1 # INSURANCE LAW REVISIONS

2 2004 GENERAL SESSION

3 STATE OF UTAH

4 **Sponsor: James A. Ferrin**

5

6 **LONG TITLE**

7 **General Description:**

8 This bill modifies the Insurance Code.

9 **Highlighted Provisions:**

10 This bill:

11 ▸ modifies definition provisions;

12 ▸ addresses examination costs;

13 ▸ addresses confidentiality and distribution of certain records or documents;

14 ▸ corrects cross references;

15 ▸ addresses extension of the deadline for filing fee payments for annual statements;

16 ▸ addresses use of technical experts in evaluating mergers and acquisitions;

17 ▸ prohibits certain activities related to Social Security numbers;

18 ▸ addresses the deposit of funds by a licensee;

19 ▸ modifies trust obligations for funds collected;

20 ▸ addresses grounds for probation;

21 ▸ modifies trust obligations for funds collected;

22 ▸ modifies the Comprehensive Health Insurance Pool Act including:

23 • defining terms;

24 • expanding the board;

25 • addressing eligibility;

26 • addressing preexisting conditions;

27 • addressing deductibles and copayments; and

28 • repealing employee contribution provisions; and
29 ▸ makes technical changes.
30 **Monies Appropriated in this Bill:**
31 None
32 **Other Special Clauses:**
33 None
34 **Utah Code Sections Affected:**
35 AMENDS:
36 **31A-1-301**, as last amended by Chapters 131 and 298, Laws of Utah 2003
37 **31A-2-205**, as last amended by Chapter 298, Laws of Utah 2003
38 **31A-2-207**, as last amended by Chapter 259, Laws of Utah 1991
39 **31A-2-309**, as last amended by Chapter 298, Laws of Utah 2003
40 **31A-4-113**, as last amended by Chapter 116, Laws of Utah 2001
41 **31A-8-103**, as last amended by Chapter 298, Laws of Utah 2003
42 **31A-16-103**, as last amended by Chapter 1, Laws of Utah 2000
43 **31A-23a-112**, as renumbered and amended by Chapter 298, Laws of Utah 2003
44 **31A-23a-409**, as renumbered and amended by Chapter 298, Laws of Utah 2003
45 **31A-29-103**, as last amended by Chapter 168, Laws of Utah 2003
46 **31A-29-104**, as last amended by Chapter 168, Laws of Utah 2003
47 **31A-29-111**, as last amended by Chapter 168, Laws of Utah 2003
48 **31A-29-112**, as last amended by Chapter 168, Laws of Utah 2003
49 **31A-29-113**, as last amended by Chapter 168, Laws of Utah 2003
50 **31A-29-114**, as last amended by Chapter 168, Laws of Utah 2003
51 **31A-29-115**, as last amended by Chapter 168, Laws of Utah 2003
52 **31A-30-103**, as last amended by Chapters 114 and 308, Laws of Utah 2002
53 **31A-30-108**, as last amended by Chapter 308, Laws of Utah 2002
54 ENACTS:
55 **31A-21-110**, Utah Code Annotated 1953
56 REPEALS:
57 **31A-29-118**, as enacted by Chapter 232, Laws of Utah 1990
58

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

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

61 **31A-1-301. Definitions.**

62 As used in this title, unless otherwise specified:

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

65 (i) a medical condition including:

66 (A) medical care expenses; or

67 (B) the risk of disability;

68 (ii) accident; or

69 (iii) sickness.

70 (b) "Accident and health insurance":

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

72 (A) an income replacement contract;

73 (B) a health care contract;

74 (C) an expense reimbursement contract;

75 (D) a credit accident and health contract;

76 (E) a continuing care contract; and

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

78 (ii) may provide:

79 (A) hospital coverage;

80 (B) surgical coverage;

81 (C) medical coverage; or

82 (D) loss of income coverage.

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

84 (2) "Actuary" is as defined by the commissioner by rule, made in accordance with Title
85 63, Chapter 46a, Utah Administrative Rulemaking Act.

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

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

88 (5) "Affiliate" means any person who controls, is controlled by, or is under common
89 control with, another person. A corporation is an affiliate of another corporation, regardless of

90 ownership, if substantially the same group of natural persons manages the corporations.
91 (6) "Agency" means:
92 (a) a person other than an individual, including a sole proprietorship by which a natural
93 person does business under an assumed name; and
94 (b) an insurance organization licensed or required to be licensed under Section
95 31A-23a-301.
96 (7) "Alien insurer" means an insurer domiciled outside the United States.
97 (8) "Amendment" means an endorsement to an insurance policy or certificate.
98 (9) "Annuity" means an agreement to make periodical payments for a period certain or
99 over the lifetime of one or more natural persons if the making or continuance of all or some of
100 the series of the payments, or the amount of the payment, is dependent upon the continuance of
101 human life.
102 (10) "Application" means a document:
103 (a) (i) completed by an applicant to provide information about the risk to be insured;
104 and
105 [~~(b)~~] (ii) that contains information that is used by the insurer to[~~: (i)~~] evaluate risk[~~;~~]
106 and [~~(ii)~~] decide whether to:
107 (A) insure the risk under:
108 (I) the coverages as originally offered; or
109 (II) a modification of the coverage as originally offered; or
110 (B) decline to insure the risk[~~.~~]; or
111 (b) used by the insurer to gather information from the applicant before issuance of an
112 annuity contract.
113 (11) "Articles" or "articles of incorporation" means the original articles, special laws,
114 charters, amendments, restated articles, articles of merger or consolidation, trust instruments,
115 and other constitutive documents for trusts and other entities that are not corporations, and
116 amendments to any of these.
117 (12) "Bail bond insurance" means a guarantee that a person will attend court when
118 required, or will obey the orders or judgment of the court, as a condition to the release of that
119 person from confinement.
120 (13) "Binder" is defined in Section 31A-21-102.

121 (14) "Board," "board of trustees," or "board of directors" means the group of persons
122 with responsibility over, or management of, a corporation, however designated.
123 (15) "Business entity" means a corporation, association, partnership, limited liability
124 company, limited liability partnership, or other legal entity.
125 (16) "Business of insurance" is defined in Subsection [~~(80)~~] (81).
126 (17) "Business plan" means the information required to be supplied to the
127 commissioner under Subsections 31A-5-204(2)(i) and (j), including the information required
128 when these subsections are applicable by reference under:
129 (a) Section 31A-7-201;
130 (b) Section 31A-8-205; or
131 (c) Subsection 31A-9-205(2).
132 (18) "Bylaws" means the rules adopted for the regulation or management of a
133 corporation's affairs, however designated and includes comparable rules for trusts and other
134 entities that are not corporations.
135 (19) "Captive insurance company" means:
136 (a) an insurance company:
137 (i) owned by another organization; and
138 (ii) whose exclusive purpose is to insure risks of the parent organization and affiliated
139 companies; or
140 (b) in the case of groups and associations, an insurance organization:
141 (i) owned by the insureds; and
142 (ii) whose exclusive purpose is to insure risks of:
143 (A) member organizations;
144 (B) group members; and
145 (C) affiliates of:
146 (I) member organizations; or
147 (II) group members.
148 (20) "Casualty insurance" means liability insurance as defined in Subsection [~~(90)~~]
149 (91).
150 (21) "Certificate" means evidence of insurance given to:
151 (a) an insured under a group insurance policy; or

152 (b) a third party.
153 (22) "Certificate of authority" is included within the term "license."
154 (23) "Claim," unless the context otherwise requires, means a request or demand on an
155 insurer for payment of benefits according to the terms of an insurance policy.
156 (24) "Claims-made coverage" means an insurance contract or provision limiting
157 coverage under a policy insuring against legal liability to claims that are first made against the
158 insured while the policy is in force.
159 (25) (a) "Commissioner" or "commissioner of insurance" means Utah's insurance
160 commissioner.
161 (b) When appropriate, the terms listed in Subsection (25)(a) apply to the equivalent
162 supervisory official of another jurisdiction.
163 (26) (a) "Continuing care insurance" means insurance that:
164 (i) provides board and lodging;
165 (ii) provides one or more of the following services:
166 (A) personal services;
167 (B) nursing services;
168 (C) medical services; or
169 (D) other health-related services; and
170 (iii) provides the coverage described in Subsection (26)(a)(i) under an agreement
171 effective:
172 (A) for the life of the insured; or
173 (B) for a period in excess of one year.
174 (b) Insurance is continuing care insurance regardless of whether or not the board and
175 lodging are provided at the same location as the services described in Subsection (26)(a)(ii).
176 (27) (a) "Control," "controlling," "controlled," or "under common control" means the
177 direct or indirect possession of the power to direct or cause the direction of the management
178 and policies of a person. This control may be:
179 (i) by contract;
180 (ii) by common management;
181 (iii) through the ownership of voting securities; or
182 (iv) by a means other than those described in Subsections (27)(a)(i) through (iii).

183 (b) There is no presumption that an individual holding an official position with another
184 person controls that person solely by reason of the position.
185 (c) A person having a contract or arrangement giving control is considered to have
186 control despite the illegality or invalidity of the contract or arrangement.
187 (d) There is a rebuttable presumption of control in a person who directly or indirectly
188 owns, controls, holds with the power to vote, or holds proxies to vote 10% or more of the
189 voting securities of another person.
190 (28) "Controlled insurer" means a licensed insurer that is either directly or indirectly
191 controlled by a producer.
192 (29) "Controlling person" means any person[, firm, association, or corporation] that
193 directly or indirectly has the power to direct or cause to be directed, the management, control,
194 or activities of a reinsurance intermediary.
195 (30) "Controlling producer" means a producer who directly or indirectly controls an
196 insurer.
197 (31) (a) "Corporation" means an insurance corporation, except when referring to:
198 (i) a corporation doing business:
199 (A) as:
200 (I) an insurance producer[,];
201 (II) a limited line producer[,];
202 (III) a consultant[,];
203 (IV) a managing general agent[,];
204 (V) a reinsurance intermediary[,];
205 (VI) a third party administrator[,]; or
206 (VII) an adjuster; and
207 (B) under:
208 [(A)] (I) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and
209 Reinsurance Intermediaries;
210 [(B)] (II) Chapter 25, Third Party Administrators; [and] or
211 [(C)] (III) Chapter 26, Insurance Adjusters; or
212 (ii) a noninsurer that is part of a holding company system under Chapter 16, Insurance
213 Holding Companies.

214 (b) "Stock corporation" means a stock insurance corporation.
215 (c) "Mutual" or "mutual corporation" means a mutual insurance corporation.
216 (32) "Credit accident and health insurance" means insurance on a debtor to provide
217 indemnity for payments coming due on a specific loan or other credit transaction while the
218 debtor is disabled.
219 (33) (a) "Credit insurance" means insurance offered in connection with an extension of
220 credit that is limited to partially or wholly extinguishing that credit obligation.
221 (b) "Credit insurance" includes:
222 (i) credit accident and health insurance;
223 (ii) credit life insurance;
224 (iii) credit property insurance;
225 (iv) credit unemployment insurance;
226 (v) guaranteed automobile protection insurance;
227 (vi) involuntary unemployment insurance;
228 (vii) mortgage accident and health insurance;
229 (viii) mortgage guaranty insurance; and
230 (ix) mortgage life insurance.
231 (34) "Credit life insurance" means insurance on the life of a debtor in connection with
232 an extension of credit that pays a person if the debtor dies.
233 (35) "Credit property insurance" means insurance:
234 (a) offered in connection with an extension of credit; and
235 (b) that protects the property until the debt is paid.
236 (36) "Credit unemployment insurance" means insurance:
237 (a) offered in connection with an extension of credit; and
238 (b) that provides indemnity if the debtor is unemployed for payments coming due on a:
239 (i) specific loan; or
240 (ii) credit transaction.
241 (37) "Creditable coverage" is as defined in 45 C.F.R. 146.113(a).
242 (38) "Creditor" means a person, including an insured, having any claim, whether:
243 (a) matured;
244 (b) unmatured;

245 (c) liquidated;
246 (d) unliquidated;
247 (e) secured;
248 (f) unsecured;
249 (g) absolute;
250 (h) fixed; or
251 (i) contingent.
252 (39) (a) "Customer service representative" means a person that provides insurance
253 services and insurance product information:
254 (i) for the customer service representative's:
255 (A) producer; or
256 (B) consultant employer; and
257 (ii) to the customer service representative's employer's:
258 (A) customer[,];
259 (B) client[,]; or
260 (C) organization.
261 (b) A customer service representative may only operate within the scope of authority of
262 the customer service representative's producer or consultant employer.
263 (40) "Deadline" means the final date or time:
264 (a) imposed by:
265 (i) statute;
266 (ii) rule; or
267 (iii) order; and
268 (b) by which a required filing or payment must be received by the department.
269 (41) "Deemer clause" means a provision under this title under which upon the
270 occurrence of a condition precedent, the commissioner is deemed to have taken a specific
271 action. If the statute so provides, the condition precedent may be the commissioner's failure to
272 take a specific action.
273 (42) "Degree of relationship" means the number of steps between two persons
274 determined by counting the generations separating one person from a common ancestor and
275 then counting the generations to the other person.

276 (43) "Department" means the Insurance Department.
277 (44) "Director" means a member of the board of directors of a corporation.
278 (45) "Disability" means a physiological or psychological condition that partially or
279 totally limits an individual's ability to:
280 (a) perform the duties of:
281 (i) that individual's occupation; or
282 (ii) any occupation for which the individual is reasonably suited by education, training,
283 or experience; or
284 (b) perform two or more of the following basic activities of daily living:
285 (i) eating;
286 (ii) toileting;
287 (iii) transferring;
288 (iv) bathing; or
289 (v) dressing.
290 (46) "Disability income insurance" is defined in Subsection [~~(71)~~] (72).
291 (47) "Domestic insurer" means an insurer organized under the laws of this state.
292 (48) "Domiciliary state" means the state in which an insurer:
293 (a) is incorporated;
294 (b) is organized; or
295 (c) in the case of an alien insurer, enters into the United States.
296 (49) (a) "Eligible employee" means:
297 (i) an employee who:
298 (A) works on a full-time basis; and
299 (B) has a normal work week of 30 or more hours; or
300 (ii) a person described in Subsection (49)(b).
301 (b) "Eligible employee" includes, if the individual is included under a health benefit
302 plan of a small employer:
303 (i) a sole proprietor;
304 (ii) a partner in a partnership; or
305 (iii) an independent contractor.
306 (c) "Eligible employee" does not include, unless eligible under Subsection (49)(b):

307 (i) an individual who works on a temporary or substitute basis for a small employer;
308 (ii) an employer's spouse; or
309 (iii) a dependent of an employer.
310 (50) "Employee" means any individual employed by an employer.
311 (51) "Employee benefits" means one or more benefits or services provided to:
312 (a) employees; or
313 (b) dependents of employees.
314 (52) (a) "Employee welfare fund" means a fund:
315 (i) established or maintained, whether directly or through trustees, by:
316 (A) one or more employers;
317 (B) one or more labor organizations; or
318 (C) a combination of employers and labor organizations; and
319 (ii) that provides employee benefits paid or contracted to be paid, other than income
320 from investments of the fund, by or on behalf of an employer doing business in this state or for
321 the benefit of any person employed in this state.
322 (b) "Employee welfare fund" includes a plan funded or subsidized by user fees or tax
323 revenues.
324 (53) "Endorsement" means a written agreement attached to a policy or certificate to
325 modify one or more of the provisions of the policy or certificate.
326 (54) (a) "Escrow" means:
327 (i) a real estate settlement or real estate closing conducted by a third party pursuant to
328 the requirements of a written agreement between the parties in a real estate transaction; or
329 (ii) a settlement or closing involving:
330 (A) a mobile home;
331 (B) a grazing right;
332 (C) a water right; or
333 (D) other personal property authorized by the commissioner.
334 (b) "Escrow" includes the act of conducting a:
335 (i) real estate settlement; or
336 (ii) real estate closing.
337 (55) "Escrow agent" means:

