ii) is a resident of this state.

(b) Notwithstanding Subsections (1) and (2)(a), a HIPAA eligible individual is not eligible for pool coverage if one or more of the following conditions apply:

(i) the individual is eligible for health care benefits under Medicaid or Medicare, except as provided in Section 31A-29-112;

(ii) the individual is eligible for other public programs for which medical care is provided;

(iii) the individual is covered under any other health insurance;

(iv) the individual is eligible for coverage under an employer group that offers health insurance or self insurance arrangements to its eligible employees, dependents, or members as:

(A) an eligible employee;

(B) a dependent of an eligible employee; or

(C) a member;

(v) the pool has paid the maximum lifetime benefit to or on behalf of the individual; or

(vi) the individual is an inmate of a public institution.

[~~(2)~~] (3) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under Subsection (1)(a), an individual whose health insurance coverage from a state [~~health~~] high risk pool with similar coverage is terminated because of nonresidency in another state may apply for coverage under the pool subject to the conditions of Subsections (1)(b)(i) through [~~(vii)~~] (viii).

(b) [~~(i)~~] Coverage sought under Subsection [~~(2)~~] (3)(a) shall be applied for within 63 days after the termination date of the previous high risk pool coverage.

[~~(ii)~~] (c) [~~If premiums are paid for the entire coverage period under the previous risk~~

~~pool with similar coverage, the~~] The effective date of this state's pool coverage shall be the date of termination of the previous high risk pool coverage.

[~~(iii) If premiums are not paid back to the previous risk pool termination date, then the effective date will be determined by the pool administrator in accordance with the date of application.~~]

[~~(c)~~] (d) The waiting period of an individual with a preexisting condition applying for coverage under this chapter shall be waived:

(i) to the extent to which the waiting period was satisfied under a similar plan from another state; and

(ii) if the other state's benefit limitation was not reached.

[~~(3)~~] (4) (a) If an eligible individual applies for pool coverage within 30 days of being denied coverage by an individual carrier, the effective date for pool coverage shall be no later than the first day of the month following the date of submission of the completed insurance application to the carrier.

(b) Notwithstanding Subsection (4)(a), for individuals eligible for coverage under Subsection (3), the effective date shall be the date of termination of the previous high risk pool coverage.

[~~(4)~~] (5) (a) The board shall establish and adjust, as necessary, health underwriting criteria based on:

(i) health condition; and

(ii) expected claims so that the expected claims are anticipated to remain within available funding.

(b) The board, with approval of the commissioner, may contract with one or more providers under Title 63, Chapter 56, Utah Procurement Code, to develop underwriting criteria under Subsection [~~(4)~~] (5)(a).

(c) If an individual is denied coverage by the pool under the criteria established in Subsection [~~(4)~~] (5)(a), the pool shall issue a certificate of insurability to the individual for coverage under Subsection 31A-30-108(3).

Section 14. Section **31A-29-112** is amended to read:

31A-29-112. Medicaid recipients.

(1) If authorized by federal statutes or rules, an individual receiving Medicaid benefits

may continue to receive those benefits while satisfying the preexisting condition requirements established by Section 31A-29-113 and the terms of the pool policy issued under this chapter.

(2) If allowed by federal statute, federal regulation, state statute, or rule, the Department of Health shall allocate premiums paid to the pool by an individual receiving Medicaid benefits to that individual's spenddown for purposes of the Medicaid program.

(3) (a) If an individual continues to receive Medicaid benefits after the requirements for a preexisting condition are satisfied, the pool administrator may not issue a pool policy or allow that individual to receive any benefit from the pool.

(b) If an individual continues to receive Medicaid benefits when the requirements for a preexisting condition are satisfied, the pool administrator shall give any premiums collected by it during the preexisting conditions period to the Medicaid program.

(4) (a) If an enrollee becomes eligible to receive Medicaid benefits, the enrollee's coverage by the pool terminates as of the effective date of Medicaid coverage.

(b) The pool administrator shall:

(i) include a provision in the pool policy requiring an enrollee to provide written notice to the pool administration if the enrollee becomes covered by Medicaid; and

(ii) terminate an enrollee's coverage by the pool as of the effective date of the enrollee's Medicaid coverage when the pool administrator becomes aware that the enrollee is covered by Medicaid.

