

HEALTH INSURANCE LAW AMENDMENTS

2005 GENERAL SESSION

STATE OF UTAH

Sponsor: James A. Dunnigan

LONG TITLE

General Description:

This bill amends provisions of the Insurance Code related to accident and health insurance policies and the Comprehensive Health Insurance Pool Act.

Highlighted Provisions:

This bill:

- ▶ adds and amends Insurance Code definitions;
- ▶ eliminates a prohibition on requiring health maintenance organizations and limited health plans to provide conversion policies to persons residing outside their service areas;
- ▶ amends preexisting condition provisions for accident and health insurance policies;
- ▶ amends incontestability provisions for accident and health insurance policies;
- ▶ amends the definition of "Medicare Supplement Policy";
- ▶ amends the types of adverse benefit determinations which may be submitted for an independent review;
- ▶ amends the application of group accident and health policy conversion requirements;
- ▶ amends notice of the right to an individual conversion policy;
- ▶ amends Comprehensive Health Insurance Pool Act definitions, pool administrator provisions, eligibility requirements, and preexisting condition provisions; and
- ▶ makes technical changes.

Monies Appropriated in this Bill:



28 None

29 **Other Special Clauses:**

30 None

31 **Utah Code Sections Affected:**

32 AMENDS:

33 **31A-1-301**, as last amended by Chapters 2 and 267, Laws of Utah 2004

34 **31A-8-402.7**, as last amended by Chapter 90, Laws of Utah 2004

35 **31A-22-605**, as last amended by Chapter 116, Laws of Utah 2001

36 **31A-22-606**, as last amended by Chapter 116, Laws of Utah 2001

37 **31A-22-609**, as last amended by Chapter 116, Laws of Utah 2001

38 **31A-22-613**, as last amended by Chapter 116, Laws of Utah 2001

39 **31A-22-620**, as last amended by Chapter 116, Laws of Utah 2001

40 **31A-22-629**, as last amended by Chapter 108, Laws of Utah 2004

41 **31A-22-723**, as enacted by Chapter 108, Laws of Utah 2004

42 **31A-29-103**, as last amended by Chapter 2, Laws of Utah 2004

43 **31A-29-110**, as last amended by Chapter 168, Laws of Utah 2003

44 **31A-29-111**, as last amended by Chapter 2, Laws of Utah 2004

45 **31A-29-113**, as last amended by Chapters 2 and 329, Laws of Utah 2004

46 **31A-30-107.5**, as last amended by Chapter 348, Laws of Utah 2004

47 ENACTS:

48 **31A-22-605.1**, Utah Code Annotated 1953



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

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

52 **31A-1-301. Definitions.**

53 As used in this title, unless otherwise specified:

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

55 economic losses resulting from:

56 (i) a medical condition including:

57 (A) medical care expenses; or

58 (B) the risk of disability;

- 59 (ii) accident; or
- 60 (iii) sickness.
- 61 (b) "Accident and health insurance":
- 62 (i) includes a contract with disability contingencies including:
- 63 (A) an income replacement contract;
- 64 (B) a health care contract;
- 65 (C) an expense reimbursement contract;
- 66 (D) a credit accident and health contract;
- 67 (E) a continuing care contract; and
- 68 (F) a long-term care contract; and
- 69 (ii) may provide:
- 70 (A) hospital coverage;
- 71 (B) surgical coverage;
- 72 (C) medical coverage; or
- 73 (D) loss of income coverage.
- 74 (c) "Accident and health insurance" does not include workers' compensation insurance.
- 75 (2) "Actuary" is as defined by the commissioner by rule, made in accordance with Title
- 76 63, Chapter 46a, Utah Administrative Rulemaking Act.
- 77 (3) "Administrator" is defined in Subsection [~~(150)~~] (155).
- 78 (4) "Adult" means a natural person who has attained the age of at least 18 years.
- 79 (5) "Affiliate" means any person who controls, is controlled by, or is under common
- 80 control with, another person. A corporation is an affiliate of another corporation, regardless of
- 81 ownership, if substantially the same group of natural persons manages the corporations.
- 82 (6) "Agency" means:
- 83 (a) a person other than an individual, including a sole proprietorship by which a natural
- 84 person does business under an assumed name; and
- 85 (b) an insurance organization licensed or required to be licensed under Section
- 86 31A-23a-301.
- 87 (7) "Alien insurer" means an insurer domiciled outside the United States.
- 88 (8) "Amendment" means an endorsement to an insurance policy or certificate.
- 89 (9) "Annuity" means an agreement to make periodical payments for a period certain or

90 over the lifetime of one or more natural persons if the making or continuance of all or some of
91 the series of the payments, or the amount of the payment, is dependent upon the continuance of
92 human life.