338 (a) an insurance producer with:
339 (i) a title insurance line of authority; and
340 (ii) an escrow subline of authority; or
341 (b) a person defined as an escrow agent in Section 7-22-101.
342 [(55)] (56) "Excludes" is not exhaustive and does not mean that other things are not
343 also excluded. The items listed are representative examples for use in interpretation of this
344 title.
345 [(56)] (57) "Expense reimbursement insurance" means insurance:
346 (a) written to provide payments for expenses relating to hospital confinements resulting
347 from illness or injury; and
348 (b) written:
349 (i) as a daily limit for a specific number of days in a hospital; and
350 (ii) to have a one or two day waiting period following a hospitalization.
351 [(57)] (58) "Fidelity insurance" means insurance guaranteeing the fidelity of persons
352 holding positions of public or private trust.
353 [(58)] (59) (a) "Filed" means that a filing is:
354 (i) submitted to the department as required by and in accordance with any applicable
355 statute, rule, or filing order;
356 (ii) received by the department within the time period provided in the applicable
357 statute, rule, or filing order; and
358 (iii) accompanied by the appropriate fee in accordance with:
359 (A) Section 31A-3-103; or
360 (B) rule.
361 (b) "Filed" does not include a filing that is rejected by the department because it is not
362 submitted in accordance with Subsection [(58)] (59)(a).
363 [(59)] (60) "Filing," when used as a noun, means an item required to be filed with the
364 department including:
365 (a) a policy;
366 (b) a rate;
367 (c) a form;
368 (d) a document;

369 (e) a plan;
370 (f) a manual;
371 (g) an application;
372 (h) a report;
373 (i) a certificate;
374 (j) an endorsement;
375 (k) an actuarial certification;
376 (l) a licensee annual statement;
377 (m) a licensee renewal application; or
378 (n) an advertisement.
379 [(60)] (61) "First party insurance" means an insurance policy or contract in which the
380 insurer agrees to pay claims submitted to it by the insured for the insured's losses.
381 [(61)] (62) "Foreign insurer" means an insurer domiciled outside of this state, including
382 an alien insurer.
383 [(62)] (63) (a) "Form" means one of the following prepared for general use:
384 (i) a policy;
385 (ii) a certificate;
386 (iii) an application; or
387 (iv) an outline of coverage.
388 (b) "Form" does not include a document specially prepared for use in an individual
389 case.
390 [(63)] (64) "Franchise insurance" means individual insurance policies provided through
391 a mass marketing arrangement involving a defined class of persons related in some way other
392 than through the purchase of insurance.
393 [(64)] (65) "General lines of authority" include:
394 (a) the general lines of insurance in Subsection [(65)] (66);
395 (b) title insurance under one of the following sublines of authority:
396 (i) search, including authority to act as a title marketing representative;
397 (ii) escrow, including authority to act as a title marketing representative;
398 (iii) search and escrow, including authority to act as a title marketing representative;
399 and

400 (iv) title marketing representative only;
401 (c) surplus lines;
402 (d) workers' compensation; and
403 (e) any other line of insurance that the commissioner considers necessary to recognize
404 in the public interest.
405 [(65)] (66) "General lines of insurance" include:
406 (a) accident and health;
407 (b) casualty;
408 (c) life;
409 (d) personal lines;
410 (e) property; and
411 (f) variable contracts, including variable life and annuity.
412 [(66)] (67) "Group health plan" means an employee welfare benefit plan to the extent
413 that the plan provides medical care:
414 (a) (i) to employees; or
415 (ii) to a dependent of an employee; and
416 (b) (i) directly;
417 (ii) through insurance reimbursement; or
418 (iii) through any other method.
419 [(67)] (68) "Guaranteed automobile protection insurance" means insurance offered in
420 connection with an extension of credit that pays the difference in amount between the
421 insurance settlement and the balance of the loan if the insured automobile is a total loss.
422 [(68) "Health] (69) (a) Except as provided in Subsection (69)(b), "health benefit plan"
423 means a policy or certificate [for] that:
424 (i) provides health care insurance[, except that health benefit plan does not include
425 coverage:];
426 (ii) provides major medical expense insurance; or
427 (iii) is offered as a substitute for hospital or medical expense insurance such as:
428 (A) a hospital confinement indemnity; or
429 (B) a limited benefit plan.
430 (b) "Health benefit plan" does not include a policy or certificate that:

431 [(a)] (i) provides benefits solely for:
432 [(i)] (A) accident;
433 [(ii)] (B) dental;
434 (C) income replacement;
435 (D) long-term care;
436 (E) a Medicare supplement;
437 (F) a specified disease;
438 [(iii)] (G) vision; or
439 [(iv) Medicare supplement;]
440 [(v) long-term care; or]
441 [(vi) income replacement; or]
442 [(b) that is:]
443 (H) a short-term limited duration; or
444 [(i)] (ii) is offered and marketed as supplemental health insurance[;].
445 [(ii) not offered or marketed as a substitute for:]
446 [(A) hospital or medical expense insurance; or]
447 [(B) major medical expense insurance; and]
448 [(iii) solely for:]
449 [(A) a specified disease;]
450 [(B) hospital confinement indemnity; or]
451 [(C) limited benefit plan.]
452 [(69)] (70) "Health care" means any of the following intended for use in the diagnosis,
453 treatment, mitigation, or prevention of a human ailment or impairment:
454 (a) professional services;
455 (b) personal services;
456 (c) facilities;
457 (d) equipment;
458 (e) devices;
459 (f) supplies; or
460 (g) medicine.
461 [(70)] (71) (a) "Health care insurance" or "health insurance" means insurance

462 providing:
463 (i) health care benefits; or
464 (ii) payment of incurred health care expenses.
465 (b) "Health care insurance" or "health insurance" does not include accident and health
466 insurance providing benefits for:
467 (i) replacement of income;
468 (ii) short-term accident;
469 (iii) fixed indemnity;
470 (iv) credit accident and health;
471 (v) supplements to liability;
472 (vi) workers' compensation;
473 (vii) automobile medical payment;
474 (viii) no-fault automobile;
475 (ix) equivalent self-insurance; or
476 (x) any type of accident and health insurance coverage that is a part of or attached to
477 another type of policy.
478 [~~(71)~~] (72) "Income replacement insurance" or "disability income insurance" means
479 insurance written to provide payments to replace income lost from accident or sickness.
480 [~~(72)~~] (73) "Indemnity" means the payment of an amount to offset all or part of an
481 insured loss.
482 [~~(73)~~] (74) "Independent adjuster" means an insurance adjuster required to be licensed
483 under Section 31A-26-201 who engages in insurance adjusting as a representative of insurers.
484 [~~(74)~~] (75) "Independently procured insurance" means insurance procured under
485 Section 31A-15-104.
486 [~~(75)~~] (76) "Individual" means a natural person.
487 [~~(76)~~] (77) "Inland marine insurance" includes insurance covering:
488 (a) property in transit on or over land;
489 (b) property in transit over water by means other than boat or ship;
490 (c) bailee liability;
491 (d) fixed transportation property such as bridges, electric transmission systems, radio
492 and television transmission towers and tunnels; and

493 (e) personal and commercial property floaters.
494 [(77)] (78) "Insolvency" means that:
495 (a) an insurer is unable to pay its debts or meet its obligations as they mature;
496 (b) an insurer's total adjusted capital is less than the insurer's mandatory control level
497 RBC under Subsection 31A-17-601(8)(c); or
498 (c) an insurer is determined to be hazardous under this title.
499 [(78)] (79) (a) "Insurance" means:
500 (i) an arrangement, contract, or plan for the transfer of a risk or risks from one or more
501 persons to one or more other persons; or
502 (ii) an arrangement, contract, or plan for the distribution of a risk or risks among a
503 group of persons that includes the person seeking to distribute that person's risk.
504 (b) "Insurance" includes:
505 (i) risk distributing arrangements providing for compensation or replacement for
506 damages or loss through the provision of services or benefits in kind;
507 (ii) contracts of guaranty or suretyship entered into by the guarantor or surety as a
508 business and not as merely incidental to a business transaction; and
509 (iii) plans in which the risk does not rest upon the person who makes the arrangements,
510 but with a class of persons who have agreed to share it.
511 [(79)] (80) "Insurance adjuster" means a person who directs the investigation,
512 negotiation, or settlement of a claim under an insurance policy other than life insurance or an
513 annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.
514 [(80)] (81) "Insurance business" or "business of insurance" includes:
515 (a) providing health care insurance, as defined in Subsection [(70)] (71), by
516 organizations that are or should be licensed under this title;
517 (b) providing benefits to employees in the event of contingencies not within the control
518 of the employees, in which the employees are entitled to the benefits as a right, which benefits
519 may be provided either:
520 (i) by single employers or by multiple employer groups; or
521 (ii) through trusts, associations, or other entities;
522 (c) providing annuities, including those issued in return for gifts, except those provided
523 by persons specified in Subsections 31A-22-1305(2) and (3);

524 (d) providing the characteristic services of motor clubs as outlined in Subsection
525 [~~(106)~~] (107);
526 (e) providing other persons with insurance as defined in Subsection [~~(78)~~] (79);
527 (f) making as insurer, guarantor, or surety, or proposing to make as insurer, guarantor,
528 or surety, any contract or policy of title insurance;
529 (g) transacting or proposing to transact any phase of title insurance, including:
530 (i) solicitation[~~,~~];
531 (ii) negotiation preliminary to execution[~~,~~];
532 (iii) execution of a contract of title insurance[~~,~~];
533 (iv) insuring[~~,~~]; and
534 (v) transacting matters subsequent to the execution of the contract and arising out of
535 [~~it~~] the contract, including reinsurance; and
536 (h) doing, or proposing to do, any business in substance equivalent to Subsections
537 [~~(80)~~] (81)(a) through (g) in a manner designed to evade the provisions of this title.
538 [~~(81)~~] (82) "Insurance consultant" or "consultant" means a person who:
539 (a) advises other persons about insurance needs and coverages;
540 (b) is compensated by the person advised on a basis not directly related to the insurance
541 placed; and
542 (c) except as provided in Section 31A-23a-501, is not compensated directly or
543 indirectly by an insurer or producer for advice given.
544 [~~(82)~~] (83) "Insurance holding company system" means a group of two or more
545 affiliated persons, at least one of whom is an insurer.
546 [~~(83)~~] (84) (a) "Insurance producer" or "producer" means a person licensed or required
547 to be licensed under the laws of this state to sell, solicit, or negotiate insurance.
548 (b) With regards to the selling, soliciting, or negotiating of an insurance product to an
549 insurance customer or an insured:
550 (i) "producer for the insurer" means a producer who is compensated directly or
551 indirectly by an insurer for selling, soliciting, or negotiating any product of that insurer; and
552 (ii) "producer for the insured" means a producer who:
553 (A) is compensated directly and only by an insurance customer or an insured; and
554 (B) receives no compensation directly or indirectly from an insurer for selling,

555 soliciting, or negotiating any product of that insurer to an insurance customer or insured.
556 [~~(84)~~] (85) (a) "Insured" means a person to whom or for whose benefit an insurer
557 makes a promise in an insurance policy and includes:
558 (i) policyholders;
559 (ii) subscribers;
560 (iii) members; and
561 (iv) beneficiaries.
562 (b) The definition in Subsection [~~(84)~~] (85)(a):
563 (i) applies only to this title; and
564 (ii) does not define the meaning of this word as used in insurance policies or
565 certificates.
566 [~~(85)~~] (86) (a) (i) "Insurer" means any person doing an insurance business as a
567 principal including:
568 (A) fraternal benefit societies;
569 (B) issuers of gift annuities other than those specified in Subsections 31A-22-1305(2)
570 and (3);
571 (C) motor clubs;
572 (D) employee welfare plans; and
573 (E) any person purporting or intending to do an insurance business as a principal on
574 that person's own account.
575 (ii) "Insurer" does not include a governmental entity, as defined in Section 63-30-2, to
576 the extent it is engaged in the activities described in Section 31A-12-107.
577 (b) "Admitted insurer" is defined in Subsection [~~(153)~~] (154)(b).
578 (c) "Alien insurer" is defined in Subsection (7).
579 (d) "Authorized insurer" is defined in Subsection [~~(153)~~] (154)(b).
580 (e) "Domestic insurer" is defined in Subsection (47).
581 (f) "Foreign insurer" is defined in Subsection [~~(61)~~] (62).
582 (g) "Nonadmitted insurer" is defined in Subsection [~~(153)~~] (154)(a).
583 (h) "Unauthorized insurer" is defined in Subsection [~~(153)~~] (154)(a).
584 [~~(86)~~] (87) "Interinsurance exchange" is defined in Subsection [~~(135)~~] (136).
585 [~~(87)~~] (88) "Involuntary unemployment insurance" means insurance:

586 (a) offered in connection with an extension of credit;
587 (b) that provides indemnity if the debtor is involuntarily unemployed for payments
588 coming due on a:
589 (i) specific loan; or
590 (ii) credit transaction.
591 [~~(88)~~] (89) "Large employer," in connection with a health benefit plan, means an
592 employer who, with respect to a calendar year and to a plan year:
593 (a) employed an average of at least 51 eligible employees on each business day during
594 the preceding calendar year; and
595 (b) employs at least two employees on the first day of the plan year.
596 [~~(89)~~] (90) (a) Except for a retainer contract or legal assistance described in Section
597 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for
598 specified legal expenses.
599 (b) "Legal expense insurance" includes arrangements that create reasonable
600 expectations of enforceable rights.
601 (c) "Legal expense insurance" does not include the provision of, or reimbursement for,
602 legal services incidental to other insurance coverages.
603 [~~(90)~~] (91) (a) "Liability insurance" means insurance against liability:
604 (i) for death, injury, or disability of any human being, or for damage to property,
605 exclusive of the coverages under:
606 (A) Subsection [~~(100)~~] (101) for medical malpractice insurance;
607 (B) Subsection [~~(127)~~] (128) for professional liability insurance; and
608 (C) Subsection [~~(157)~~] (158) for workers' compensation insurance;
609 (ii) for medical, hospital, surgical, and funeral benefits to persons other than the
610 insured who are injured, irrespective of legal liability of the insured, when issued with or
611 supplemental to insurance against legal liability for the death, injury, or disability of human
612 beings, exclusive of the coverages under:
613 (A) Subsection [~~(100)~~] (101) for medical malpractice insurance;
614 (B) Subsection [~~(127)~~] (128) for professional liability insurance; and
615 (C) Subsection [~~(157)~~] (158) for workers' compensation insurance;
616 (iii) for loss or damage to property resulting from accidents to or explosions of boilers,

617 pipes, pressure containers, machinery, or apparatus;
618 (iv) for loss or damage to any property caused by the breakage or leakage of sprinklers,
619 water pipes and containers, or by water entering through leaks or openings in buildings; or
620 (v) for other loss or damage properly the subject of insurance not within any other kind
621 or kinds of insurance as defined in this chapter, if such insurance is not contrary to law or
622 public policy.
623 (b) "Liability insurance" includes:
624 (i) vehicle liability insurance as defined in Subsection [~~(155)~~] (156);
625 (ii) residential dwelling liability insurance as defined in Subsection [~~(138)~~] (139); and
626 (iii) making inspection of, and issuing certificates of inspection upon, elevators,
627 boilers, machinery, and apparatus of any kind when done in connection with insurance on
628 them.
629 [~~(91)~~] (92) (a) "License" means the authorization issued by the commissioner to engage
630 in some activity that is part of or related to the insurance business.
631 (b) "License" includes certificates of authority issued to insurers.
632 [~~(92)~~] (93) (a) "Life insurance" means insurance on human lives and insurances
633 pertaining to or connected with human life.
634 (b) The business of life insurance includes:
635 (i) granting death benefits;
636 (ii) granting annuity benefits;
637 (iii) granting endowment benefits;
638 (iv) granting additional benefits in the event of death by accident;
639 (v) granting additional benefits to safeguard the policy against lapse in the event of
640 disability; and
641 (vi) providing optional methods of settlement of proceeds.
642 [~~(93)~~] (94) "Limited license" means a license that:
643 (a) is issued for a specific product of insurance; and
644 (b) limits an individual or agency to transact only for that product or insurance.
645 [~~(94)~~] (95) "Limited line credit insurance" includes the following forms of insurance:
646 (a) credit life;
647 (b) credit accident and health;