(5) If an individual terminates coverage under Medicaid and applies for coverage under a pool policy within 45 days after terminating the coverage, the individual may begin coverage under a pool policy as of the date that Medicaid coverage terminated, if an individual meets the other eligibility requirements of the chapter and pays the required premium.

(6) Notwithstanding [~~the provision of Subsection~~] Subsections 31A-29-111(1)(b)(i) and (2)(b)(i), an individual is eligible for coverage by the pool if the requirements of Section 31A-29-111 are met and if:

(a) the individual's eligibility for Medicaid requires a spenddown, as defined by rule, that exceeds the premium for a pool policy; or

(b) the individual is eligible for the Primary Care Network program administered by the Department of Health.

Section 15. Section **31A-29-113** is amended to read:

31A-29-113. Benefits -- Additional types of pool insurance -- Preexisting conditions -- Waiver -- Maximum benefits.

(1) (a) The pool policy shall pay for eligible medical expenses rendered or furnished for the diagnoses or treatment of illness or injury that:

(i) exceed the deductible and copayment amounts applicable under Section 31A-29-114; and

(ii) are not otherwise limited or excluded.

(b) Eligible medical expenses are the allowed charges established by the board for the health care services and items rendered during times for which benefits are extended under the pool policy.

(2) The coverage to be issued by the pool, its schedule of benefits, exclusions, and other limitations shall be established by the board.

(3) The commissioner shall approve the benefit package developed by the board to ensure its compliance with this chapter.

(4) The pool shall offer at least one benefit plan through a managed care program as authorized under Section 31A-29-106.

(5) This chapter may not be construed to prohibit the pool from issuing additional types of pool policies with different types of benefits which in the opinion of the board may be of benefit to the citizens of Utah.

(6) (a) The board shall design and require an administrator to employ cost containment measures and requirements including preadmission certification and concurrent inpatient review for the purpose of making the pool more cost effective. [~~The provisions of~~]

(b) Sections 31A-22-617 and 31A-22-618 do not apply to coverage issued under this chapter.

(7) (a) A pool policy may contain provisions under which coverage for a preexisting condition is excluded during a six-month period following the effective date of plan coverage for a given individual.

(b) Subsection (7)(a) does not apply to a HIPAA eligible individual.

(8) (a) A pool policy may [~~exclude coverage for pregnancies for ten months following the effective date of coverage, unless the individual is HIPAA eligible~~] contain provisions under which coverage for a preexisting pregnancy is excluded during a ten-month period

following the effective date of plan coverage for a given individual.

(b) Subsection (8)(a) does not apply to a HIPAA eligible individual.

(9) (a) The pool will waive the preexisting condition exclusion described in [~~Subsection~~] Subsections (7)(a) and (8)(a) for an individual that is changing health coverage to the pool, to the extent to which similar exclusions have been satisfied under any prior health insurance coverage if:

(i) the individual applies not later than 63 days following the date of involuntary termination, other than for nonpayment of premiums, from health coverage; or

(ii) the individual's premium rate exceeds the rate of the pool for equal or lesser coverage provided that the application for pool coverage is made no later than 63 days following the termination from the prior health insurance coverage.

[~~(b) In accordance with Subsections (7)(b) and (8), the pool may not apply a preexisting condition exclusion if the individual is HIPAA eligible.~~]

[~~(c)~~] (b) If this Subsection (9) applies, coverage in the pool shall be effective from the date on which the prior coverage was terminated.

(10) Covered benefits available from the pool may not exceed a $1,000,000 lifetime maximum, which includes a per enrollee calendar year maximum established by the board.

Section 16. Section **31A-29-114** is amended to read:

31A-29-114. Deductibles -- Copayments.

(1) (a) [~~Subject to the limits provided in Subsection (3), a~~] A pool policy shall impose a deductible on a per calendar year basis.

(b) [~~Deductible~~] At least two deductible plans [~~of $500 and $1,000~~] shall [~~initially~~] be offered. [~~Other higher deductible plans may be offered by the pool.~~]

(c) The deductible is applied to all of the eligible medical expenses as defined in Section 31A-29-113, incurred by the enrollee until the deductible has been satisfied. There are no benefits payable before the deductible has been satisfied.

(d) The pool may offer separate deductibles for prescription benefits.

(2) (a) [~~Subject to the limits provided in Subsection (3), a~~] A mandatory coinsurance requirement shall be imposed at the rate of at least 20% of eligible medical expenses in excess of the mandatory deductible.