93 (10) "Application" means a document:

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

96 (ii) that contains information that is used by the insurer to evaluate risk and decide
97 whether to:

98 (A) insure the risk under:

99 (I) the coverages as originally offered; or

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

101 (B) decline to insure the risk; or

102 (b) used by the insurer to gather information from the applicant before issuance of an
103 annuity contract.

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

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

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

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

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

116 (16) "Business of insurance" is defined in Subsection [~~(81)~~] (82).

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

120 (a) Section 31A-7-201;

- 121 (b) Section 31A-8-205; or
- 122 (c) Subsection 31A-9-205(2).
- 123 (18) "Bylaws" means the rules adopted for the regulation or management of a
- 124 corporation's affairs, however designated and includes comparable rules for trusts and other
- 125 entities that are not corporations.
- 126 (19) "Captive insurance company" means:
- 127 (a) an insurance company:
- 128 (i) owned by another organization; and
- 129 (ii) whose exclusive purpose is to insure risks of the parent organization and affiliated
- 130 companies; or
- 131 (b) in the case of groups and associations, an insurance organization:
- 132 (i) owned by the insureds; and
- 133 (ii) whose exclusive purpose is to insure risks of:
- 134 (A) member organizations;
- 135 (B) group members; and
- 136 (C) affiliates of:
- 137 (I) member organizations; or
- 138 (II) group members.
- 139 (20) "Casualty insurance" means liability insurance as defined in Subsection [~~(91)~~
- 140 (94)].
- 141 (21) "Certificate" means evidence of insurance given to:
- 142 (a) an insured under a group insurance policy; or
- 143 (b) a third party.
- 144 (22) "Certificate of authority" is included within the term "license."
- 145 (23) "Claim," unless the context otherwise requires, means a request or demand on an
- 146 insurer for payment of benefits according to the terms of an insurance policy.
- 147 (24) "Claims-made coverage" means an insurance contract or provision limiting
- 148 coverage under a policy insuring against legal liability to claims that are first made against the
- 149 insured while the policy is in force.
- 150 (25) (a) "Commissioner" or "commissioner of insurance" means Utah's insurance
- 151 commissioner.

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

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

155 (i) provides board and lodging;

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

157 (A) personal services;

158 (B) nursing services;

159 (C) medical services; or

160 (D) other health-related services; and

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

163 (A) for the life of the insured; or

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

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

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

170 (i) by contract;

171 (ii) by common management;

172 (iii) through the ownership of voting securities; or

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

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

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

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

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

183 (29) "Controlling person" means any person that directly or indirectly has the power to
184 direct or cause to be directed, the management, control, or activities of a reinsurance
185 intermediary.

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

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

189 (i) a corporation doing business:

190 (A) as:

191 (I) an insurance producer;

192 (II) a limited line producer;

193 (III) a consultant;

194 (IV) a managing general agent;

195 (V) a reinsurance intermediary;

196 (VI) a third party administrator; or

197 (VII) an adjuster; and

198 (B) under:

199 (I) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and
200 Reinsurance Intermediaries;

201 (II) Chapter 25, Third Party Administrators; or

202 (III) Chapter 26, Insurance Adjusters; or

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

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

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

207 (32) "Creditable coverage" has the same meaning as provided in federal regulations
208 adopted pursuant to the Health Insurance Portability and Accountability Act of 1996, Pub. L.
209 No. 104-191, 110 Stat. 1936.

210 [~~32~~] (33) "Credit accident and health insurance" means insurance on a debtor to
211 provide indemnity for payments coming due on a specific loan or other credit transaction while
212 the debtor is disabled.