648 (c) credit property;
649 (d) credit unemployment;
650 (e) involuntary unemployment;
651 (f) mortgage life;
652 (g) mortgage guaranty;
653 (h) mortgage accident and health;
654 (i) guaranteed automobile protection; and
655 (j) any other form of insurance offered in connection with an extension of credit that:
656 (i) is limited to partially or wholly extinguishing the credit obligation; and
657 (ii) the commissioner determines by rule should be designated as a form of limited line
658 credit insurance.
659 [~~(95)~~] (96) "Limited line credit insurance producer" means a person who sells, solicits,
660 or negotiates one or more forms of limited line credit insurance coverage to individuals through
661 a master, corporate, group, or individual policy.
662 [~~(96)~~] (97) "Limited line insurance" includes:
663 (a) bail bond;
664 (b) limited line credit insurance;
665 (c) legal expense insurance;
666 (d) motor club insurance;
667 (e) rental car-related insurance;
668 (f) travel insurance; and
669 (g) any other form of limited insurance that the commissioner determines by rule
670 should be designated a form of limited line insurance.
671 [~~(97)~~] (98) "Limited lines authority" includes:
672 (a) the lines of insurance listed in Subsection [~~(96)~~] (97); and
673 (b) a customer service representative.
674 [~~(98)~~] (99) "Limited lines producer" means a person who sells, solicits, or negotiates
675 limited lines insurance.
676 [~~(99)~~] (100) (a) "Long-term care insurance" means an insurance policy or rider
677 advertised, marketed, offered, or designated to provide coverage:
678 (i) in a setting other than an acute care unit of a hospital;

679 (ii) for not less than 12 consecutive months for each covered person on the basis of:
680 (A) expenses incurred;
681 (B) indemnity;
682 (C) prepayment; or
683 (D) another method;
684 (iii) for one or more necessary or medically necessary services that are:
685 (A) diagnostic;
686 (B) preventative;
687 (C) therapeutic;
688 (D) rehabilitative;
689 (E) maintenance; or
690 (F) personal care; and
691 (iv) that may be issued by:
692 (A) an insurer;
693 (B) a fraternal benefit society;
694 (C) (I) a nonprofit health hospital; and
695 (II) a medical service corporation;
696 (D) a prepaid health plan;
697 (E) a health maintenance organization; or
698 (F) an entity similar to the entities described in Subsections [(99)] (100)(a)(iv)(A)
699 through (E) to the extent that the entity is otherwise authorized to issue life or health care
700 insurance.
701 (b) "Long-term care insurance" includes:
702 (i) any of the following that provide directly or supplement long-term care insurance:
703 (A) a group or individual annuity or rider; or
704 (B) a life insurance policy or rider;
705 (ii) a policy or rider that provides for payment of benefits based on:
706 (A) cognitive impairment; or
707 (B) functional capacity; or
708 (iii) a qualified long-term care insurance contract.
709 (c) "Long-term care insurance" does not include:

710 (i) a policy that is offered primarily to provide basic Medicare supplement coverage;
711 (ii) basic hospital expense coverage;
712 (iii) basic medical/surgical expense coverage;
713 (iv) hospital confinement indemnity coverage;
714 (v) major medical expense coverage;
715 (vi) income replacement or related asset-protection coverage;
716 (vii) accident only coverage;
717 (viii) coverage for a specified:
718 (A) disease; or
719 (B) accident;
720 (ix) limited benefit health coverage; or
721 (x) a life insurance policy that accelerates the death benefit to provide the option of a
722 lump sum payment:
723 (A) if the following are not conditioned on the receipt of long-term care:
724 (I) benefits; or
725 (II) eligibility; and
726 (B) the coverage is for one or more the following qualifying events:
727 (I) terminal illness;
728 (II) medical conditions requiring extraordinary medical intervention; or
729 (III) permanent institutional confinement.
730 [~~(100)~~] <u>(101)</u> "Medical malpractice insurance" means insurance against legal liability
731 incident to the practice and provision of medical services other than the practice and provision
732 of dental services.
733 [~~(101)~~] <u>(102)</u> "Member" means a person having membership rights in an insurance
734 corporation.
735 [~~(102)~~] <u>(103)</u> "Minimum capital" or "minimum required capital" means the capital that
736 must be constantly maintained by a stock insurance corporation as required by statute.
737 [~~(103)~~] <u>(104)</u> "Mortgage accident and health insurance" means insurance offered in
738 connection with an extension of credit that provides indemnity for payments coming due on a
739 mortgage while the debtor is disabled.
740 [~~(104)~~] <u>(105)</u> "Mortgage guaranty insurance" means surety insurance under which

741 mortgagees and other creditors are indemnified against losses caused by the default of debtors.
742 [(105)] (106) "Mortgage life insurance" means insurance on the life of a debtor in
743 connection with an extension of credit that pays if the debtor dies.
744 [(106)] (107) "Motor club" means a person:
745 (a) licensed under:
746 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
747 (ii) Chapter 11, Motor Clubs; or
748 (iii) Chapter 14, Foreign Insurers; and
749 (b) that promises for an advance consideration to provide for a stated period of time:
750 (i) legal services under Subsection 31A-11-102(1)(b);
751 (ii) bail services under Subsection 31A-11-102(1)(c); or
752 (iii) trip reimbursement, towing services, emergency road services, stolen automobile
753 services, a combination of these services, or any other services given in Subsections
754 31A-11-102(1)(b) through (f).
755 [(107)] (108) "Mutual" means a mutual insurance corporation.
756 [(108)] (109) "Network plan" means health care insurance:
757 (a) that is issued by an insurer; and
758 (b) under which the financing and delivery of medical care is provided, in whole or in
759 part, through a defined set of providers under contract with the insurer, including the financing
760 and delivery of items paid for as medical care.
761 [(109)] (110) "Nonparticipating" means a plan of insurance under which the insured is
762 not entitled to receive dividends representing shares of the surplus of the insurer.
763 [(110)] (111) "Ocean marine insurance" means insurance against loss of or damage to:
764 (a) ships or hulls of ships;
765 (b) goods, freight, cargoes, merchandise, effects, disbursements, profits, moneys,
766 securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia
767 interests, or other cargoes in or awaiting transit over the oceans or inland waterways;
768 (c) earnings such as freight, passage money, commissions, or profits derived from
769 transporting goods or people upon or across the oceans or inland waterways; or
770 (d) a vessel owner or operator as a result of liability to employees, passengers, bailors,
771 owners of other vessels, owners of fixed objects, customs or other authorities, or other persons

772 in connection with maritime activity.

773 [(111)] (112) "Order" means an order of the commissioner.

774 [(112)] (113) "Outline of coverage" means a summary that explains an accident and
775 health insurance policy.

776 [(113)] (114) "Participating" means a plan of insurance under which the insured is
777 entitled to receive dividends representing shares of the surplus of the insurer.

778 [(114)] (115) "Participation," as used in a health benefit plan, means a requirement
779 relating to the minimum percentage of eligible employees that must be enrolled in relation to
780 the total number of eligible employees of an employer reduced by each eligible employee who
781 voluntarily declines coverage under the plan because the employee has other group health care
782 insurance coverage.

783 [(115)] (116) "Person" includes an individual, partnership, corporation, incorporated or
784 unincorporated association, joint stock company, trust, limited liability company, reciprocal,
785 syndicate, or any similar entity or combination of entities acting in concert.

786 [(116)] (117) "Personal lines insurance" means property and casualty insurance
787 coverage sold for primarily noncommercial purposes to:

788 (a) individuals; and

789 (b) families.

790 [(117)] (118) "Plan sponsor" is as defined in 29 U.S.C. Sec. 1002(16)(B).

791 [(118)] (119) "Plan year" means:

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

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

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

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

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

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

800 (iii) the employer's taxable year if:

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

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

803 (II) the insurance policy is not renewed on an annual basis; or
804 (c) in a case not described in Subsection [~~(118)~~] (119)(a) or (b), the calendar year.
805 [~~(119)~~] (120) (a) (i) "Policy" means any document, including attached endorsements
806 and riders, purporting to be an enforceable contract, which memorializes in writing some or all
807 of the terms of an insurance contract.
808 (ii) "Policy" includes a service contract issued by:
809 (A) a motor club under Chapter 11, Motor Clubs;
810 (B) a service contract provided under Chapter 6a, Service Contracts; and
811 (C) a corporation licensed under:
812 (I) Chapter 7, Nonprofit Health Service Insurance Corporations; or
813 (II) Chapter 8, Health Maintenance Organizations and Limited Health Plans.
814 (iii) "Policy" does not include:
815 (A) a certificate under a group insurance contract; or
816 (B) a document that does not purport to have legal effect.
817 (b) (i) "Group insurance policy" means a policy covering a group of persons that is
818 issued to a policyholder on behalf of the group, for the benefit of group members who are
819 selected under procedures defined in the policy or in agreements which are collateral to the
820 policy.
821 (ii) A group insurance policy may include members of the policyholder's family or
822 dependents.
823 (c) "Blanket insurance policy" means a group policy covering classes of persons
824 without individual underwriting, where the persons insured are determined by definition of the
825 class with or without designating the persons covered.
826 [~~(120)~~] (121) "Policyholder" means the person who controls a policy, binder, or oral
827 contract by ownership, premium payment, or otherwise.
828 [~~(121)~~] (122) "Policy illustration" means a presentation or depiction that includes
829 nonguaranteed elements of a policy of life insurance over a period of years.
830 [~~(122)~~] (123) "Policy summary" means a synopsis describing the elements of a life
831 insurance policy.
832 [~~(123)~~] (124) "Preexisting condition," in connection with a health benefit plan, means:
833 (a) a condition for which medical advice, diagnosis, care, or treatment was

834 recommended or received during the six months immediately preceding the earlier of:
835 (i) the enrollment date; or
836 (ii) the effective date of coverage; or
837 (b) for an individual insurance policy, a pregnancy existing on the effective date of
838 coverage.
839 [(124)] (125) (a) "Premium" means the monetary consideration for an insurance
840 policy[, and].
841 (b) "Premium" includes, however designated:
842 (i) assessments[,];
843 (ii) membership fees[,];
844 (iii) required contributions[,]; or
845 (iv) monetary consideration[, however designated].
846 [(b)] (c) (i) Consideration paid to third party administrators for their services is not
847 "premium[,]." [though amounts]
848 (ii) Amounts paid by third party administrators to insurers for insurance on the risks
849 administered by the third party administrators are "premium."
850 [(125)] (126) "Principal officers" of a corporation means the officers designated under
851 Subsection 31A-5-203(3).
852 [(126)] (127) "Proceedings" includes actions and special statutory proceedings.
853 [(127)] (128) "Professional liability insurance" means insurance against legal liability
854 incident to the practice of a profession and provision of any professional services.
855 [(128)] (129) "Property insurance" means insurance against loss or damage to real or
856 personal property of every kind and any interest in that property, from all hazards or causes,
857 and against loss consequential upon the loss or damage including vehicle comprehensive and
858 vehicle physical damage coverages, but excluding inland marine insurance and ocean marine
859 insurance as defined under Subsections [(76)] (77) and [(110)] (111).
860 [(129)] (130) "Qualified long-term care insurance contract" or "federally tax qualified
861 long-term care insurance contract" means:
862 (a) an individual or group insurance contract that meets the requirements of Section
863 7702B(b), Internal Revenue Code; or
864 (b) the portion of a life insurance contract that provides long-term care insurance:

865 (i) (A) by rider; or
866 (B) as a part of the contract; and
867 (ii) that satisfies the requirements of Section 7702B(b) and (e), Internal Revenue Code.
868 [~~(130)~~] (131) "Qualified United States financial institution" means an institution that:
869 (a) is:
870 (i) organized under the laws of the United States or any state; or
871 (ii) in the case of a United States office of a foreign banking organization, licensed
872 under the laws of the United States or any state;
873 (b) is regulated, supervised, and examined by United States federal or state authorities
874 having regulatory authority over banks and trust companies; and
875 (c) meets the standards of financial condition and standing that are considered
876 necessary and appropriate to regulate the quality of financial institutions whose letters of credit
877 will be acceptable to the commissioner as determined by:
878 (i) the commissioner by rule; or
879 (ii) the Securities Valuation Office of the National Association of Insurance
880 Commissioners.
881 [~~(131)~~] (132) (a) "Rate" means:
882 (i) the cost of a given unit of insurance; or
883 (ii) for property-casualty insurance, that cost of insurance per exposure unit either
884 expressed as:
885 (A) a single number; or
886 (B) a pure premium rate, adjusted before any application of individual risk variations
887 based on loss or expense considerations to account for the treatment of:
888 (I) expenses;
889 (II) profit; and
890 (III) individual insurer variation in loss experience.
891 (b) "Rate" does not include a minimum premium.
892 [~~(132)~~] (133) (a) Except as provided in Subsection [~~(132)~~] (133)(b), "rate service
893 organization" means any person who assists insurers in rate making or filing by:
894 (i) collecting, compiling, and furnishing loss or expense statistics;
895 (ii) recommending, making, or filing rates or supplementary rate information; or

896 (iii) advising about rate questions, except as an attorney giving legal advice.
897 (b) "Rate service organization" does not mean:
898 (i) an employee of an insurer;
899 (ii) a single insurer or group of insurers under common control;
900 (iii) a joint underwriting group; or
901 (iv) a natural person serving as an actuarial or legal consultant.
902 [~~(133)~~] (134) "Rating manual" means any of the following used to determine initial and
903 renewal policy premiums:
904 (a) a manual of rates;
905 (b) classifications;
906 (c) rate-related underwriting rules; and
907 (d) rating formulas that describe steps, policies, and procedures for determining initial
908 and renewal policy premiums.
909 [~~(134)~~] (135) "Received by the department" means:
910 (a) except as provided in Subsection [~~(134)~~] (135)(b), the date delivered to and
911 stamped received by the department, whether delivered:
912 (i) in person; or
913 (ii) electronically; and
914 (b) if delivered to the department by a delivery service, the delivery service's postmark
915 date or pick-up date unless otherwise stated in:
916 (i) statute;
917 (ii) rule; or
918 (iii) a specific filing order.
919 [~~(135)~~] (136) "Reciprocal" or "interinsurance exchange" means any unincorporated
920 association of persons:
921 (a) operating through an attorney-in-fact common to all of them; and
922 (b) exchanging insurance contracts with one another that provide insurance coverage
923 on each other.
924 [~~(136)~~] (137) "Reinsurance" means an insurance transaction where an insurer, for
925 consideration, transfers any portion of the risk it has assumed to another insurer. In referring to
926 reinsurance transactions, this title sometimes refers to:

927 (a) the insurer transferring the risk as the "ceding insurer"; and
928 (b) the insurer assuming the risk as the:
929 (i) "assuming insurer"; or
930 (ii) "assuming reinsurer."
931 [~~(137)~~] (138) "Reinsurer" means any person[~~, firm, association, or corporation~~]
932 licensed in this state as an insurer with the authority to assume reinsurance.
933 [~~(138)~~] (139) "Residential dwelling liability insurance" means insurance against
934 liability resulting from or incident to the ownership, maintenance, or use of a residential
935 dwelling that is a detached single family residence or multifamily residence up to four units.
936 [~~(139)~~] (140) "Retrocession" means reinsurance with another insurer of a liability
937 assumed under a reinsurance contract. A reinsurer "retrocedes" when it reinsures with another
938 insurer part of a liability assumed under a reinsurance contract.
939 [~~(140)~~] (141) "Rider" means an endorsement to:
940 (a) an insurance policy; or
941 (b) an insurance certificate.
942 [~~(141)~~] (142) (a) "Security" means any:
943 (i) note;
944 (ii) stock;
945 (iii) bond;
946 (iv) debenture;
947 (v) evidence of indebtedness;
948 (vi) certificate of interest or participation in any profit-sharing agreement;
949 (vii) collateral-trust certificate;
950 (viii) preorganization certificate or subscription;
951 (ix) transferable share;
952 (x) investment contract;
953 (xi) voting trust certificate;
954 (xii) certificate of deposit for a security;
955 (xiii) certificate of interest of participation in an oil, gas, or mining title or lease or in
956 payments out of production under such a title or lease;
957 (xiv) commodity contract or commodity option;