(b) Any coinsurance imposed under this Subsection (2) shall be designated in the pool

policy.

(3) [~~Except as provided in Subsection (4), the~~] The board shall establish maximum aggregate out-of-pocket payments for eligible medical expenses incurred by the enrollee [~~in the form of deductibles and coinsurance may not exceed:~~] for each of the deductible plans offered under Subsection (1)(b).

[~~(a) $1,500 per individual per calendar year for the $500 deductible plan;~~]

[~~(b) $2,000 per individual per calendar year for the $1,000 deductible plan; or~~]

[~~(c) if other deductible plans are offered by the pool, an amount per individual will be established by the board.~~]

(4) (a) When the enrollee has incurred the maximum aggregate out-of-pocket payments under Subsection (3), the board may establish a coinsurance requirement to be imposed on eligible medical expenses in excess of the maximum aggregate out-of-pocket expense [~~limits set forth in Subsection (3)~~].

(b) The circumstances in which the coinsurance authorized by this Subsection (4) may be imposed shall be designated in the pool policy.

(c) The coinsurance authorized by this Subsection (4) may be imposed at a rate not to exceed 5% of eligible medical expenses.

(5) The limits on maximum aggregate out-of-pocket payments for eligible medical expenses incurred by the enrollee [~~in the form of deductibles and coinsurance~~] under this section shall not include out-of-pocket payments for prescription benefits.

Section 17. Section **31A-29-115** is amended to read:

31A-29-115. Cancellation -- Notice.

(1) (a) On the date of renewal, the pool may cancel an enrollee's policy if:

(i) the enrollee's health condition does not meet the criteria established in Subsection 31A-29-111[~~(4)~~](5);

(ii) the pool has provided written notice to the enrollee's last-known address no less than 60 days before cancellation; and

(iii) at least one individual carrier has not reached the individual enrollment cap established in Section 31A-30-110.

(b) The pool shall issue a certificate of insurability to an enrollee whose policy is cancelled under Subsection (1)(a) for coverage under Subsection 31A-30-108(3) if the

requirements of Subsection 31A-29-111[~~(4)~~](5) are met.

(2) The pool may cancel an enrollee's policy at any time if:

(a) the pool has provided written notice to the enrollee's last-known address no less than 15 days before cancellation; and

(b) (i) the enrollee establishes a residency outside of Utah for three consecutive months;

(ii) there is nonpayment of premiums; or

(iii) the pool determines that the enrollee does not meet the eligibility requirements set forth in Section 31A-29-111, in which case:

(A) the policy may be retroactively terminated for the period of time in which the enrollee was not eligible;

(B) retroactive termination may not exceed three years; and

(C) the board's remedy under this Subsection (2)(b) shall be a cause of action against the enrollee for benefits paid during the period of ineligibility in accordance with Subsection 31A-29-119(3).

Section 18. Section **31A-30-103** is amended to read:

31A-30-103. Definitions.

As used in this chapter:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual approved by the commissioner that a covered carrier is in compliance with Section 31A-30-106, based upon the examination of the covered carrier, including review of the appropriate records and of the actuarial assumptions and methods used by the covered carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

(3) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the covered carrier to covered insureds with similar case characteristics for health benefit plans with the same or similar coverage.

(4) "Basic coverage" means the coverage provided in the Basic Health Care Plan under

Subsection 31A-22-613.5(2).

(5) "Carrier" means any person or entity that provides health insurance in this state including:

(a) an insurance company;

(b) a prepaid hospital or medical care plan;

(c) a health maintenance organization;

(d) a multiple employer welfare arrangement; and

(e) any other person or entity providing a health insurance plan under this title.

(6) (a) Except as provided in Subsection (6)(b), "case characteristics" means demographic or other objective characteristics of a covered insured that are considered by the carrier in determining premium rates for the covered insured.

(b) "Case characteristics" does not include:

(i) duration of coverage since the policy was issued;

(ii) claim experience; and

(iii) health status.

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

(8) "Conversion policy" means a policy providing coverage under the conversion provisions required in Chapter 22, Part VII, Group Accident and Health Insurance.

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

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

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

(12) "Dependent" means an individual to the extent that the individual is defined to be a dependent by:

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

(b) Chapter 22, Part VI, Accident and Health Insurance.