213 [~~33~~] (34) (a) "Credit insurance" means insurance offered in connection with an

214 extension of credit that is limited to partially or wholly extinguishing that credit obligation.

215 (b) "Credit insurance" includes:

216 (i) credit accident and health insurance;

217 (ii) credit life insurance;

218 (iii) credit property insurance;

219 (iv) credit unemployment insurance;

220 (v) guaranteed automobile protection insurance;

221 (vi) involuntary unemployment insurance;

222 (vii) mortgage accident and health insurance;

223 (viii) mortgage guaranty insurance; and

224 (ix) mortgage life insurance.

225 [~~34~~] 35 "Credit life insurance" means insurance on the life of a debtor in connection

226 with an extension of credit that pays a person if the debtor dies.

227 [~~35~~] 36 "Credit property insurance" means insurance:

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

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

230 [~~36~~] 37 "Credit unemployment insurance" means insurance:

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

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

233 (i) specific loan; or

234 (ii) credit transaction.

235 [~~37~~] "~~Creditable coverage~~" is as defined in ~~45 C.F.R. 146.113(a)~~;

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

237 (a) matured;

238 (b) unmatured;

239 (c) liquidated;

240 (d) unliquidated;

241 (e) secured;

242 (f) unsecured;

243 (g) absolute;

244 (h) fixed; or

- 245 (i) contingent.
- 246 (39) (a) "Customer service representative" means a person that provides insurance
- 247 services and insurance product information:
- 248 (i) for the customer service representative's:
- 249 (A) producer; or
- 250 (B) consultant employer; and
- 251 (ii) to the customer service representative's employer's:
- 252 (A) customer;
- 253 (B) client; or
- 254 (C) organization.
- 255 (b) A customer service representative may only operate within the scope of authority of
- 256 the customer service representative's producer or consultant employer.
- 257 (40) "Deadline" means the final date or time:
- 258 (a) imposed by:
- 259 (i) statute;
- 260 (ii) rule; or
- 261 (iii) order; and
- 262 (b) by which a required filing or payment must be received by the department.
- 263 (41) "Deemer clause" means a provision under this title under which upon the
- 264 occurrence of a condition precedent, the commissioner is deemed to have taken a specific
- 265 action. If the statute so provides, the condition precedent may be the commissioner's failure to
- 266 take a specific action.
- 267 (42) "Degree of relationship" means the number of steps between two persons
- 268 determined by counting the generations separating one person from a common ancestor and
- 269 then counting the generations to the other person.
- 270 (43) "Department" means the Insurance Department.
- 271 (44) "Director" means a member of the board of directors of a corporation.
- 272 (45) "Disability" means a physiological or psychological condition that partially or
- 273 totally limits an individual's ability to:
- 274 (a) perform the duties of:
- 275 (i) that individual's occupation; or

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

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

279 (i) eating;

280 (ii) toileting;

281 (iii) transferring;

282 (iv) bathing; or

283 (v) dressing.

284 (46) "Disability income insurance" is defined in Subsection [~~(72)~~] (73).

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

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

287 (a) is incorporated;

288 (b) is organized; or

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

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

291 (i) an employee who:

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

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

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

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

297 (i) a sole proprietor;

298 (ii) a partner in a partnership; or

299 (iii) an independent contractor.

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

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

302 (ii) an employer's spouse; or

303 (iii) a dependent of an employer.

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

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

306 (a) employees; or

307 (b) dependents of employees.

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

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

310 (A) one or more employers;

311 (B) one or more labor organizations; or

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

313 (ii) that provides employee benefits paid or contracted to be paid, other than income

314 from investments of the fund, by or on behalf of an employer doing business in this state or for

315 the benefit of any person employed in this state.

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

318 (53) "Endorsement" means a written agreement attached to a policy or certificate to

319 modify one or more of the provisions of the policy or certificate.

320 (54) "Enrollment date," with respect to a health benefit plan, means the first day of
321 coverage or, if there is a waiting period, the first day of the waiting period.

322 [~~54~~] (55) (a) "Escrow" means:

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

325 (ii) a settlement or closing involving:

326 (A) a mobile home;

327 (B) a grazing right;

328 (C) a water right; or

329 (D) other personal property authorized by the commissioner.