958 (xv) any certificate of interest or participation in, temporary or interim certificate for,
959 receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed
960 in Subsections [(141)] (142)(a)(i) through (xiv); or
961 (xvi) any other interest or instrument commonly known as a security.
962 (b) "Security" does not include:
963 (i) any [insurance or endowment policy or annuity contract] of the following under
964 which an insurance company promises to pay money in a specific lump sum or periodically for
965 life or some other specified period[; or]:
966 (A) insurance;
967 (B) endowment policy; or
968 (C) annuity contract; or
969 (ii) a burial certificate or burial contract.
970 [(142)] (143) "Self-insurance" means any arrangement under which a person provides
971 for spreading its own risks by a systematic plan.
972 (a) Except as provided in this Subsection [(142)] (143), "self-insurance" does not
973 include an arrangement under which a number of persons spread their risks among themselves.
974 (b) "Self-insurance" [does include] includes:
975 (i) an arrangement by which a governmental entity, as defined in Section 63-30-2,
976 undertakes to indemnify its employees for liability arising out of the employees' employment[.
977 (c) Self-insurance does include]; and
978 (ii) an arrangement by which a person with a managed program of self-insurance and
979 risk management undertakes to indemnify its affiliates, subsidiaries, directors, officers, or
980 employees for liability or risk which is related to the relationship or employment.
981 [(d)] (c) "Self-insurance" does not include any arrangement with independent
982 contractors.
983 [(143)] (144) "Sell" means to exchange a contract of insurance:
984 (a) by any means;
985 (b) for money or its equivalent; and
986 (c) on behalf of an insurance company.
987 [(144)] (145) "Short-term care insurance" means any insurance policy or rider
988 advertised, marketed, offered, or designed to provide coverage that is similar to long-term care

989 insurance but that provides coverage for less than 12 consecutive months for each covered
990 person.
991 [(145)] (146) "Small employer," in connection with a health benefit plan, means an
992 employer who, with respect to a calendar year and to a plan year:
993 (a) employed an average of at least two employees but not more than 50 eligible
994 employees on each business day during the preceding calendar year; and
995 (b) employs at least two employees on the first day of the plan year.
996 [(146)] (147) (a) "Subsidiary" of a person means an affiliate controlled by that person
997 either directly or indirectly through one or more affiliates or intermediaries.
998 (b) "Wholly owned subsidiary" of a person is a subsidiary of which all of the voting
999 shares are owned by that person either alone or with its affiliates, except for the minimum
1000 number of shares the law of the subsidiary's domicile requires to be owned by directors or
1001 others.
1002 [(147)] (148) Subject to Subsection [(78)] (79)(b), "surety insurance" includes:
1003 (a) a guarantee against loss or damage resulting from failure of principals to pay or
1004 perform their obligations to a creditor or other obligee;
1005 (b) bail bond insurance; and
1006 (c) fidelity insurance.
1007 [(148)] (149) (a) "Surplus" means the excess of assets over the sum of paid-in capital
1008 and liabilities.
1009 (b) (i) "Permanent surplus" means the surplus of a mutual insurer that has been
1010 designated by the insurer as permanent.
1011 (ii) Sections 31A-5-211, 31A-7-201, 31A-8-209, 31A-9-209, and 31A-14-209 require
1012 that mutuals doing business in this state maintain specified minimum levels of permanent
1013 surplus.
1014 (iii) Except for assessable mutuals, the minimum permanent surplus requirement is
1015 essentially the same as the minimum required capital requirement that applies to stock insurers.
1016 (c) "Excess surplus" means:
1017 (i) for life or accident and health insurers, health organizations, and property and
1018 casualty insurers as defined in Section 31A-17-601, the lesser of:
1019 (A) that amount of an insurer's or health organization's total adjusted capital, as defined

1020 in Subsection [(151)] (152), that exceeds the product of:
1021 (I) 2.5; and
1022 (II) the sum of the insurer's or health organization's minimum capital or permanent
1023 surplus required under Section 31A-5-211, 31A-9-209, or 31A-14-205; or
1024 (B) that amount of an insurer's or health organization's total adjusted capital, as defined
1025 in Subsection [(151)] (152), that exceeds the product of:
1026 (I) 3.0; and
1027 (II) the authorized control level RBC as defined in Subsection 31A-17-601(8)(a); and
1028 (ii) for monoline mortgage guaranty insurers, financial guaranty insurers, and title
1029 insurers, that amount of an insurer's paid-in-capital and surplus that exceeds the product of:
1030 (A) 1.5; and
1031 (B) the insurer's total adjusted capital required by Subsection 31A-17-609(1).
1032 [(149)] (150) "Third party administrator" or "administrator" means any person who
1033 collects charges or premiums from, or who, for consideration, adjusts or settles claims of
1034 residents of the state in connection with insurance coverage, annuities, or service insurance
1035 coverage, except:
1036 (a) a union on behalf of its members;
1037 (b) a person administering any:
1038 (i) pension plan subject to the federal Employee Retirement Income Security Act of
1039 1974;
1040 (ii) governmental plan as defined in Section 414(d), Internal Revenue Code; or
1041 (iii) nonelecting church plan as described in Section 410(d), Internal Revenue Code;
1042 (c) an employer on behalf of the employer's employees or the employees of one or
1043 more of the subsidiary or affiliated corporations of the employer;
1044 (d) an insurer licensed under Chapter 5, 7, 8, 9, or 14, but only for a line of insurance
1045 for which the insurer holds a license in this state; or
1046 (e) a person:
1047 (i) licensed or exempt from licensing under:
1048 (A) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and
1049 Reinsurance Intermediaries[;]; or
1050 (B) Chapter 26, Insurance Adjusters[;]; and

1051 (ii) whose activities are limited to those authorized under the license the person holds
1052 or for which the person is exempt.
1053 [(150)] (151) "Title insurance" means the insuring, guaranteeing, or indemnifying of
1054 owners of real or personal property or the holders of liens or encumbrances on that property, or
1055 others interested in the property against loss or damage suffered by reason of liens or
1056 encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity
1057 or unenforceability of any liens or encumbrances on the property.
1058 [(151)] (152) "Total adjusted capital" means the sum of an insurer's or health
1059 organization's statutory capital and surplus as determined in accordance with:
1060 (a) the statutory accounting applicable to the annual financial statements required to be
1061 filed under Section 31A-4-113; and
1062 (b) any other items provided by the RBC instructions, as RBC instructions is defined in
1063 Section 31A-17-601.
1064 [(152)] (153) (a) "Trustee" means "director" when referring to the board of directors of
1065 a corporation.
1066 (b) "Trustee," when used in reference to an employee welfare fund, means an
1067 individual, firm, association, organization, joint stock company, or corporation, whether acting
1068 individually or jointly and whether designated by that name or any other, that is charged with
1069 or has the overall management of an employee welfare fund.
1070 [(153)] (154) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted
1071 insurer" means an insurer:
1072 (i) not holding a valid certificate of authority to do an insurance business in this state;
1073 or
1074 (ii) transacting business not authorized by a valid certificate.
1075 (b) "Admitted insurer" or "authorized insurer" means an insurer:
1076 (i) holding a valid certificate of authority to do an insurance business in this state; and
1077 (ii) transacting business as authorized by a valid certificate.
1078 [(154)] (155) "Underwrite" means the authority to accept or reject risk on behalf of the
1079 insurer.
1080 [(155)] (156) "Vehicle liability insurance" means insurance against liability resulting
1081 from or incident to ownership, maintenance, or use of any land vehicle or aircraft, exclusive of

1082 vehicle comprehensive and vehicle physical damage coverages under Subsection [~~(128)~~] (129).
1083 [~~(156)~~] (157) "Voting security" means a security with voting rights, and includes any
1084 security convertible into a security with a voting right associated with [~~it~~] the security.
1085 [~~(157)~~] (158) "Workers' compensation insurance" means:
1086 (a) insurance for indemnification of employers against liability for compensation based
1087 on:
1088 (i) compensable accidental injuries; and
1089 (ii) occupational disease disability;
1090 (b) employer's liability insurance incidental to workers' compensation insurance and
1091 written in connection with [~~it~~] workers' compensation insurance; and
1092 (c) insurance assuring to the persons entitled to workers' compensation benefits the
1093 compensation provided by law.
1094 Section 2. Section **31A-2-205** is amended to read:
1095 **31A-2-205. Examination costs.**
1096 (1) (a) Except as provided in Subsection (3), [~~examinees that are insurers~~] an examinee
1097 that is an insurer, rate service [~~organizations~~] organization, or the [~~subsidiaries~~] subsidiary of
1098 either shall reimburse the [~~Insurance Department~~] department for the reasonable costs of
1099 examinations made under Sections 31A-2-203 and 31A-2-204. The following costs shall be
1100 reimbursed:
1101 (i) actual travel expenses;
1102 (ii) reasonable living expense allowance;
1103 (iii) compensation at reasonable rates for all professionals reasonably employed for the
1104 examination under Subsection (4);
1105 (iv) the administration and supervisory expense of:
1106 (A) the [~~Insurance Department~~] department; and
1107 (B) the attorney general's office; and
1108 (v) an amount necessary to cover fringe benefits authorized by the commissioner or
1109 provided by law.
1110 (b) In determining rates, the commissioner shall consider the rates recommended [~~by~~
1111 ~~the National Association of Insurance Commissioners~~] and outlined in the examination manual
1112 sponsored by the [~~association~~] National Association of Insurance Commissioners.

1113 [(b)] (c) This Subsection (1) applies to a surplus lines [producers] producer to the
1114 extent that the examinations are of [their] the surplus line producer's surplus lines business.
1115 (2) An insurer requesting the examination of one of its producers shall pay the cost of
1116 the examination. Otherwise, the department shall pay the cost of examining [licensees] a
1117 licensee other than those specified under Subsection (1).
1118 (3) (a) On the examinee's request or at the commissioner's discretion, the [Insurance
1119 Department] department may pay all or part of the costs of an examination whenever the
1120 commissioner finds that because of the frequency of examinations or the financial condition of
1121 the examinee, imposition of the costs would place an unreasonable burden on the examinee.
1122 (b) The commissioner shall include in [his] the commissioner's annual report
1123 information about any instance in which the commissioner has applied this Subsection (3).
1124 (4) (a) [Technical experts] A technical expert employed under Subsection
1125 31A-2-203(3) shall present to the commissioner a statement of all expenses incurred by [them]
1126 the technical expert in conjunction with an examination.
1127 (b) The examined insurer shall, at the commissioner's direction, pay to the technical
1128 experts or specialists the:
1129 (i) actual travel expenses[,];
1130 (ii) reasonable living expenses[,]; and
1131 (iii) compensation at customary rates for expenses necessarily incurred as approved by
1132 the commissioner.
1133 (c) The examined insurer shall reimburse:
1134 (i) department examiners for their:
1135 (A) actual travel expenses; and
1136 (B) reasonable living expenses; and [shall reimburse]
1137 (ii) the department for the compensation of department examiners involved in the
1138 examination.
1139 (d) (i) The examined insurer shall certify the consolidated account of all charges and
1140 expenses for the examination. [One]
1141 (ii) The insurer shall:
1142 (A) retain a copy [shall be retained by the insurer and the other shall be filed] of the
1143 consolidated account; and

1144 (B) file a copy of the consolidated account with the department as a public record.
1145 (e) (i) An annual report of examination charges paid by examined insurers directly to
1146 persons employed under Subsection 31A-2-203(3) or to department examiners shall be
1147 included with the department's budget request[, but amounts].
1148 (f) Amounts paid directly by examined insurers to persons employed under Subsection
1149 31A-2-203(3) or to department examiners may not be deducted from the department's
1150 appropriation.
1151 (5) (a) The amount payable under Subsection (1) is due ten days after the examinee has
1152 been served with a detailed account of the costs.
1153 (b) Payments received by the department under this Subsection (5) shall be handled as
1154 provided by [Subsection] Section 31A-3-101.
1155 (6) (a) The commissioner may require an examinee under Subsection (1), or an insurer
1156 requesting an examination under Subsection (2), either before or during an examination, to
1157 make deposits with the state treasurer to pay the costs of examination.
1158 (b) Any deposit made under this Subsection (6) shall be held in trust by the state
1159 treasurer until applied to pay the [Insurance Department] department the costs payable under
1160 this section.
1161 (c) If a deposit made under this Subsection (6) exceeds examination costs, the state
1162 treasurer shall refund the surplus.
1163 (7) [Domestic insurers] A domestic insurer may offset the examination expenses paid
1164 under this section against premium taxes under Subsection 59-9-102(2).
1165 Section 3. Section **31A-2-207** is amended to read:
1166 **31A-2-207. Commissioner's records and reports.**
1167 (1) The commissioner shall maintain all [Insurance Department] department records
1168 [which] that are:
1169 (a) required by law;
1170 (b) necessary for the effective operation of the department; or
1171 (c) necessary to maintain a full record of department activities.
1172 (2) The records of the department may be preserved, managed, stored, and made
1173 available for review consistent with:
1174 (a) another Utah statute;

1175 (b) the rules made under Section 63-2-904;
1176 (c) the decisions of the State Records Committee made under Title 63, Chapter 2,
1177 Government Records Access and Management Act; or
1178 (d) the needs of the public.
1179 (3) [No Insurance Department] A department record may not be destroyed, damaged,
1180 or disposed of without:
1181 (a) authorization of the commissioner; and
1182 (b) compliance with all other applicable laws.
1183 (4) The commissioner shall maintain a permanent record of [his] the commissioner's
1184 proceedings and important activities, including:
1185 (a) a concise statement of the condition of each insurer examined by [him,] the
1186 commissioner; and
1187 (b) a record of all certificates of authority and licenses issued by [him] the
1188 commissioner.
1189 (5) (a) Prior to October 1 of each year, the commissioner shall prepare an annual report
1190 to the governor which shall include, for the preceding calendar year, the information
1191 concerning the department and the insurance industry which the commissioner believes will be
1192 useful to the governor and the public. [This]
1193 (b) The report required by this Subsection (5) shall include the information required
1194 under Chapter 27 and Subsections 31A-2-106(2), 31A-2-205(3), and 31A-2-208(3).
1195 (c) The commissioner shall [have this] make the report [printed in sufficient numbers
1196 to meet the expected] required by this Subsection (5) available to the public and industry
1197 [demand for the document] in electronic format.
1198 (6) All department records and reports are open to public inspection unless specifically
1199 provided otherwise by statute or by Title 63, Chapter 2, Government Records Access and
1200 Management Act.
1201 (7) On request, the commissioner shall provide to any person certified or uncertified
1202 copies of any record in the department that is open to public inspection.
1203 (8) Notwithstanding Subsection (6) and Title 63, Chapter 2, Government Records
1204 Access and Management Act, the commissioner shall protect from disclosure any record, as
1205 defined in Section 63-2-103, or other document received from an insurance regulator of

1206 another jurisdiction:
1207 (a) at least to the same extent the record or document is protected from disclosure
1208 under the laws applicable to the insurance regulator providing the record or document; or
1209 (b) under the same terms and conditions of confidentiality as the National Association
1210 of Insurance Commissioners requires as a condition of participating in any of the National
1211 Association of Insurance Commissioners' programs.
1212 Section 4. Section **31A-2-309** is amended to read:
1213 **31A-2-309. Service of process through state officer.**
1214 (1) The commissioner, or the lieutenant governor when the subject proceeding is
1215 brought by the state, is the agent for receipt of service of any summons, notice, order, pleading,
1216 or any other legal process relating to a Utah court or administrative agency upon the following:
1217 (a) all insurers authorized to do business in this state, while authorized to do business
1218 in this state, and thereafter in any proceeding arising from or related to any transaction having a
1219 connection with this state;
1220 (b) all surplus lines insurers for any proceeding arising out of a contract of insurance
1221 that is subject to the surplus lines law, or out of a certificate, cover note, or other confirmation
1222 of that type of insurance;
1223 (c) all unauthorized insurers or other persons assisting unauthorized insurers under
1224 Subsection 31A-15-102(1) by doing an act specified in Subsection 31A-15-102(2), for a
1225 proceeding arising out of the transaction that is subject to the unauthorized insurance law;
1226 (d) any nonresident producer, consultant, adjuster, and third party administrator, while
1227 authorized to do business in this state, and thereafter in any proceeding arising from or related
1228 to any transaction having a connection with this state; and
1229 (e) any reinsurer submitting to the commissioner's jurisdiction under Subsection
1230 31A-17-404(7).
1231 (2) [~~Each~~] The following is considered to have irrevocably appointed the commissioner
1232 and lieutenant governor as that person's agents in accordance with Subsection (1):
1233 (a) each licensed insurer by applying for and receiving a certificate of authority[~~,~~];
1234 (b) each surplus lines insurer by entering into a contract subject to the surplus lines
1235 law[~~,~~];
1236 (c) each unauthorized insurer by doing in this state any of the acts prohibited by

1237 Section [~~31A-15-101,~~] 31A-15-103; and
1238 (d) each nonresident producer, consultant, adjuster, and third party administrator [~~is~~
1239 ~~considered to have irrevocably appointed the commissioner and lieutenant governor as his~~
1240 ~~agents in accordance with Subsection (1)~~].
1241 (3) The commissioner and lieutenant governor are also agents for the executors,
1242 administrators or personal representatives, receivers, trustees, or other successors in interest of
1243 the persons specified under Subsection (1).
1244 (4) Litigants serving process on the commissioner or lieutenant governor under this
1245 section shall pay the fee applicable under Section 31A-3-103.
1246 (5) The right to substituted service under this section does not limit the right to serve a
1247 summons, notice, order, pleading, demand, or other process upon a person in any other manner
1248 provided by law.
1249 Section 5. Section **31A-4-113** is amended to read:
1250 **31A-4-113. Annual statements.**
1251 (1) (a) Each authorized insurer shall annually, on or before March 1, file with the
1252 commissioner a true statement of [~~its~~] the authorized insurer's financial condition, transactions,
1253 and affairs as of December 31 of the preceding year.
1254 (b) The statement required by Subsection (1)(a) shall be:
1255 (i) verified by the oaths of at least two of the insurer's principal officers; and
1256 (ii) in the general form and provide the information as prescribed by the commissioner
1257 by rule.
1258 (c) The commissioner may, for good cause shown, extend the date for filing the
1259 statement required by Subsection (1)(a)[~~, except that the deadline for filing fee payment may~~
1260 ~~not be extended~~].
1261 (2) The annual statement of an alien insurer shall:
1262 (a) relate only to [~~its~~] the alien insurer's transactions and affairs in the United States
1263 unless the commissioner requires otherwise; and
1264 (b) be verified by:
1265 (i) the insurer's United States manager; or
1266 (ii) the insurer's authorized officers.
1267 Section 6. Section **31A-8-103** is amended to read:

1268 **31A-8-103. Applicability to other provisions of law.**

1269 (1) (a) Except for exemptions specifically granted under this title, an organization is
1270 subject to regulation under all of the provisions of this title.