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

(14) "Index rate" means, for each class of business as to a rating period for covered insureds with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(15) "Individual carrier" means a carrier that provides coverage on an individual basis through a health benefit plan regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar groups; or

(b) the policy or contract is situated out-of-state.

(16) "Individual conversion policy" means a conversion policy issued to:

(a) an individual; or

(b) an individual with a family.

(17) "Individual coverage count" means the number of natural persons covered under a carrier's health benefit products that are individual policies.

(18) "Individual enrollment cap" means the percentage set by the commissioner in accordance with Section 31A-30-110.

(19) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or that could have been charged or offered, by the carrier to covered insureds with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(20) "Preexisting condition" is as defined in Section 31A-1-301.

(21) "Premium" means all monies paid by covered insureds and covered individuals as a condition of receiving coverage from a covered carrier, including any fees or other contributions associated with the health benefit plan.

(22) (a) "Rating period" means the calendar period for which premium rates established by a covered carrier are assumed to be in effect, as determined by the carrier.

(b) A covered carrier may not have:

(i) more than one rating period in any calendar month; and

(ii) no more than 12 rating periods in any calendar year.

(23) "Resident" means an individual who has resided in this state for at least 12 consecutive months immediately preceding the date of application.

(24) "Short-term limited duration insurance" means a health benefit product that:

(a) is not renewable; and

(b) has an expiration date specified in the contract that is less than 364 days after the date the plan became effective.

(25) "Small employer carrier" means a carrier that provides health benefit plans covering eligible employees of one or more small employers in this state, regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar grouping; or

(b) the policy or contract is situated out-of-state.

(26) "Uninsurable" means an individual who:

(a) is eligible for the Comprehensive Health Insurance Pool coverage under the underwriting criteria established in Subsection 31A-29-111[~~(4)~~](5); or

(b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and

(ii) has a condition of health that does not meet consistently applied underwriting criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(i) and (j) for which coverage the applicant is applying.

(27) "Uninsurable percentage" for a given calendar year equals UC/CI where, for purposes of this formula:

(a) "UC" means the number of uninsurable individuals who were issued an individual policy on or after July 1, 1997; and

(b) "CI" means the carrier's individual coverage count as of December 31 of the preceding year.

Section 19. Section **31A-30-108** is amended to read:

31A-30-108. Eligibility for small employer and individual market.

(1) (a) Small employer carriers shall accept residents for small group coverage as set

forth in the Health Insurance Portability and Accountability Act, P.L. 104-191, 110 Stat. 1962, Sec. 2701(f) and 2711(a).

(b) Individual carriers shall accept residents for individual coverage pursuant:

(i) to P.L. 104-191, 110 Stat. 1979, Sec. 2741(a)-(b); and

(ii) Subsection (3).

(2) (a) Small employer carriers shall offer to accept all eligible employees and their dependents at the same level of benefits under any health benefit plan provided to a small employer.

(b) Small employer carriers may:

(i) request a small employer to submit a copy of the small employer's quarterly income tax withholdings to determine whether the employees for whom coverage is provided or requested are bona fide employees of the small employer; and

(ii) deny or terminate coverage if the small employer refuses to provide documentation requested under Subsection (2)(b)(i).

(3) Except as provided in Subsection (5) and Section 31A-30-110, individual carriers shall accept for coverage individuals to whom all of the following conditions apply:

(a) the individual is not covered or eligible for coverage:

(i) (A) as an employee of an employer;

(B) as a member of an association; or

(C) as a member of any other group; and

(ii) under:

(A) a health benefit plan; or

(B) a self-insured arrangement that provides coverage similar to that provided by a health benefit plan as defined in Section 31A-1-301;

(b) the individual is not covered and is not eligible for coverage under any public health benefits arrangement including:

(i) the Medicare program established under Title XVIII of the Social Security Act;

(ii) the Medicaid program established under Title XIX of the Social Security Act;

(iii) any act of Congress or law of this or any other state that provides benefits comparable to the benefits provided under this chapter; or

(iv) coverage under the Comprehensive Health Insurance Pool Act created in Chapter

29, Comprehensive Health Insurance Pool Act;

(c) unless the maximum benefit has been reached the individual is not covered or eligible for coverage under any:

(i) Medicare supplement policy;

(ii) conversion option;