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

331 (i) real estate settlement; or

332 (ii) real estate closing.

333 [~~55~~] (56) "Escrow agent" means:

334 (a) an insurance producer with:

335 (i) a title insurance line of authority; and

336 (ii) an escrow subline of authority; or

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

338 [~~(56)~~] (57) "Excludes" is not exhaustive and does not mean that other things are not
339 also excluded. The items listed are representative examples for use in interpretation of this
340 title.

341 [~~(57)~~] (58) "Expense reimbursement insurance" means insurance:

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

344 (b) written:

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

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

347 [~~(58)~~] (59) "Fidelity insurance" means insurance guaranteeing the fidelity of persons
348 holding positions of public or private trust.

349 [~~(59)~~] (60) (a) "Filed" means that a filing is:

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

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

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

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

356 (B) rule.

357 (b) "Filed" does not include a filing that is rejected by the department because it is not
358 submitted in accordance with Subsection [~~(59)~~] (60)(a).

359 [~~(60)~~] (61) "Filing," when used as a noun, means an item required to be filed with the
360 department including:

361 (a) a policy;

362 (b) a rate;

363 (c) a form;

364 (d) a document;

365 (e) a plan;

366 (f) a manual;

367 (g) an application;

368 (h) a report;

- 369 (i) a certificate;
- 370 (j) an endorsement;
- 371 (k) an actuarial certification;
- 372 (l) a licensee annual statement;
- 373 (m) a licensee renewal application; or
- 374 (n) an advertisement.

375 [~~(61)~~] (62) "First party insurance" means an insurance policy or contract in which the
376 insurer agrees to pay claims submitted to it by the insured for the insured's losses.

377 [~~(62)~~] (63) "Foreign insurer" means an insurer domiciled outside of this state, including
378 an alien insurer.

379 [~~(63)~~] (64) (a) "Form" means one of the following prepared for general use:

- 380 (i) a policy;
- 381 (ii) a certificate;
- 382 (iii) an application; or
- 383 (iv) an outline of coverage.

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

386 [~~(64)~~] (65) "Franchise insurance" means individual insurance policies provided through
387 a mass marketing arrangement involving a defined class of persons related in some way other
388 than through the purchase of insurance.

389 [~~(65)~~] (66) "General lines of authority" include:

- 390 (a) the general lines of insurance in Subsection [~~(66)~~] (67);
- 391 (b) title insurance under one of the following sublines of authority:
 - 392 (i) search, including authority to act as a title marketing representative;
 - 393 (ii) escrow, including authority to act as a title marketing representative;
 - 394 (iii) search and escrow, including authority to act as a title marketing representative;

395 and

- 396 (iv) title marketing representative only;
- 397 (c) surplus lines;
- 398 (d) workers' compensation; and
- 399 (e) any other line of insurance that the commissioner considers necessary to recognize

400 in the public interest.

401 [~~(66)~~] (67) "General lines of insurance" include:

402 (a) accident and health;

403 (b) casualty;

404 (c) life;

405 (d) personal lines;

406 (e) property; and

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

408 [~~(67)~~] (68) "Group health plan" means an employee welfare benefit plan to the extent
409 that the plan provides medical care:

410 (a) (i) to employees; or

411 (ii) to a dependent of an employee; and

412 (b) (i) directly;

413 (ii) through insurance reimbursement; or

414 (iii) through any other method.

415 [~~(68)~~] (69) "Guaranteed automobile protection insurance" means insurance offered in
416 connection with an extension of credit that pays the difference in amount between the
417 insurance settlement and the balance of the loan if the insured automobile is a total loss.

418 [~~(69)~~] (70) (a) Except as provided in Subsection [~~(69)~~] (70)(b), "health benefit plan"
419 means a policy or certificate that:

420 (i) provides health care insurance;

421 (ii) provides major medical expense insurance; or

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

423 (A) a hospital confinement indemnity; or

424 (B) a limited benefit plan.