1271 (b) Notwithstanding any provision of this title, an organization licensed under this
1272 chapter:

1273 (i) is wholly exempt from:

1274 (A) Chapter 7, Nonprofit Health Service Insurance Corporations;

1275 (B) Chapter 9, Insurance Fraternals;

1276 (C) Chapter 10, Annuities;

1277 (D) Chapter 11, Motor Clubs;

1278 (E) Chapter 12, State Risk Management Fund;

1279 (F) Chapter 13, Employee Welfare Funds and Plans;

1280 (G) Chapter 19a, Utah Rate Regulation Act; and

1281 (H) Chapter 28, Guaranty Associations; and

1282 (ii) is not subject to:

1283 (A) Chapter 3, Department Funding, Fees, and Taxes, except for Part I;

1284 (B) Section 31A-4-107;

1285 (C) Chapter 5, Domestic Stock and Mutual Insurance Corporations, except for
1286 provisions specifically made applicable by this chapter;

1287 (D) Chapter 14, Foreign Insurers, except for provisions specifically made applicable by
1288 this chapter;

1289 (E) Chapter 17, Determination of Financial Condition, except:

1290 (I) Parts II and VI; or

1291 (II) as made applicable by the commissioner by rule consistent with this chapter;

1292 (F) Chapter 18, Investments, except as made applicable by the commissioner by rule
1293 consistent with this chapter; and

1294 (G) Chapter 22, Contracts in Specific Lines, except for Parts VI, VII, and XII.

1295 (2) The commissioner may by rule waive other specific provisions of this title that the
1296 commissioner considers inapplicable to health maintenance organizations or limited health
1297 plans, upon a finding that the waiver will not endanger the interests of:

1298 (a) enrollees;

1299 (b) investors; or
1300 (c) the public.
1301 (3) Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, and Title 16,
1302 Chapter 10a, Utah Revised Business Corporation Act, do not apply to an organization except as
1303 specifically made applicable by:
1304 (a) this chapter;
1305 (b) a provision referenced under this chapter; or
1306 (c) a rule adopted by the commissioner to deal with corporate law issues of health
1307 maintenance organizations that are not settled under this chapter.
1308 (4) (a) Whenever in this chapter, Chapter 5, or Chapter 14 is made applicable to an
1309 organization, the application is:
1310 (i) of those provisions that apply to a mutual corporation if the organization is
1311 nonprofit; and
1312 (ii) of those that apply to a stock corporation if the organization is for profit.
1313 (b) When Chapter 5 or 14 is made applicable to an organization under this chapter,
1314 "mutual" means nonprofit organization.
1315 (5) Solicitation of enrollees by an organization is not a violation of any provision of
1316 law relating to solicitation or advertising by health professionals if that solicitation is made in
1317 accordance with:
1318 (a) this chapter; and
1319 (b) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and
1320 Reinsurance Intermediaries.
1321 (6) This title does not prohibit any health maintenance organization from meeting the
1322 requirements of any federal law that enables the health maintenance organization to:
1323 (a) receive federal funds; or
1324 (b) obtain or maintain federal qualification status.
1325 (7) Except as provided in Section 31A-8-501, an organization is exempt from statutes
1326 in this title or department rules that restrict or limit the organization's freedom of choice in
1327 contracting with or selecting health care providers, including Section 31A-22-618.
1328 (8) An organization is exempt from the assessment or payment of premium taxes
1329 imposed by Sections 59-9-101 through 59-9-104.

1330 Section 7. Section **31A-16-103** is amended to read:

1331 **31A-16-103. Acquisition of control of or merger with domestic insurer --**
1332 **Required filings -- Content of statement -- Alternative filing materials -- Criminal**
1333 **background information -- Approval by commissioner -- Dissenting shareholders --**
1334 **Violations -- Jurisdiction, consent to service of process.**

1335 (1) (a) A person may not take the actions described in Subsections (1)(b) or (c) unless,
1336 at the time any offer, request, or invitation is made or any such agreement is entered into, or
1337 prior to the acquisition of securities if no offer or agreement is involved:
1338 (i) the person files with the commissioner a statement containing the information
1339 required by this section;
1340 (ii) the person provides a copy of the statement described in Subsection (1)(a)(i) to the
1341 insurer; and
1342 (iii) the commissioner approves the offer, request, invitation, agreement, or acquisition.
1343 (b) Unless the person complies with Subsection (1)(a), a person other than the issuer
1344 may not make a tender offer for, a request or invitation for tenders of, or enter into any
1345 agreement to exchange securities, or seek to acquire or acquire in the open market or otherwise,
1346 any voting security of a domestic insurer if after the acquisition, the person would directly,
1347 indirectly, by conversion, or by exercise of any right to acquire be in control of the insurer.
1348 (c) Unless the person complies with Subsection (1)(a), a person may not enter into an
1349 agreement to merge with or otherwise to acquire control of:
1350 (i) a domestic insurer; or
1351 (ii) any person controlling a domestic insurer.
1352 (d) (i) For purposes of this section, a domestic insurer includes any person controlling a
1353 domestic insurer unless the person as determined by the commissioner is either directly or
1354 through its affiliates primarily engaged in business other than the business of insurance.
1355 (ii) The controlling person described in Subsection (1)(d)(i) shall file with the
1356 commissioner a preacquisition notification containing the information required in Subsection
1357 (2) 30 calendar days before the proposed effective date of the acquisition.
1358 (iii) For the purposes of this section, "person" does not include any securities broker
1359 [~~holding~~] that in the usual and customary brokers function holds less than 20% of:
1360 (A) the voting securities of an insurance company; or [~~of~~]

1361 (B) any person that controls an insurance company [in the usual and customary brokers
1362 function].
1363 (iv) This section applies to all domestic insurers and other entities licensed under
1364 Chapters 5, 7, 8, 9, and 11.
1365 (e) (i) An agreement for acquisition of control or merger as contemplated by this
1366 Subsection (1) is not valid or enforceable unless the agreement:
1367 (A) is in writing; and
1368 (B) includes a provision that the agreement is subject to the approval of the
1369 commissioner upon the filing of any applicable statement required under this chapter.
1370 (ii) A written agreement for acquisition or control that includes the provision described
1371 in Subsection (1)(e)(i) satisfies the requirements of this Subsection (1).
1372 (2) The statement to be filed with the commissioner under Subsection (1) shall be
1373 made under oath or affirmation and shall contain the following information:
1374 (a) the name and address of the "acquiring party," which means each person by whom
1375 or on whose behalf the merger or other acquisition of control referred to in Subsection (1) is to
1376 be effected; and
1377 (i) if the person is an individual:
1378 (A) the person's principal occupation;
1379 (B) a listing of all offices and positions held by the person during the past five years;
1380 and
1381 (C) any conviction of crimes other than minor traffic violations during the past ten
1382 years; and
1383 (ii) if the person is not an individual:
1384 (A) a report of the nature of its business operations during:
1385 (I) the past five years; or
1386 (II) for any lesser period as the person and any of its predecessors has been in
1387 existence;
1388 (B) an informative description of the business intended to be done by the person and
1389 the person's subsidiaries;
1390 (C) a list of all individuals who are or who have been selected to become directors or
1391 executive officers of the person, or individuals who perform, or who will perform functions

1392 appropriate to such positions; and
1393 (D) for each individual described in Subsection (2)(a)(ii)(C), the information required
1394 by Subsection (2)(a)(i)[(A)] for each individual;
1395 (b) (i) the source, nature, and amount of the consideration used or to be used in
1396 effecting the merger or acquisition of control;
1397 (ii) a description of any transaction in which funds were or are to be obtained for [that]
1398 the purpose of effecting the merger or acquisition of control, including any pledge of:
1399 (A) the insurer's stock; or
1400 (B) the stock of any of [its] the insurer's subsidiaries or controlling affiliates; and
1401 (iii) the identity of persons furnishing the consideration;
1402 (c) (i) fully audited financial information, or other financial information considered
1403 acceptable by the commissioner, of the earnings and financial condition of each acquiring party
1404 for:
1405 (A) the preceding five fiscal years of each acquiring party[,]; or [for]
1406 (B) any lesser period the acquiring party and any of its predecessors shall have been in
1407 existence[,]; and [similar]
1408 (ii) unaudited information:
1409 (A) similar to the information described in Subsection (2)(c)(i); and
1410 (B) prepared within the 90 days prior to the filing of the statement;
1411 (d) any plans or proposals which each acquiring party may have to:
1412 (i) liquidate the insurer;
1413 (ii) sell its assets;
1414 (iii) merge or consolidate the insurer with any person; or
1415 (iv) make any other material change in the insurer's:
1416 (A) business[,];
1417 (B) corporate structure[,]; or
1418 (C) management;
1419 (e) (i) the number of shares of any security referred to in Subsection (1) that each
1420 acquiring party proposes to acquire;
1421 (ii) the terms of the offer, request, invitation, agreement, or acquisition referred to in
1422 Subsection (1); and

1423 (iii) a statement as to the method by which the fairness of the proposal was arrived at;
1424 (f) the amount of each class of any security referred to in Subsection (1) that:
1425 (i) is beneficially owned; or
1426 (ii) concerning which there is a right to acquire beneficial ownership by each acquiring
1427 party;
1428 (g) a full description of any contract, arrangement, or understanding with respect to any
1429 security referred to in Subsection (1) in which any acquiring party is involved, including:
1430 (i) the transfer of any of the securities;
1431 (ii) joint ventures;
1432 (iii) loan or option arrangements;
1433 (iv) puts or calls;
1434 (v) guarantees of loans;
1435 (vi) guarantees against loss or guarantees of profits;
1436 (vii) division of losses or profits; or
1437 (viii) the giving or withholding of proxies;
1438 (h) a description of the purchase by any acquiring party of any security referred to in
1439 Subsection (1) during the 12 calendar months preceding the filing of the statement including:
1440 (i) the dates of purchase;
1441 (ii) the names of the purchasers; and
1442 (iii) the consideration paid or agreed to be paid for the purchase;
1443 (i) a description of:
1444 (i) any recommendations to purchase by any acquiring party any security referred to in
1445 Subsection (1) made during the 12 calendar months preceding the filing of the statement; or
1446 (ii) any recommendations made by anyone based upon interviews or at the suggestion
1447 of the acquiring party;
1448 (j) (i) copies of all tender offers for, requests for, or invitations for tenders of, exchange
1449 offers for, and agreements to acquire or exchange any securities referred to in Subsection (1);
1450 and
1451 (ii) if distributed, copies of additional soliciting material relating to the transactions
1452 described in Subsection (2)(j)(i);
1453 (k) (i) the term of any agreement, contract, or understanding made with, or proposed to

1454 be made with, any broker-dealer as to solicitation of securities referred to in Subsection (1) for
1455 tender; and
1456 (ii) the amount of any fees, commissions, or other compensation to be paid to
1457 broker-dealers with regard to any agreement, contract, or understanding described in
1458 Subsection (2)(k)(i); and
1459 (l) any additional information the commissioner requires by rule, which the
1460 commissioner determines to be:
1461 (i) necessary or appropriate for the protection of policyholders of the insurer; or
1462 (ii) in the public interest.
1463 (3) The department may request:
1464 (a) (i) criminal background information maintained pursuant to Title 53, Chapter 10,
1465 Part 2, from the Bureau of Criminal Identification; and
1466 (ii) complete Federal Bureau of Investigation criminal background checks through the
1467 national criminal history system.
1468 (b) Information obtained by the department from the review of criminal history records
1469 received under Subsection (3)(a) shall be used by the department for the purpose of:
1470 (i) verifying the information in Subsection (2)(a)(i);
1471 (ii) determining the integrity of persons who would control the operation of an insurer;
1472 and
1473 (iii) preventing persons who violate 18 U.S.C. Sections 1033 and 1034 from engaging
1474 in the business of insurance in the state.
1475 (c) If the department requests the criminal background information, the department
1476 shall:
1477 (i) pay to the Department of Public Safety the costs incurred by the Department of
1478 Public Safety in providing the department criminal background information under Subsection
1479 (3)(a)(i);
1480 (ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau
1481 of Investigation in providing the department criminal background information under
1482 Subsection (3)(a)(ii); and
1483 (iii) charge the person required to file the statement referred to in Subsection (1) a fee
1484 equal to the aggregate of Subsections (3)(c)(i) and (ii).

1485 (4) (a) If the source of the consideration under Subsection (2)(b)(i) is a loan made in
1486 the lender's ordinary course of business, the identity of the lender shall remain confidential, if
1487 the person filing the statement so requests.
1488 (b) (i) Under Subsection (2)(e), the commissioner may require a statement of the
1489 adjusted book value assigned by the acquiring party to each security in arriving at the terms of
1490 the offer[~~, with~~].
1491 (ii) For purposes of this Subsection (4)(b), "adjusted book value" [~~meaning~~] means
1492 each security's proportional interest in the capital and surplus of the insurer with adjustments
1493 that reflect:
1494 [~~(i)~~] (A) market conditions;
1495 [~~(ii)~~] (B) business in force; and
1496 [~~(iii)~~] (C) other intangible assets or liabilities of the insurer.
1497 (c) The description required by Subsection (2)(g) shall identify the persons with whom
1498 the contracts, arrangements, or understandings have been entered into.
1499 (5) (a) If the person required to file the statement referred to in Subsection (1) is a
1500 partnership, limited partnership, syndicate, or other group, the commissioner may require that
1501 all the information called for by Subsections (2), (3), or (4) shall be given with respect to each:
1502 (i) partner of the partnership or limited partnership;
1503 (ii) member of the syndicate or group; and
1504 (iii) person who controls the partner or member.
1505 (b) If any partner, member, or person referred to in Subsection (5)(a) is a corporation,
1506 or if the person required to file the statement referred to in Subsection (1) is a corporation, the
1507 commissioner may require that the information called for by Subsection (2) shall be given with
1508 respect to:
1509 (i) the corporation;
1510 (ii) each officer and director of the corporation; and
1511 (iii) each person who is directly or indirectly the beneficial owner of more than 10% of
1512 the outstanding voting securities of the corporation.
1513 (6) If any material change occurs in the facts set forth in the statement filed with the
1514 commissioner and sent to the insurer pursuant to Subsection (2), an amendment setting forth
1515 the change, together with copies of all documents and other material relevant to the change,