(iii) continuation or extension under COBRA; or

(iv) state extension;

(d) the individual has not terminated or declined coverage described in Subsection (3)(a), (b), or (c) within 93 days of application for coverage, unless the individual is eligible for individual coverage under P.L. 104-191, 110 Stat. 1979, Sec. 2741(b), in which case, the requirement of this Subsection (3)(d) does not apply; and

(e) the individual is certified as ineligible for the Health Insurance Pool if:

(i) the individual applies for coverage with the Comprehensive Health Insurance Pool within 30 days after being rejected or refused coverage by the covered carrier and reapplies for coverage with that covered carrier within 30 days after the date of issuance of a certificate under Subsection 31A-29-111[~~(4)~~](5)(c); or

(ii) the individual applies for coverage with any individual carrier within 45 days after:

(A) notice of cancellation of coverage under Subsection 31A-29-115(1); or

(B) the date of issuance of a certificate under Subsection 31A-29-111[~~(4)~~](5)(c) if the individual applied first for coverage with the Comprehensive Health Insurance Pool.

(4) (a) If coverage is obtained under Subsection (3)(e)(i) and the required premium is paid, the effective date of coverage shall be the first day of the month following the individual's submission of a completed insurance application to that covered carrier.

(b) If coverage is obtained under Subsection (3)(e)(ii) and the required premium is paid, the effective date of coverage shall be the day following the:

(i) cancellation of coverage under Subsection 31A-29-115(1); or

(ii) submission of a completed insurance application to the Comprehensive Health Insurance Pool.

(5) (a) An individual carrier is not required to accept individuals for coverage under Subsection (3) if the carrier issues no new individual policies in the state after July 1, 1997.

(b) A carrier described in Subsection (5)(a) may not issue new individual policies in

the state for five years from July 1, 1997.

(c) Notwithstanding Subsection (5)(b), a carrier may request permission to issue new policies after July 1, 1999, which may only be granted if:

(i) the carrier accepts uninsurables as is required of a carrier entering the market under Subsection 31A-30-110; and

(ii) the commissioner finds that the carrier's issuance of new individual policies:

(A) is in the best interests of the state; and

(B) does not provide an unfair advantage to the carrier.

(6) (a) If a small employer carrier offers health benefit plans to small employers through a network plan, the small employer carrier may:

(i) limit the employers that may apply for the coverage to those employers with eligible employees who live, reside, or work in the service area for the network plan; and

(ii) within the service area of the network plan, deny coverage to an employer if the small employer carrier has demonstrated to the commissioner that the small employer carrier:

(A) will not have the capacity to deliver services adequately to enrollees of any additional groups because of the small employer carrier's obligations to existing group contract holders and enrollees; and

(B) applies this section uniformly to all employers without regard to:

(I) the claims experience of an employer, an employer's employee, or a dependent of an employee; or

(II) any health status-related factor relating to an employee or dependent of an employee.

(b) (i) A small employer carrier that denies a health benefit product to an employer in any service area in accordance with this section may not offer coverage in the small employer market within the service area to any employer for a period of 180 days after the date the coverage is denied.

(ii) This Subsection (6)(b) does not:

(A) limit the small employer carrier's ability to renew coverage that is in force; or

(B) relieve the small employer carrier of the responsibility to renew coverage that is in force.

(c) Coverage offered within a service area after the 180-day period specified in

Subsection (6)(b) is subject to the requirements of this section.

Section 20. Section **31A-38-101** is enacted to read:

CHAPTER 38. FEDERAL HEALTH CARE TAX CREDIT PROGRAM ACT

31A-38-101. Title.

This chapter is known as the "Federal Health Care Tax Credit Program Act."

Section 21. Section **31A-38-102** is enacted to read:

31A-38-102. Definitions.

As used in this chapter:

(1) "Bridge program" means the program established by the Department of Workforce Services on July 1, 2003:

(a) to implement the federal health coverage tax credit program;

(b) with federal funds; and

(c) for qualified participants.

(2) "Federal health coverage tax credit program" means the health care tax credit program authorized by the Trade Reform Act.

(3) "Qualified participant" means an individual:

(a) eligible for coverage under the state program in accordance with Section 31A-38-103; and

(b) qualified by the Internal Revenue Service and the Department of the United States Treasury to participate in the federal health coverage tax credit program.