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

426 (i) provides benefits solely for:

427 (A) accident;

428 (B) dental;

429 (C) income replacement;

430 (D) long-term care;

431 (E) a Medicare supplement;

432 (F) a specified disease;

433 (G) vision; or

434 (H) a short-term limited duration; or

435 (ii) is offered and marketed as supplemental health insurance.

436 [~~(70)~~] (71) "Health care" means any of the following intended for use in the diagnosis,
437 treatment, mitigation, or prevention of a human ailment or impairment:

438 (a) professional services;

439 (b) personal services;

440 (c) facilities;

441 (d) equipment;

442 (e) devices;

443 (f) supplies; or

444 (g) medicine.

445 [~~(71)~~] (72) (a) "Health care insurance" or "health insurance" means insurance
446 providing:

447 (i) health care benefits; or

448 (ii) payment of incurred health care expenses.

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

451 (i) replacement of income;

452 (ii) short-term accident;

453 (iii) fixed indemnity;

454 (iv) credit accident and health;

455 (v) supplements to liability;

456 (vi) workers' compensation;

457 (vii) automobile medical payment;

458 (viii) no-fault automobile;

459 (ix) equivalent self-insurance; or

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

462 [~~(72)~~] (73) "Income replacement insurance" or "disability income insurance" means
463 insurance written to provide payments to replace income lost from accident or sickness.

464 [~~(73)~~] (74) "Indemnity" means the payment of an amount to offset all or part of an
465 insured loss.

466 [~~(74)~~] (75) "Independent adjuster" means an insurance adjuster required to be licensed
467 under Section 31A-26-201 who engages in insurance adjusting as a representative of insurers.

468 [~~(75)~~] (76) "Independently procured insurance" means insurance procured under
469 Section 31A-15-104.

470 [~~(76)~~] (77) "Individual" means a natural person.

471 [~~(77)~~] (78) "Inland marine insurance" includes insurance covering:

472 (a) property in transit on or over land;

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

474 (c) bailee liability;

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

477 (e) personal and commercial property floaters.

478 [~~(78)~~] (79) "Insolvency" means that:

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

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

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

483 [~~(79)~~] (80) (a) "Insurance" means:

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

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

488 (b) "Insurance" includes:

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

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

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

495 ~~[(80)]~~ (81) "Insurance adjuster" means a person who directs the investigation,
496 negotiation, or settlement of a claim under an insurance policy other than life insurance or an
497 annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.

498 ~~[(81)]~~ (82) "Insurance business" or "business of insurance" includes:

499 (a) providing health care insurance, as defined in Subsection ~~[(71)]~~ (72), by
500 organizations that are or should be licensed under this title;

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

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

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

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

508 (d) providing the characteristic services of motor clubs as outlined in Subsection
509 ~~[(107)]~~ (110);

510 (e) providing other persons with insurance as defined in Subsection ~~[(79)]~~ (80);

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

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

514 (i) solicitation;

515 (ii) negotiation preliminary to execution;

516 (iii) execution of a contract of title insurance;

517 (iv) insuring; and

518 (v) transacting matters subsequent to the execution of the contract and arising out of
519 the contract, including reinsurance; and

520 (h) doing, or proposing to do, any business in substance equivalent to Subsections

521 ~~[(81)]~~ (82)(a) through (g) in a manner designed to evade the provisions of this title.

522 ~~[(82)]~~ (83) "Insurance consultant" or "consultant" means a person who:

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

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

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

528 [~~(83)~~] (84) "Insurance holding company system" means a group of two or more
529 affiliated persons, at least one of whom is an insurer.

530 [~~(84)~~] (85) (a) "Insurance producer" or "producer" means a person licensed or required
531 to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

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

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

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

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

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

540 [~~(85)~~] (86) (a) "Insured" means a person to whom or for whose benefit an insurer
541 makes a promise in an insurance policy and includes:

542 (i) policyholders;

543 (ii) subscribers;

544 (iii) members; and

545 (iv) beneficiaries.

546 (b) The definition in Subsection [~~(85)~~] (86)(a):

547 (i) applies only to this title; and

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

550 [~~(86)~~] (87) (a) (i) "Insurer" means any person doing an insurance business as a
551 principal including:

552 (A) fraternal benefit societies;

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

554 and (3);

555 (C) motor clubs;
556 (D) employee welfare plans; and
557 (E) any person purporting or intending to do an insurance business as a principal on
558 that person's own account.