1516 shall be filed with the commissioner and sent to the insurer within two business days after the
1517 filing person learns of such change.
1518 (7) If any offer, request, invitation, agreement, or acquisition referred to in Subsection
1519 (1) is proposed to be made by means of a registration statement under the Securities Act of
1520 1933, or under circumstances requiring the disclosure of similar information under the
1521 Securities Exchange Act of 1934, or under a state law requiring similar registration or
1522 disclosure, a person required to file the statement referred to in Subsection (1) may use copies
1523 of any registration or disclosure documents in furnishing the information called for by the
1524 statement.
1525 (8) (a) The commissioner shall approve any merger or other acquisition of control
1526 referred to in Subsection (1) unless, after a public hearing on the merger or acquisition, the
1527 commissioner finds that:
1528 (i) after the change of control, the domestic insurer referred to in Subsection (1) would
1529 not be able to satisfy the requirements for the issuance of a license to write the line or lines of
1530 insurance for which it is presently licensed;
1531 (ii) the effect of the merger or other acquisition of control would:
1532 (A) substantially lessen competition in insurance in this state; or
1533 (B) tend to create a monopoly in insurance;
1534 (iii) the financial condition of any acquiring party might:
1535 (A) jeopardize the financial stability of the insurer; or
1536 (B) prejudice the interest of:
1537 (I) its policyholders; or
1538 (II) any remaining securityholders who are unaffiliated with the acquiring party;
1539 (iv) the terms of the offer, request, invitation, agreement, or acquisition referred to in
1540 Subsection (1) are unfair and unreasonable to the securityholders of the insurer;
1541 (v) the plans or proposals which the acquiring party has to liquidate the insurer, sell its
1542 assets, or consolidate or merge it with any person, or to make any other material change in its
1543 business or corporate structure or management, are:
1544 (A) unfair and unreasonable to policyholders of the insurer; and
1545 (B) not in the public interest; or
1546 (vi) the competence, experience, and integrity of those persons who would control the

1547 operation of the insurer are such that it would not be in the interest of the policyholders of the
1548 insurer and the public to permit the merger or other acquisition of control.
1549 (b) For purposes of Subsection (8)(a)(iv), the offering price for each security may not
1550 be considered unfair if the adjusted book values under Subsection (2)(e):
1551 (i) are disclosed to the securityholders; and
1552 (ii) determined by the commissioner to be reasonable.
1553 (9) (a) The public hearing referred to in Subsection (8) shall be held within 30 days
1554 after the statement required by Subsection (1) is filed.
1555 (b) (i) At least 20 days notice of the hearing shall be given by the commissioner to the
1556 person filing the statement.
1557 (ii) Affected parties may waive the notice required by this Subsection (9)(b).
1558 (iii) Not less than seven days notice of the public hearing shall be given by the person
1559 filing the statement to:
1560 (A) the insurer; and
1561 (B) any person designated by the commissioner.
1562 (c) The commissioner shall make a determination within 30 days after the conclusion
1563 of the hearing.
1564 (d) At the hearing, the person filing the statement, the insurer, any person to whom
1565 notice of hearing was sent, and any other person whose interest may be affected by the hearing
1566 may:
1567 (i) present evidence;
1568 (ii) examine and cross-examine witnesses; and
1569 (iii) offer oral and written arguments.
1570 (e) (i) A person or insurer described in Subsection (9)(d) may conduct discovery
1571 proceedings in the same manner as is presently allowed in the district courts of this state.
1572 (ii) All discovery proceedings shall be concluded not later than three days before the
1573 commencement of the public hearing.
1574 [~~(10) At the acquiring person's expense and consent, the commissioner may retain any~~
1575 ~~attorneys, actuaries, accountants, and other experts not otherwise a part of the commissioner's~~
1576 ~~staff, which are reasonably necessary to assist the commissioner in reviewing the proposed~~
1577 ~~acquisition of control.~~]

1578 (10) (a) The commissioner may retain technical experts to assist in reviewing all, or a
1579 portion of, information filed in connection with a proposed merger or other acquisition of
1580 control referred to in Subsection (1).
1581 (b) In determining whether any of the conditions in Subsection (8) exist, the
1582 commissioner may consider the findings of technical experts employed to review applicable
1583 filings.
1584 (c) (i) A technical expert employed under Subsection (10)(a) shall present to the
1585 commissioner a statement of all expenses incurred by the technical expert in conjunction with
1586 the technical expert's review of a proposed merger or other acquisition of control.
1587 (ii) At the commissioner's direction the acquiring person shall compensate the technical
1588 expert at customary rates for time and expenses:
1589 (A) necessarily incurred; and
1590 (B) approved by the commissioner.
1591 (iii) The acquiring person shall:
1592 (A) certify the consolidated account of all charges and expenses incurred for the review
1593 by technical experts;
1594 (B) retain a copy of the consolidated account described in Subsection (10)(c)(iii)(A);
1595 and
1596 (C) file with the department as a public record a copy of the consolidated account
1597 described in Subsection (10)(c)(iii)(A).
1598 (11) (a) (i) If a domestic insurer proposes to merge into another insurer, any
1599 securityholder electing to exercise a right of dissent may file with the insurer a written request
1600 for payment of the adjusted book value given in the statement required by Subsection (1) and
1601 approved under Subsection (8), in return for the surrender of the security holder's securities.
1602 (ii) The request described in Subsection (11)(a)(i) shall be filed not later than ten days
1603 after the day of the securityholders' meeting where the corporate action is approved.
1604 (b) The dissenting securityholder is entitled to and the insurer is required to pay to the
1605 dissenting securityholder the specified value within 60 days of receipt of the dissenting security
1606 holder's security.
1607 (c) Persons electing under this Subsection (11) to receive cash for their securities waive
1608 the dissenting shareholder and appraisal rights otherwise applicable under Title 16, Chapter

1609 10a, Part 13, Dissenters' Rights.
1610 (d) (i) This Subsection (11) provides an elective procedure for dissenting
1611 securityholders to resolve their objections to the plan of merger.
1612 (ii) This section does not restrict the rights of dissenting securityholders under Title 16,
1613 Chapter 10a, Utah Revised Business Corporation Act, unless this election is made under this
1614 Subsection (11).
1615 (12) (a) All statements, amendments, or other material filed under Subsection (1), and
1616 all notices of public hearings held under Subsection (8), shall be mailed by the insurer to its
1617 securityholders within five business days after the insurer has received the statements,
1618 amendments, other material, or notices.
1619 (b) (i) Mailing expenses shall be paid by the person making the filing.
1620 (ii) As security for the payment of [~~these~~] mailing expenses, that person shall file with
1621 the commissioner an acceptable bond or other deposit in an amount determined by the
1622 commissioner.
1623 (13) This section does not apply to any offer, request, invitation, agreement, or
1624 acquisition that the commissioner by order exempts from the requirements of this section as:
1625 (a) not having been made or entered into for the purpose of, and not having the effect
1626 of, changing or influencing the control of a domestic insurer; or
1627 (b) as otherwise not comprehended within the purposes of this section.
1628 (14) The following are violations of this section:
1629 (a) the failure to file any statement, amendment, or other material required to be filed
1630 pursuant to Subsections (1), (2), and (5); or
1631 (b) the effectuation, or any attempt to effectuate, an acquisition of control of or merger
1632 with a domestic insurer unless the commissioner has given the commissioner's approval to the
1633 acquisition or merger.
1634 (15) (a) The courts of this state are vested with jurisdiction over:
1635 (i) a person who:
1636 (A) files a statement with the commissioner under this section; and
1637 (B) is not resident, domiciled, or authorized to do business in this state; and
1638 (ii) overall actions involving persons described in Subsection (15)(a)(i) arising out of a
1639 violation of this section.

1640 (b) A person described in Subsection (15)(a) is considered to have performed acts
1641 equivalent to and constituting an appointment of the commissioner by that person, to be that
1642 person's lawful [~~attorney~~] agent upon whom may be served all lawful process in any action,
1643 suit, or proceeding arising out of a violation of this section.
1644 (c) A copy of a lawful process described in Subsection (15)(b) shall be:
1645 (i) served on the commissioner; and
1646 (ii) transmitted by registered or certified mail by the commissioner to the person at that
1647 person's last-known address.
1648 Section 8. Section **31A-21-110** is enacted to read:
1649 **31A-21-110. Prohibition against certain use of Social Security number --**
1650 **Exceptions -- Applicability of section.**
1651 (1) As used in this section "publicly display or publicly post" means to intentionally
1652 communicate or otherwise make available to the general public.
1653 (2) An insurer not subject to Section 31A-22-634 may not do any of the following:
1654 (a) publicly display or publicly post in any manner an individual's Social Security
1655 number; or
1656 (b) print an individual's Social Security number on any card required for the individual
1657 to access products or services provided or covered by the insurer.
1658 (3) This section does not prevent:
1659 (a) the collection, use, or release of a Social Security number as required by state or
1660 federal law;
1661 (b) the use of a Social Security number for internal verification or administrative
1662 purposes; or
1663 (c) the release of a Social Security number:
1664 (i) for claims administration purposes; or
1665 (ii) as part of the verification, eligibility, or payment process.
1666 (4) (a) An insurer shall comply with this section by July 1, 2005.
1667 (b) An insurer may obtain an extension for compliance with this section in accordance
1668 with this Subsection (4)(b).
1669 (i) The request for extension shall:
1670 (A) be in writing to the department prior to July 1, 2005; and

1671 (B) provide an explanation as to why the insurer cannot comply.
1672 (ii) The commissioner shall grant a request for extension:
1673 (A) for a period of time not to exceed March 1, 2006; and
1674 (B) if the commissioner finds that the explanation provided under Subsection (4)(b)(i)
1675 is a reasonable explanation.
1676 Section 9. Section **31A-23a-112** is amended to read:
1677 **31A-23a-112. Probation -- Grounds for revocation.**
1678 (1) The commissioner may place a licensee on probation for a period not to exceed 24
1679 months as follows:
1680 (a) after an adjudicative proceeding under Title 63, Chapter 46b, Administrative
1681 Procedures Act, for any circumstances that would justify a suspension under Section
1682 31A-23a-111; or
1683 (b) at the issuance of a new license:
1684 (i) with an admitted violation under 18 U.S.C. Sections 1033 and 1034; or
1685 (ii) with a response to background information questions on any new license
1686 application indicating that:
1687 (A) the person has been convicted of a crime, [~~as defined~~] that is listed by rule made in
1688 accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, as a crime that is
1689 grounds for probation;
1690 (B) the person is currently charged with a crime, [~~as defined~~] that is listed by rule made
1691 in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, as a crime that
1692 is grounds for probation regardless of whether adjudication was withheld;
1693 (C) the person has been involved in an administrative proceeding regarding any
1694 professional or occupational license; or
1695 (D) any business in which the person is or was an owner, partner, officer, or director
1696 has been involved in an administrative proceeding regarding any professional or occupational
1697 license.
1698 (2) The commissioner may put a new licensee on probation for a specified period no
1699 longer than 12 months if the licensee has admitted to violations under 18 U.S.C. Sections 1033
1700 and 1034.
1701 (3) The probation order shall state the conditions for retention of the license, which

1702 shall be reasonable.
1703 (4) Any violation of the probation is grounds for revocation pursuant to any proceeding
1704 authorized under Title 63, Chapter 46b, Administrative Procedures Act.
1705 Section 10. Section **31A-23a-409** is amended to read:
1706 **31A-23a-409. Trust obligation for funds collected.**
1707 (1) (a) Every licensee is a trustee for all funds received or collected for forwarding to
1708 insurers or to insureds.
1709 (b) Except for amounts necessary to pay bank charges, and except for funds paid by
1710 insureds and belonging in part to the licensee as fees or commissions, a licensee may not
1711 commingle trust funds with:
1712 (i) the licensee's own funds; or [~~with~~]
1713 (ii) funds held in any other capacity.
1714 (c) Except as provided under Subsection (4), every licensee owes to insureds and
1715 insurers the fiduciary duties of a trustee with respect to money to be forwarded to insurers or
1716 insureds through the licensee.
1717 (d) (i) Unless the funds are sent to the appropriate payee by the close of the next
1718 business day after their receipt, the licensee shall deposit them in an account authorized under
1719 Subsection (2).
1720 (ii) Funds [~~so~~] deposited under this Subsection (1)(d) shall remain in an account
1721 authorized under Subsection (2) until sent to the appropriate payee.
1722 (2) Funds required to be deposited under Subsection (1) shall be deposited:
1723 (a) in a federally insured trust account [~~with a financial institution located in this state~~]
1724 in a depository institution, as defined in Section 7-1-103, which:
1725 (i) has an office in this state;
1726 (ii) has federal deposit insurance; and
1727 (iii) is authorized by its primary regulator to engage in the trust business, as defined by
1728 Section 7-5-1, in this state; or
1729 (b) in some other account, approved by the commissioner by rule or order, providing
1730 safety comparable to federally insured trust accounts.
1731 (3) It is not a violation of Subsection (2)(a) if the amounts in the accounts exceed the
1732 amount of the federal insurance on the accounts.

1733 (4) A trust account into which funds are deposited may be interest bearing. The
1734 interest accrued on the account may be paid to the licensee, so long as the licensee otherwise
1735 complies with this section and with the contract with the insurer.
1736 (5) A financial institution or other organization holding trust funds under this section
1737 may not offset or impound trust account funds against debts and obligations incurred by the
1738 licensee.
1739 (6) Any licensee who, not being lawfully entitled thereto, diverts or appropriates any
1740 portion of the funds held under Subsection (1) to the licensee's own use, is guilty of theft under
1741 Title 76, Chapter 6, Part 4. Section 76-6-412 applies in determining the classification of the
1742 offense. Sanctions under Section 31A-2-308 also apply.
1743 Section 11. Section **31A-29-103** is amended to read:
1744 **31A-29-103. Definitions.**
1745 As used in this chapter:
1746 (1) "Board" means the board of directors of the pool created in Section 31A-29-104.
1747 (2) (a) "Creditable coverage" has the same meaning as provided in the Health Insurance
1748 Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat.1956, Sec. 2701(c)(1) and 45
1749 C.F.R. Sec. 146.11(a)(1)[;].
1750 (b) "Creditable coverage" does not include a period of time in which there is a
1751 significant break in coverage as described in the Health Insurance Portability and
1752 Accountability Act, Pub. L. No. 104-191, 110 Stat. 1956, Sec. 2701(c)(2).
1753 (3) "Domicile" means the place where an individual has a fixed and permanent home
1754 and principal establishment:
1755 (a) to which the individual, if absent, intends to return; and
1756 (b) in which the individual, and the individual's family voluntarily reside, not for a
1757 special or temporary purpose, but with the intention of making a permanent home.
1758 [(3)] (4) "Enrollee" means an individual who has met the eligibility requirements of the
1759 pool and is covered by a pool policy under this chapter.
1760 [(4)] (5) "Health care facility" means any entity providing health care services which is
1761 licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act.
1762 [(5)] (6) "Health care provider" has the same meaning as provided in Section 78-14-3.
1763 [(6)] (7) "Health care services" means:

1764 (a) any service or product:
1765 (i) used in furnishing to any individual medical care or hospitalization[;]; or
1766 (ii) incidental to furnishing medical care or hospitalization[;]; and
1767 (b) any other service or product furnished for the purpose of preventing, alleviating,
1768 curing, or healing human illness or injury.
1769 [(7)] (8) (a) "Health insurance" means any:
1770 (i) hospital and medical expense-incurred policy;
1771 (ii) nonprofit health care service plan contract; or
1772 (iii) health maintenance organization subscriber contract.
1773 (b) "Health insurance" does not mean:
1774 (i) any insurance arising out of [the Workers' Compensation Act] Title 34A, Chapter 2
1775 or 3, or similar law;
1776 (ii) automobile medical payment insurance; or
1777 (iii) insurance under which benefits are payable with or without regard to fault and
1778 which is required by law to be contained in any liability insurance policy.
1779 [(8)] (9) "Health maintenance organization" has the same meaning as provided in
1780 Section 31A-8-101.
1781 [(9)] (10) (a) "Health plan" means any arrangement by which an individual, including a
1782 dependent or spouse, covered or making application to be covered under the pool has:
1783 (i) access to hospital and medical benefits or reimbursement including group or
1784 individual insurance or subscriber contract;
1785 (ii) coverage through:
1786 (A) a health maintenance organization[;];
1787 (B) a preferred provider prepayment[;];
1788 (C) group practice[;]; or
1789 (D) individual practice plan;
1790 (iii) coverage under an uninsured arrangement of group or group-type contracts
1791 including employer self-insured, cost-plus, or other benefits methodologies not involving
1792 insurance;
1793 (iv) coverage under a group type contract which is not available to the general public
1794 and can be obtained only because of connection with a particular organization or group; and