(4) "State program" means the program established under this chapter:

(a) to implement the federal health coverage tax credit program; and

(b) for qualified participants.

(5) "Trade Reform Act" means the Trade Adjustment Assistance Reform Act of 2002, 107 P.L. 210.

Section 22. Section **31A-38-103** is enacted to read:

31A-38-103. Implementation of the federal health coverage tax credit program.

(1) An employee is considered to be an employee of the employee's last employer for purposes of participating in the federal health coverage tax credit program if:

(a) the employee is or was an employee of the employer;

(b) the employer is or was doing business in this state;

(c) the employee requires health care services from a licensed health care provider doing business in this state;

(d) the health insurance benefit plan covering the employee is terminated by the employer or former employer; and

(e) the employee is a qualified participant.

(2) (a) Qualified participants eligible for the federal health coverage tax credit program and qualifying family members of qualified participants shall be:

(i) grouped together under the state program;

(ii) considered a single group risk pool; and

(iii) considered to be a group for purposes of:

(A) implementing the federal health coverage tax credit program; and

(B) providing health insurance coverage.

(b) The coverage provided to the group formed under this Subsection (2) shall be considered to be group coverage.

(c) Notwithstanding that the coverage is considered group coverage, a member of the group may be individually underwritten and rated at the time of enrollment in the group.

(3) (a) Except as expressly provided in this chapter, the state program is excluded from regulation under this title if the state program:

(i) meets the requirements of this Subsection (3) upon implementation of the state program; and

(ii) continuously complies with the requirements listed in this Subsection (3).

(b) The Department of Workforce Services shall contract, in compliance with state purchasing rules:

(i) with an insurance company licensed to provide accident and health insurance:

(A) to provide insurance for the state program;

(B) to assume the risk of the health insurance coverage of the qualified participants in the state program; and

(C) to take an action described in this Subsection (3)(b)(i) in consideration of receipt of:

(I) a reasonable premium from qualified participants; and

(II) the advance health coverage tax credits from the United States Treasury; or

(ii) with a licensed third party administrator to administer the state program as a self-insurance program that provides accident and health insurance coverage of the qualified participants in the state program in consideration of receipt of:

(A) a reasonable premium from qualified participants; and

(B) the advance health coverage tax credit from the United States Treasury.

(c) (i) If the Department of Workforce Services contracts with a third party administrator under Subsection (3)(b)(ii), the Department of Workforce Services shall create and maintain a fund authorized under Subsection 31A-38-104(1)(b) to:

(A) pay claims covered by the state program; and

(B) receive the:

(I) reasonable premium from qualified participants; and

(II) advance health coverage tax credits from the United States Treasury.

(ii) The Department of Workforce Services shall ensure that the fund described in this Subsection (3)(c):

(A) is actuarially sound upon implementation of the state program; and

(B) is continuously maintained and managed on an actuarially sound basis.

(iii) The actuarial soundness of a fund created pursuant to this Subsection (3)(c) shall be supported by an opinion of an actuary that is a fellow in a nationally recognized actuary association designated by the Department of Workforce Services.

(d) (i) The insurance company or third party administrator under contract with the Department of Workforce Services shall:

(A) establish premium rates for health insurance coverage provided under this chapter that are reasonable and actuarially sound to:

(I) cover the payment of existing claims; and

(II) build reasonable and adequate reserves to pay future claims; and

(B) adjust its premium rates as needed to:

(I) reflect the claim experience of the group;

(II) cover administrative and reinsurance costs related solely to the group;

(III) provide for a reasonable margin of profit from the group's coverage, not to exceed 15% of its premiums; and

(IV) build actuarially reasonable reserves for the payment of future claims.

(ii) If the Department of Workforce Services creates a fund pursuant to Subsection (3)(c), the premiums paid by participants in the state program shall be designed to:

(A) cover claims paid from the fund; and

(B) to build reasonable and appropriate reserves for the payment of future claims.

(e) (i) The insurance coverage designed by the insurance company or the third party administrator:

(A) shall reflect the characteristics of the group;

(B) shall meet the group's needs; and

(C) may offer coverage that includes or does not include variable benefits.

(ii) In designing the group coverage, the insurance company or third party administrator shall ensure that the coverage and the premiums are not discriminatory.