559 (ii) "Insurer" does not include a governmental entity to the extent it is engaged in the
560 activities described in Section 31A-12-107.

561 (b) "Admitted insurer" is defined in Subsection [~~(154)~~] (159)(b).

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

563 (d) "Authorized insurer" is defined in Subsection [~~(154)~~] (159)(b).

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

565 (f) "Foreign insurer" is defined in Subsection [~~(62)~~] (63).

566 (g) "Nonadmitted insurer" is defined in Subsection [~~(154)~~] (159)(a).

567 (h) "Unauthorized insurer" is defined in Subsection [~~(154)~~] (159)(a).

568 [~~(87)~~] (88) "Interinsurance exchange" is defined in Subsection [~~(136)~~] (139).

569 [~~(88)~~] (89) "Involuntary unemployment insurance" means insurance:

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

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

573 (i) specific loan; or

574 (ii) credit transaction.

575 [~~(89)~~] (90) "Large employer," in connection with a health benefit plan, means an
576 employer who, with respect to a calendar year and to a plan year:

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

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

580 (91) "Late enrollee," with respect to an employer health benefit plan, means an
581 individual whose enrollment is a late enrollment.

582 (92) "Late enrollment," with respect to an employer health benefit plan, means
583 enrollment of an individual other than:

584 (a) on the earliest date on which coverage can become effective for the individual
585 under the terms of the plan; or

586 (b) through special enrollment.

587 [~~90~~] (93) (a) Except for a retainer contract or legal assistance described in Section
588 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for
589 specified legal expenses.

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

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

594 [~~91~~] (94) (a) "Liability insurance" means insurance against liability:

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

597 (A) Subsection [~~101~~] (104) for medical malpractice insurance;

598 (B) Subsection [~~128~~] (131) for professional liability insurance; and

599 (C) Subsection [~~158~~] (164) for workers' compensation insurance;

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

604 (A) Subsection [~~101~~] (104) for medical malpractice insurance;

605 (B) Subsection [~~128~~] (131) for professional liability insurance; and

606 (C) Subsection [~~158~~] (164) for workers' compensation insurance;

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

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

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

614 (b) "Liability insurance" includes:

615 (i) vehicle liability insurance as defined in Subsection [~~156~~] (161);

616 (ii) residential dwelling liability insurance as defined in Subsection [~~139~~] (142); and

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

620 ~~[(92)]~~ (95) (a) "License" means the authorization issued by the commissioner to engage
621 in some activity that is part of or related to the insurance business.

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

623 ~~[(93)]~~ (96) (a) "Life insurance" means insurance on human lives and insurances
624 pertaining to or connected with human life.

625 (b) The business of life insurance includes:

626 (i) granting death benefits;

627 (ii) granting annuity benefits;

628 (iii) granting endowment benefits;

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

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

632 (vi) providing optional methods of settlement of proceeds.

633 ~~[(94)]~~ (97) "Limited license" means a license that:

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

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

636 ~~[(95)]~~ (98) "Limited line credit insurance" includes the following forms of insurance:

637 (a) credit life;

638 (b) credit accident and health;

639 (c) credit property;

640 (d) credit unemployment;

641 (e) involuntary unemployment;

642 (f) mortgage life;

643 (g) mortgage guaranty;

644 (h) mortgage accident and health;

645 (i) guaranteed automobile protection; and

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

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

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

650 [~~96~~] (99) "Limited line credit insurance producer" means a person who sells, solicits,
651 or negotiates one or more forms of limited line credit insurance coverage to individuals through
652 a master, corporate, group, or individual policy.

653 [~~97~~] (100) "Limited line insurance" includes:

- 654 (a) bail bond;
- 655 (b) limited line credit insurance;
- 656 (c) legal expense insurance;
- 657 (d) motor club insurance;
- 658 (e) rental car-related insurance;
- 659 (f) travel insurance; and
- 660 (g) any other form of limited insurance that the commissioner determines by rule
661 should be designated a form of limited line insurance.