1795 (v) coverage by Medicare or other governmental benefit. [The term]
1796 (b) "Health plan" includes coverage through health insurance.
1797 [(10)] (11) "HIPAA" means the Health Insurance Portability and Accountability Act,
1798 Pub. L. No. 104-191, 110 Stat.1962.
1799 [(11)] (12) "HIPAA eligible" means an individual who is eligible under the provisions
1800 of the Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat.
1801 1979, Sec. 2741(b).
1802 [(12)] (13) "Insurer" means:
1803 (a) an insurance company authorized to transact accident and health insurance business
1804 in this state[,];
1805 (b) a health maintenance organization[,]; and
1806 (c) a self-insurer not subject to federal preemption.
1807 [(13)] (14) "Medicaid" means coverage under Title XIX of the Social Security Act, 42
1808 U.S.C. Sec. 1396 et seq., as amended.
1809 [(14)] (15) "Medicare" means coverage under both Part A and B of Title XVIII of the
1810 Social Security Act, 42 U.S.C. 1395 et seq., as amended.
1811 [(15)] (16) "Plan of operation" means the plan developed by the board in accordance
1812 with Section 31A-29-105 and includes the articles, bylaws, and operating rules adopted by the
1813 board under Section 31A-29-106.
1814 [(16)] (17) "Pool" means the Utah Comprehensive Health Insurance Pool created in
1815 Section 31A-29-104.
1816 [(17)] (18) "Pool fund" means the Comprehensive Health Insurance Pool Enterprise
1817 Fund created in Section 31A-29-120.
1818 [(18)] (19) "Pool policy" means a health insurance policy issued under this chapter.
1819 [(19)] (20) "Preexisting condition" means a condition, regardless of the cause of the
1820 condition, for which medical advice, diagnosis, care, or treatment was recommended or
1821 received within the six-month period immediately prior to the enrollment date.
1822 [(20)] (21) (a) "Resident" or "residency" means [an individual] a person who is
1823 domiciled in this state [as defined in Section 23-13-2].
1824 (b) A resident retains residency if that resident leaves this state:
1825 (i) to serve in the armed forces of the United States; or

1826 (ii) for religious or educational purposes.
1827 [(21)] (22) "Third-party administrator" has the same meaning as provided in Section
1828 31A-1-301.
1829 Section 12. Section **31A-29-104** is amended to read:
1830 **31A-29-104. Creation of pool -- Board of directors -- Appointment -- Terms --**
1831 **Quorum -- Plan preparation.**
1832 (1) There is created the "Utah Comprehensive Health Insurance Pool," a nonprofit
1833 entity within the Insurance Department.
1834 (2) The pool shall be under the direction of a board of directors composed of [11] 12
1835 members.
1836 (a) The governor shall appoint ten of the directors with the consent of the Senate as
1837 follows:
1838 (i) two representatives of health insurance companies or health service organizations;
1839 (ii) one representative of a health maintenance organization;
1840 (iii) one physician;
1841 (iv) one representative of hospitals;
1842 (v) one representative of the general public who is reasonably expected to qualify for
1843 coverage under the pool;
1844 (vi) one parent or spouse of such an individual;
1845 (vii) one representative of the general public; [and]
1846 (viii) one representative of employers[.]; and
1847 (ix) one licensed producer with an accident and health line of authority.
1848 (b) The board shall also include:
1849 (i) the commissioner or [his] the commissioner's designee; and
1850 (ii) the executive director of the Department of Health or [his] the executive director's
1851 designee.
1852 (3) (a) Except as required by Subsection (3)(b), as terms of current board members
1853 expire, the governor shall appoint each new member or reappointed member to a four-year
1854 term.
1855 (b) Notwithstanding the requirements of Subsection (3)(a), the governor shall, at the
1856 time of appointment or reappointment, adjust the length of terms to ensure that the terms of

1857 board members are staggered so that approximately half of the board is appointed every two
1858 years.
1859 (4) When a vacancy occurs in the membership for any reason, the replacement shall be
1860 appointed for the unexpired term in the same manner as the original appointment was made.
1861 (5) (a) (i) Members who are not government employees shall receive no compensation
1862 or benefits for their services, but may receive per diem and expenses incurred in the
1863 performance of the member's official duties at the rates established by the Division of Finance
1864 under Sections 63A-3-106 and 63A-3-107 from the Pool Fund.
1865 (ii) Members may decline to receive per diem and expenses for their service.
1866 (b) (i) State government officer and employee members who do not receive salary, per
1867 diem, or expenses from their agency for their service may receive per diem and expenses
1868 incurred in the performance of their official duties from the pool at the rates established by the
1869 Division of Finance under Sections 63A-3-106 and 63A-3-107.
1870 (ii) A state government member who is a member because of their state government
1871 position may not receive per diem or expenses for their service.
1872 (iii) State government officer and employee members may decline to receive per diem
1873 and expenses for their service.
1874 (6) The board shall elect annually a chair and vice chair from its membership.
1875 (7) Six board members are a quorum for the transaction of business.
1876 (8) The action of a majority of the members of the quorum is the action of the board.
1877 (9) The board shall submit a plan of operation to the commissioner no later than
1878 January 1, 1991.
1879 (10) The sale of policies under this chapter shall commence on July 1, 1991, or as soon
1880 thereafter as adequate funding for the coverage is available as determined by the commissioner.
1881 Section 13. Section **31A-29-111** is amended to read:
1882 **31A-29-111. Eligibility -- Limitations.**
1883 (1) (a) Except as provided in [~~Subsection~~] Subsections (1)(b) and (2), an individual
1884 who is not HIPAA eligible is eligible for pool coverage if the individual:
1885 (i) pays the established premium;
1886 (ii) is a resident of this state; and
1887 (iii) meets the health underwriting criteria under Subsection [~~(4)~~] (5)(a).

1888 (b) Notwithstanding Subsection (1)(a), an individual who is not HIPAA eligible is not
1889 eligible for pool coverage if one or more of the following conditions apply:
1890 (i) [at the time of application,] the individual is eligible for health care benefits under
1891 Medicaid or Medicare, except as provided in Section 31A-29-112;
1892 (ii) the individual has terminated coverage in the pool, unless:
1893 (A) 12 months have elapsed since the termination date; or
1894 (B) the individual demonstrates that creditable coverage has been involuntarily
1895 terminated for any reason other than nonpayment of premium;
1896 (iii) the pool has paid the maximum lifetime benefit to or on behalf of the individual;
1897 (iv) the individual is an inmate of a public institution;
1898 (v) the individual is eligible for other public programs for which medical care is
1899 provided;
1900 (vi) the individual's health condition does not meet the criteria established under
1901 Subsection [(4)] (5);
1902 (vii) [the individual is an eligible employee, a dependent of an eligible employee, or a
1903 member of] as for an employer group that offers health insurance or a self-insurance
1904 arrangement to [all] its eligible employees, dependents, or members[;], the individual is:
1905 (A) an eligible employee;
1906 (B) a dependent of an eligible employee; or
1907 (C) a member;
1908 (viii) [at the time the pool coverage is applied for,] the individual:
1909 (A) has coverage substantially equivalent to a pool policy, as established by the board
1910 in administrative rule, either as an insured or a covered dependent[;]; or [the individual]
1911 (B) would be eligible for the substantially equivalent coverage if the individual elected
1912 to obtain the coverage; or
1913 (ix) at the time of application, the individual[: (A) is not HIPAA eligible; and (B)] has
1914 not resided in Utah for at least 12 consecutive months preceding the date of application.
1915 (2) (a) Except as provided in Subsections (1) and (2)(b), an individual who is HIPAA
1916 eligible is eligible for pool coverage if the individual:
1917 (i) pays the established premium; and
1918 (ii) is a resident of this state.

1919 (b) Notwithstanding Subsections (1) and (2)(a), a HIPAA eligible individual is not
1920 eligible for pool coverage if one or more of the following conditions apply:
1921 (i) the individual is eligible for health care benefits under Medicaid or Medicare,
1922 except as provided in Section 31A-29-112;
1923 (ii) the individual is eligible for other public programs for which medical care is
1924 provided;
1925 (iii) the individual is covered under any other health insurance;
1926 (iv) as for an employer group that offers health insurance or a self-insurance
1927 arrangement to its eligible employees, dependents, or members, the individual is:
1928 (A) an eligible employee;
1929 (B) a dependent of an eligible employee; or
1930 (C) a member;
1931 (v) the pool has paid the maximum lifetime benefit to or on behalf of the individual; or
1932 (vi) the individual is an inmate of a public institution.
1933 [(2)] (3) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under
1934 Subsection (1)(a), an individual whose health insurance coverage from a state [health] high risk
1935 pool with similar coverage is terminated because of nonresidency in another state may apply
1936 for coverage under the pool subject to the conditions of Subsections (1)(b)(i) through [(vii)]
1937 (viii).
1938 (b) [(i)] Coverage sought under Subsection [(2)] (3)(a) shall be applied for within 63
1939 days after the termination date of the previous high risk pool coverage.
1940 [(ii)] (c) [If premiums are paid for the entire coverage period under the previous risk
1941 pool with similar coverage, the] The effective date of this state's pool coverage shall be the date
1942 of termination of the previous high risk pool coverage.
1943 [(iii) If premiums are not paid back to the previous risk pool termination date, then the
1944 effective date will be determined by the pool administrator in accordance with the date of
1945 application.]
1946 [(c)] (d) The waiting period of an individual with a preexisting condition applying for
1947 coverage under this chapter shall be waived:
1948 (i) to the extent to which the waiting period was satisfied under a similar plan from
1949 another state; and

1950 (ii) if the other state's benefit limitation was not reached.
1951 [(3)] (4) (a) If an eligible individual applies for pool coverage within 30 days of being
1952 denied coverage by an individual carrier, the effective date for pool coverage shall be no later
1953 than the first day of the month following the date of submission of the completed insurance
1954 application to the carrier.
1955 (b) Notwithstanding Subsection (4)(a), for individuals eligible for coverage under
1956 Subsection (3), the effective date shall be the date of termination of the previous high risk pool
1957 coverage.
1958 [(4)] (5) (a) The board shall establish and adjust, as necessary, health underwriting
1959 criteria based on:
1960 (i) health condition; and
1961 (ii) expected claims so that the expected claims are anticipated to remain within
1962 available funding.
1963 (b) The board, with approval of the commissioner, may contract with one or more
1964 providers under Title 63, Chapter 56, Utah Procurement Code, to develop underwriting criteria
1965 under Subsection [(4)] (5)(a).
1966 (c) If an individual is denied coverage by the pool under the criteria established in
1967 Subsection [(4)] (5)(a), the pool shall issue a certificate of insurability to the individual for
1968 coverage under Subsection 31A-30-108(3).
1969 Section 14. Section **31A-29-112** is amended to read:
1970 **31A-29-112. Medicaid recipients.**
1971 (1) If authorized by federal statutes or rules, an individual receiving Medicaid benefits
1972 may continue to receive those benefits while satisfying the preexisting condition requirements
1973 established by Section 31A-29-113 and the terms of the pool policy issued under this chapter.
1974 (2) If allowed by federal statute, federal regulation, state statute, or rule, the
1975 Department of Health shall allocate premiums paid to the pool by an individual receiving
1976 Medicaid benefits to that individual's spenddown for purposes of the Medicaid program.
1977 (3) (a) If an individual continues to receive Medicaid benefits after the requirements for
1978 a preexisting condition are satisfied, the pool administrator may not issue a pool policy or
1979 allow that individual to receive any benefit from the pool.
1980 (b) If an individual continues to receive Medicaid benefits when the requirements for a

1981 preexisting condition are satisfied, the pool administrator shall give any premiums collected by
1982 it during the preexisting conditions period to the Medicaid program.
1983 (4) (a) If an enrollee becomes eligible to receive Medicaid benefits, the enrollee's
1984 coverage by the pool terminates as of the effective date of Medicaid coverage.
1985 (b) The pool administrator shall:
1986 (i) include a provision in the pool policy requiring an enrollee to provide written notice
1987 to the pool administration if the enrollee becomes covered by Medicaid; and
1988 (ii) terminate an enrollee's coverage by the pool as of the effective date of the enrollee's
1989 Medicaid coverage when the pool administrator becomes aware that the enrollee is covered by
1990 Medicaid.
1991 (5) If an individual terminates coverage under Medicaid and applies for coverage under
1992 a pool policy within 45 days after terminating the coverage, the individual may begin coverage
1993 under a pool policy as of the date that Medicaid coverage terminated, if an individual meets the
1994 other eligibility requirements of the chapter and pays the required premium.
1995 (6) Notwithstanding [~~the provision of Subsection~~] Subsections 31A-29-111(1)(b)(i)
1996 and (2)(b)(i), an individual is eligible for coverage by the pool if the requirements of Section
1997 31A-29-111 are met and if:
1998 (a) the individual's eligibility for Medicaid requires a spenddown, as defined by rule,
1999 that exceeds the premium for a pool policy; or
2000 (b) the individual is eligible for the Primary Care Network program administered by
2001 the Department of Health.
2002 Section 15. Section **31A-29-113** is amended to read:
2003 **31A-29-113. Benefits -- Additional types of pool insurance -- Preexisting**
2004 **conditions -- Waiver -- Maximum benefits.**
2005 (1) (a) The pool policy shall pay for eligible medical expenses rendered or furnished
2006 for the diagnoses or treatment of illness or injury that:
2007 (i) exceed the deductible and copayment amounts applicable under Section
2008 31A-29-114; and
2009 (ii) are not otherwise limited or excluded.
2010 (b) Eligible medical expenses are the allowed charges established by the board for the
2011 health care services and items rendered during times for which benefits are extended under the

2012 pool policy.
2013 (2) The coverage to be issued by the pool, its schedule of benefits, exclusions, and
2014 other limitations shall be established by the board.
2015 (3) The commissioner shall approve the benefit package developed by the board to
2016 ensure its compliance with this chapter.
2017 (4) The pool shall offer at least one benefit plan through a managed care program as
2018 authorized under Section 31A-29-106.
2019 (5) This chapter may not be construed to prohibit the pool from issuing additional types
2020 of pool policies with different types of benefits which in the opinion of the board may be of
2021 benefit to the citizens of Utah.
2022 (6) (a) The board shall design and require an administrator to employ cost containment
2023 measures and requirements including preadmission certification and concurrent inpatient
2024 review for the purpose of making the pool more cost effective. [~~The provisions of~~]
2025 (b) Sections 31A-22-617 and 31A-22-618 do not apply to coverage issued under this
2026 chapter.
2027 (7) (a) A pool policy may contain provisions under which coverage for a preexisting
2028 condition is excluded during a six-month period following the effective date of plan coverage
2029 for a given individual.
2030 (b) Subsection (7)(a) does not apply to a HIPAA eligible individual.
2031 (8) (a) A pool policy may [~~exclude coverage for pregnancies for ten months following~~
2032 ~~the effective date of coverage, unless the individual is HIPAA eligible~~] contain provisions
2033 under which coverage for a preexisting pregnancy is excluded during a ten-month period
2034 following the effective date of plan coverage for a given individual.
2035 (b) Subsection (8)(a) does not apply to a HIPAA eligible individual.
2036 (9) (a) The pool will waive the preexisting condition exclusion described in
2037 [~~Subsection~~] Subsections (7)(a) and (8)(a) for an individual that is changing health coverage to
2038 the pool, to the extent to which similar exclusions have been satisfied under any prior health
2039 insurance coverage if:
2040 (i) the individual applies not later than 63 days following the date of involuntary
2041 termination, other than for nonpayment of premiums, from health coverage; or
2042 (ii) the individual's premium rate exceeds the rate of the pool for equal or lesser