(f) The coverage under the state program shall comply with:

(i) all requirements of federal law pertaining to the federal health coverage tax credit program; and

(ii) any federal requirement applicable to the health insurance coverage provided under the state program.

(g) The commissioner shall approve:

(i) the coverage design;

(ii) the policy or coverage form; and

(iii) the premium rates that are used to provide coverage under this section.

(h) (i) The commissioner shall certify that the state program complies with the requirements of this chapter:

(A) upon the initial implementation of the state program; and

(B) every third year after implementation of the state program.

(ii) If the Department of Workforce Services elects to operate the state program through a § [~~self-insurance~~] SELF-INSURANCE § program, before issuance of certification by the commissioner, the executive director of § THE § Department of Workforce Services shall certify to the commissioner that:

(A) the following are in compliance with the requirements of this Subsection (3):

(I) state program coverage;

(II) premium rates;

(III) fund balances; and

(IV) reserves; and

(B) the state program is in compliance and will continue to be in compliance with the requirements of this chapter and the Trade Reform Act.

(4) Qualified participants enrolled in the bridge program prior to and after the effective date of this chapter shall be enrolled in the state program provided for in this chapter retroactive to § ~~[which ever]~~ WHICHEVER § of the following dates ensures the continuance of health insurance coverage:

(a) the date of their enrollment in the bridge program; or

(b) July 1, 2003.

(5) (a) The state is not liable, obligated, or responsible to guarantee the payment of claims of qualified participants enrolled in the state program created by this chapter.

(b) Any guaranty association created under Chapter 28, Guaranty Associations, is not liable, obligated, or responsible to guarantee the payment of the claims of:

(i) any fund created by this chapter; or

(ii) the insurance company that is under contract with the Department of Workforce Services to provide the health insurance coverage intended by this chapter.

Section 23. Section **31A-38-104** is enacted to read:

31A-38-104. Interim Authorization -- Monies transferred for reserves -- Reporting.

(1) Until July 1, 2005, the Department of Workforce Services may:

(a) convert the bridge program to the state program through any of the following, or combination of the following, that the Department of Workforce Services considers best serves the needs of qualified participants:

(i) a contract with a licensed insurance company authorized to do business in the state;

(ii) through any other arrangement acceptable under the Trade Reform Act; or

(iii) a § ~~[self insurance]~~ SELF-INSURANCE § program through a third party administrator as provided in Subsection 31A-38-103(3)(b)(ii);

(b) (i) in cooperation with the Division of Finance, establish an appropriate state fund for the purpose of operation of the state program; and

(ii) transfer the balance of any monies received under the bridge program into this fund; and

(c) obligate up to $2,000,000 of the Workforce Services Special Administrative Expense Fund as reserves for the state program.

(2) The monies in the fund created under Subsection (1)(b): § ARE §

(a) § ~~[are]~~ § nonlapsing; and

(b) restricted to the purposes of the state program established under this chapter.

(3) The monies in Subsection (1)(c) may be:

(a) used until the reserves in the state program become adequate; and

(b) transferred into or out of any fund created under Subsection (1)(b).

(4) If legislation is needed to continue the state program beyond July 1, 2005, the Department of Workforce Services shall prepare draft legislation to be presented to the Workforce Services and Community and Economic Development Interim Committee by November 30, 2004.

Section 24. Section **63-55b-131** is amended to read:

63-55b-131. Repeal dates, Title 31A.

(1) Section 31A-22-626 is repealed July 1, 2004.

(2) Section 31A-23a-415 is repealed July 1, 2006.

(3) Title 31A, Chapter 38, Federal Health Care Tax Credit Program is repealed July 1, 2005.

Section 25. **Repealer.**

This bill repeals:

Section **31A-29-118, Employer contributions.**

Section 26. **Effective date.**

If approved by two-thirds of all the members elected to each house, Title 31, § A § Chapter 38, Federal Health Care Tax Credit Program Act, and the amendments in this bill to Section 63-55b-131 take effect upon approval by the governor, or the day following the constitutional time limit of Utah Constitution Article VII, Section 8, without the governor's signature, or in the case of veto, the date of veto override.

Section 27. **Revisor instructions.**

It is the intent of the Legislature that in preparing the Utah Code database for publication the Office of Legislative Research and General Counsel shall change the reference in Subsection 31A-38-103(4) to "the effective date of this chapter" with the date that is the

effective date of the chapter.