2043 coverage provided that the application for pool coverage is made no later than 63 days
2044 following the termination from the prior health insurance coverage.
2045 [~~(b) In accordance with Subsections (7)(b) and (8), the pool may not apply a~~
2046 ~~preexisting condition exclusion if the individual is HIPAA eligible.~~]
2047 [~~(c)~~] <u>(b)</u> If <u>this</u> Subsection (9) applies, coverage in the pool shall be effective from the
2048 date on which the prior coverage was terminated.
2049 (10) Covered benefits available from the pool may not exceed a $1,000,000 lifetime
2050 maximum, which includes a per enrollee calendar year maximum established by the board.
2051 Section 16. Section **31A-29-114** is amended to read:
2052 **31A-29-114. Deductibles -- Copayments.**
2053 (1) (a) [~~Subject to the limits provided in Subsection (3), a~~] <u>A</u> pool policy shall impose
2054 a deductible on a per calendar year basis.
2055 (b) [~~Deductible~~] <u>At least two deductible</u> plans [~~of $500 and $1,000~~] shall [~~initially~~] be
2056 offered. [~~Other higher deductible plans may be offered by the pool.~~]
2057 (c) The deductible is applied to all of the eligible medical expenses as defined in
2058 Section 31A-29-113, incurred by the enrollee until the deductible has been satisfied. There are
2059 no benefits payable before the deductible has been satisfied.
2060 (d) The pool may offer separate deductibles for prescription benefits.
2061 (2) (a) [~~Subject to the limits provided in Subsection (3), a~~] <u>A</u> mandatory coinsurance
2062 requirement shall be imposed at the rate of at least 20% of eligible medical expenses in excess
2063 of the mandatory deductible.
2064 (b) Any coinsurance imposed under this Subsection (2) shall be designated in the pool
2065 policy.
2066 (3) [~~Except as provided in Subsection (4), the~~] <u>The board shall establish</u> maximum
2067 aggregate out-of-pocket payments for eligible medical expenses incurred by the enrollee [~~in the~~
2068 ~~form of deductibles and coinsurance may not exceed:~~] <u>for each of the deductible plans offered</u>
2069 <u>under Subsection (1)(b).</u>
2070 [~~(a) $1,500 per individual per calendar year for the $500 deductible plan;~~]
2071 [~~(b) $2,000 per individual per calendar year for the $1,000 deductible plan; or~~]
2072 [~~(c) if other deductible plans are offered by the pool, an amount per individual will be~~
2073 ~~established by the board.~~]

2074 (4) (a) When the enrollee has incurred the maximum aggregate out-of-pocket payments
2075 under Subsection (3), the board may establish a coinsurance requirement to be imposed on
2076 eligible medical expenses in excess of the maximum aggregate out-of-pocket expense [~~limits~~
2077 ~~set forth in Subsection (3)~~].
2078 (b) The circumstances in which the coinsurance authorized by this Subsection (4) may
2079 be imposed shall be designated in the pool policy.
2080 (c) The coinsurance authorized by this Subsection (4) may be imposed at a rate not to
2081 exceed 5% of eligible medical expenses.
2082 (5) The limits on maximum aggregate out-of-pocket payments for eligible medical
2083 expenses incurred by the enrollee [~~in the form of deductibles and coinsurance~~] under this
2084 section shall not include out-of-pocket payments for prescription benefits.
2085 Section 17. Section **31A-29-115** is amended to read:
2086 **31A-29-115. Cancellation -- Notice.**
2087 (1) (a) On the date of renewal, the pool may cancel an enrollee's policy if:
2088 (i) the enrollee's health condition does not meet the criteria established in Subsection
2089 31A-29-111[~~(4)~~](5);
2090 (ii) the pool has provided written notice to the enrollee's last-known address no less
2091 than 60 days before cancellation; and
2092 (iii) at least one individual carrier has not reached the individual enrollment cap
2093 established in Section 31A-30-110.
2094 (b) The pool shall issue a certificate of insurability to an enrollee whose policy is
2095 cancelled under Subsection (1)(a) for coverage under Subsection 31A-30-108(3) if the
2096 requirements of Subsection 31A-29-111[~~(4)~~](5) are met.
2097 (2) The pool may cancel an enrollee's policy at any time if:
2098 (a) the pool has provided written notice to the enrollee's last-known address no less
2099 than 15 days before cancellation; and
2100 (b) (i) the enrollee establishes a residency outside of Utah for three consecutive
2101 months;
2102 (ii) there is nonpayment of premiums; or
2103 (iii) the pool determines that the enrollee does not meet the eligibility requirements set
2104 forth in Section 31A-29-111, in which case:

2105 (A) the policy may be retroactively terminated for the period of time in which the
2106 enrollee was not eligible;
2107 (B) retroactive termination may not exceed three years; and
2108 (C) the board's remedy under this Subsection (2)(b) shall be a cause of action against
2109 the enrollee for benefits paid during the period of ineligibility in accordance with Subsection
2110 31A-29-119(3).
2111 Section 18. Section **31A-30-103** is amended to read:
2112 **31A-30-103. Definitions.**
2113 As used in this chapter:
2114 (1) "Actuarial certification" means a written statement by a member of the American
2115 Academy of Actuaries or other individual approved by the commissioner that a covered carrier
2116 is in compliance with Section 31A-30-106, based upon the examination of the covered carrier,
2117 including review of the appropriate records and of the actuarial assumptions and methods used
2118 by the covered carrier in establishing premium rates for applicable health benefit plans.
2119 (2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly
2120 through one or more intermediaries, controls or is controlled by, or is under common control
2121 with, a specified entity or person.
2122 (3) "Base premium rate" means, for each class of business as to a rating period, the
2123 lowest premium rate charged or that could have been charged under a rating system for that
2124 class of business by the covered carrier to covered insureds with similar case characteristics for
2125 health benefit plans with the same or similar coverage.
2126 (4) "Basic coverage" means the coverage provided in the Basic Health Care Plan under
2127 Subsection 31A-22-613.5(2).
2128 (5) "Carrier" means any person or entity that provides health insurance in this state
2129 including:
2130 (a) an insurance company;
2131 (b) a prepaid hospital or medical care plan;
2132 (c) a health maintenance organization;
2133 (d) a multiple employer welfare arrangement; and
2134 (e) any other person or entity providing a health insurance plan under this title.
2135 (6) (a) Except as provided in Subsection (6)(b), "case characteristics" means

2136 demographic or other objective characteristics of a covered insured that are considered by the
2137 carrier in determining premium rates for the covered insured.
2138 (b) "Case characteristics" does not include:
2139 (i) duration of coverage since the policy was issued;
2140 (ii) claim experience; and
2141 (iii) health status.
2142 (7) "Class of business" means all or a separate grouping of covered insureds
2143 established under Section 31A-30-105.
2144 (8) "Conversion policy" means a policy providing coverage under the conversion
2145 provisions required in Chapter 22, Part VII, Group Accident and Health Insurance.
2146 (9) "Covered carrier" means any individual carrier or small employer carrier subject to
2147 this chapter.
2148 (10) "Covered individual" means any individual who is covered under a health benefit
2149 plan subject to this chapter.
2150 (11) "Covered insureds" means small employers and individuals who are issued a
2151 health benefit plan that is subject to this chapter.
2152 (12) "Dependent" means an individual to the extent that the individual is defined to be
2153 a dependent by:
2154 (a) the health benefit plan covering the covered individual; and
2155 (b) Chapter 22, Part VI, Accident and Health Insurance.
2156 (13) "Established geographic service area" means a geographical area approved by the
2157 commissioner within which the carrier is authorized to provide coverage.
2158 (14) "Index rate" means, for each class of business as to a rating period for covered
2159 insureds with similar case characteristics, the arithmetic average of the applicable base
2160 premium rate and the corresponding highest premium rate.
2161 (15) "Individual carrier" means a carrier that provides coverage on an individual basis
2162 through a health benefit plan regardless of whether:
2163 (a) coverage is offered through:
2164 (i) an association;
2165 (ii) a trust;
2166 (iii) a discretionary group; or

2167 (iv) other similar groups; or
2168 (b) the policy or contract is situated out-of-state.
2169 (16) "Individual conversion policy" means a conversion policy issued to:
2170 (a) an individual; or
2171 (b) an individual with a family.
2172 (17) "Individual coverage count" means the number of natural persons covered under a
2173 carrier's health benefit products that are individual policies.
2174 (18) "Individual enrollment cap" means the percentage set by the commissioner in
2175 accordance with Section 31A-30-110.
2176 (19) "New business premium rate" means, for each class of business as to a rating
2177 period, the lowest premium rate charged or offered, or that could have been charged or offered,
2178 by the carrier to covered insureds with similar case characteristics for newly issued health
2179 benefit plans with the same or similar coverage.
2180 (20) "Preexisting condition" is as defined in Section 31A-1-301.
2181 (21) "Premium" means all monies paid by covered insureds and covered individuals as
2182 a condition of receiving coverage from a covered carrier, including any fees or other
2183 contributions associated with the health benefit plan.
2184 (22) (a) "Rating period" means the calendar period for which premium rates
2185 established by a covered carrier are assumed to be in effect, as determined by the carrier.
2186 (b) A covered carrier may not have:
2187 (i) more than one rating period in any calendar month; and
2188 (ii) no more than 12 rating periods in any calendar year.
2189 (23) "Resident" means an individual who has resided in this state for at least 12
2190 consecutive months immediately preceding the date of application.
2191 (24) "Short-term limited duration insurance" means a health benefit product that:
2192 (a) is not renewable; and
2193 (b) has an expiration date specified in the contract that is less than 364 days after the
2194 date the plan became effective.
2195 (25) "Small employer carrier" means a carrier that provides health benefit plans
2196 covering eligible employees of one or more small employers in this state, regardless of
2197 whether:

2198 (a) coverage is offered through:
2199 (i) an association;
2200 (ii) a trust;
2201 (iii) a discretionary group; or
2202 (iv) other similar grouping; or
2203 (b) the policy or contract is situated out-of-state.
2204 (26) "Uninsurable" means an individual who:
2205 (a) is eligible for the Comprehensive Health Insurance Pool coverage under the
2206 underwriting criteria established in Subsection 31A-29-111[(4)](5); or
2207 (b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and
2208 (ii) has a condition of health that does not meet consistently applied underwriting
2209 criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(i)
2210 and (j) for which coverage the applicant is applying.
2211 (27) "Uninsurable percentage" for a given calendar year equals UC/CI where, for
2212 purposes of this formula:
2213 (a) "UC" means the number of uninsurable individuals who were issued an individual
2214 policy on or after July 1, 1997; and
2215 (b) "CI" means the carrier's individual coverage count as of December 31 of the
2216 preceding year.
2217 Section 19. Section **31A-30-108** is amended to read:
2218 **31A-30-108. Eligibility for small employer and individual market.**
2219 (1) (a) Small employer carriers shall accept residents for small group coverage as set
2220 forth in the Health Insurance Portability and Accountability Act, P.L. 104-191, 110 Stat. 1962,
2221 Sec. 2701(f) and 2711(a).
2222 (b) Individual carriers shall accept residents for individual coverage pursuant:
2223 (i) to P.L. 104-191, 110 Stat. 1979, Sec. 2741(a)-(b); and
2224 (ii) Subsection (3).
2225 (2) (a) Small employer carriers shall offer to accept all eligible employees and their
2226 dependents at the same level of benefits under any health benefit plan provided to a small
2227 employer.
2228 (b) Small employer carriers may:

2229 (i) request a small employer to submit a copy of the small employer's quarterly income
2230 tax withholdings to determine whether the employees for whom coverage is provided or
2231 requested are bona fide employees of the small employer; and
2232 (ii) deny or terminate coverage if the small employer refuses to provide documentation
2233 requested under Subsection (2)(b)(i).
2234 (3) Except as provided in Subsection (5) and Section 31A-30-110, individual carriers
2235 shall accept for coverage individuals to whom all of the following conditions apply:
2236 (a) the individual is not covered or eligible for coverage:
2237 (i) (A) as an employee of an employer;
2238 (B) as a member of an association; or
2239 (C) as a member of any other group; and
2240 (ii) under:
2241 (A) a health benefit plan; or
2242 (B) a self-insured arrangement that provides coverage similar to that provided by a
2243 health benefit plan as defined in Section 31A-1-301;
2244 (b) the individual is not covered and is not eligible for coverage under any public
2245 health benefits arrangement including:
2246 (i) the Medicare program established under Title XVIII of the Social Security Act;
2247 (ii) the Medicaid program established under Title XIX of the Social Security Act;
2248 (iii) any act of Congress or law of this or any other state that provides benefits
2249 comparable to the benefits provided under this chapter; or
2250 (iv) coverage under the Comprehensive Health Insurance Pool Act created in Chapter
2251 29, Comprehensive Health Insurance Pool Act;
2252 (c) unless the maximum benefit has been reached the individual is not covered or
2253 eligible for coverage under any:
2254 (i) Medicare supplement policy;
2255 (ii) conversion option;
2256 (iii) continuation or extension under COBRA; or
2257 (iv) state extension;
2258 (d) the individual has not terminated or declined coverage described in Subsection
2259 (3)(a), (b), or (c) within 93 days of application for coverage, unless the individual is eligible for

2260 individual coverage under P.L. 104-191, 110 Stat. 1979, Sec. 2741(b), in which case, the
2261 requirement of this Subsection (3)(d) does not apply; and
2262 (e) the individual is certified as ineligible for the Health Insurance Pool if:
2263 (i) the individual applies for coverage with the Comprehensive Health Insurance Pool
2264 within 30 days after being rejected or refused coverage by the covered carrier and reapplies for
2265 coverage with that covered carrier within 30 days after the date of issuance of a certificate
2266 under Subsection 31A-29-111[~~(4)~~](5)(c); or
2267 (ii) the individual applies for coverage with any individual carrier within 45 days after:
2268 (A) notice of cancellation of coverage under Subsection 31A-29-115(1); or
2269 (B) the date of issuance of a certificate under Subsection 31A-29-111[~~(4)~~](5)(c) if the
2270 individual applied first for coverage with the Comprehensive Health Insurance Pool.
2271 (4) (a) If coverage is obtained under Subsection (3)(e)(i) and the required premium is
2272 paid, the effective date of coverage shall be the first day of the month following the individual's
2273 submission of a completed insurance application to that covered carrier.
2274 (b) If coverage is obtained under Subsection (3)(e)(ii) and the required premium is
2275 paid, the effective date of coverage shall be the day following the:
2276 (i) cancellation of coverage under Subsection 31A-29-115(1); or
2277 (ii) submission of a completed insurance application to the Comprehensive Health
2278 Insurance Pool.
2279 (5) (a) An individual carrier is not required to accept individuals for coverage under
2280 Subsection (3) if the carrier issues no new individual policies in the state after July 1, 1997.
2281 (b) A carrier described in Subsection (5)(a) may not issue new individual policies in
2282 the state for five years from July 1, 1997.
2283 (c) Notwithstanding Subsection (5)(b), a carrier may request permission to issue new
2284 policies after July 1, 1999, which may only be granted if:
2285 (i) the carrier accepts uninsurables as is required of a carrier entering the market under
2286 Subsection 31A-30-110; and
2287 (ii) the commissioner finds that the carrier's issuance of new individual policies:
2288 (A) is in the best interests of the state; and
2289 (B) does not provide an unfair advantage to the carrier.
2290 (6) (a) If a small employer carrier offers health benefit plans to small employers

2291 through a network plan, the small employer carrier may:
2292 (i) limit the employers that may apply for the coverage to those employers with eligible
2293 employees who live, reside, or work in the service area for the network plan; and
2294 (ii) within the service area of the network plan, deny coverage to an employer if the
2295 small employer carrier has demonstrated to the commissioner that the small employer carrier:
2296 (A) will not have the capacity to deliver services adequately to enrollees of any
2297 additional groups because of the small employer carrier's obligations to existing group contract
2298 holders and enrollees; and
2299 (B) applies this section uniformly to all employers without regard to:
2300 (I) the claims experience of an employer, an employer's employee, or a dependent of an
2301 employee; or
2302 (II) any health status-related factor relating to an employee or dependent of an
2303 employee.
2304 (b) (i) A small employer carrier that denies a health benefit product to an employer in
2305 any service area in accordance with this section may not offer coverage in the small employer
2306 market within the service area to any employer for a period of 180 days after the date the
2307 coverage is denied.
2308 (ii) This Subsection (6)(b) does not:
2309 (A) limit the small employer carrier's ability to renew coverage that is in force; or
2310 (B) relieve the small employer carrier of the responsibility to renew coverage that is in
2311 force.
2312 (c) Coverage offered within a service area after the 180-day period specified in
2313 Subsection (6)(b) is subject to the requirements of this section.
2314 Section 20. **Repealer.**
2315 This bill repeals:
2316 Section **31A-29-118, Employer contributions.**

Legislative Review Note
as of 1-12-04 12:40 PM

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

Office of Legislative Research and General Counsel

Fiscal Note

Bill Number HB0245

Insurance Law Revisions

29-Jan-04

12:37 PM

State Impact

Any fiscal impacts can be handled within existing budgets.

Individual and Business Impact

Companies applying to merge or acquire control of domestic insurance companies can be required to pay the costs of technical experts hired by the commissioner to analyze their application. Out-of-pocket maximums for HIPUtah enrollees will be increased, saving the pool money but costing enrollees more.

Office of the Legislative Fiscal Analyst