662 [~~98~~] (101) "Limited lines authority" includes:

- 663 (a) the lines of insurance listed in Subsection [~~97~~] (100); and
- 664 (b) a customer service representative.

665 [~~99~~] (102) "Limited lines producer" means a person who sells, solicits, or negotiates
666 limited lines insurance.

667 [~~100~~] (103) (a) "Long-term care insurance" means an insurance policy or rider
668 advertised, marketed, offered, or designated to provide coverage:

- 669 (i) in a setting other than an acute care unit of a hospital;
- 670 (ii) for not less than 12 consecutive months for each covered person on the basis of:
 - 671 (A) expenses incurred;
 - 672 (B) indemnity;
 - 673 (C) prepayment; or
 - 674 (D) another method;
- 675 (iii) for one or more necessary or medically necessary services that are:
 - 676 (A) diagnostic;
 - 677 (B) preventative;
 - 678 (C) therapeutic;

- 679 (D) rehabilitative;
680 (E) maintenance; or
681 (F) personal care; and
682 (iv) that may be issued by:
683 (A) an insurer;
684 (B) a fraternal benefit society;
685 (C) (I) a nonprofit health hospital; and
686 (II) a medical service corporation;
687 (D) a prepaid health plan;
688 (E) a health maintenance organization; or
689 (F) an entity similar to the entities described in Subsections [~~(100)~~] (103)(a)(iv)(A)
690 through (E) to the extent that the entity is otherwise authorized to issue life or health care
691 insurance.
- 692 (b) "Long-term care insurance" includes:
693 (i) any of the following that provide directly or supplement long-term care insurance:
694 (A) a group or individual annuity or rider; or
695 (B) a life insurance policy or rider;
696 (ii) a policy or rider that provides for payment of benefits based on:
697 (A) cognitive impairment; or
698 (B) functional capacity; or
699 (iii) a qualified long-term care insurance contract.
- 700 (c) "Long-term care insurance" does not include:
701 (i) a policy that is offered primarily to provide basic Medicare supplement coverage;
702 (ii) basic hospital expense coverage;
703 (iii) basic medical/surgical expense coverage;
704 (iv) hospital confinement indemnity coverage;
705 (v) major medical expense coverage;
706 (vi) income replacement or related asset-protection coverage;
707 (vii) accident only coverage;
708 (viii) coverage for a specified:
709 (A) disease; or

710 (B) accident;
711 (ix) limited benefit health coverage; or
712 (x) a life insurance policy that accelerates the death benefit to provide the option of a
713 lump sum payment:

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

715 (I) benefits; or

716 (II) eligibility; and

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

718 (I) terminal illness;

719 (II) medical conditions requiring extraordinary medical intervention; or

720 (III) permanent institutional confinement.

721 [~~(101)~~] (104) "Medical malpractice insurance" means insurance against legal liability
722 incident to the practice and provision of medical services other than the practice and provision
723 of dental services.

724 [~~(102)~~] (105) "Member" means a person having membership rights in an insurance
725 corporation.

726 [~~(103)~~] (106) "Minimum capital" or "minimum required capital" means the capital that
727 must be constantly maintained by a stock insurance corporation as required by statute.

728 [~~(104)~~] (107) "Mortgage accident and health insurance" means insurance offered in
729 connection with an extension of credit that provides indemnity for payments coming due on a
730 mortgage while the debtor is disabled.

731 [~~(105)~~] (108) "Mortgage guaranty insurance" means surety insurance under which
732 mortgagees and other creditors are indemnified against losses caused by the default of debtors.

733 [~~(106)~~] (109) "Mortgage life insurance" means insurance on the life of a debtor in
734 connection with an extension of credit that pays if the debtor dies.

735 [~~(107)~~] (110) "Motor club" means a person:

736 (a) licensed under:

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

738 (ii) Chapter 11, Motor Clubs; or

739 (iii) Chapter 14, Foreign Insurers; and

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

741 (i) legal services under Subsection 31A-11-102(1)(b);
742 (ii) bail services under Subsection 31A-11-102(1)(c); or
743 (iii) trip reimbursement, towing services, emergency road services, stolen automobile
744 services, a combination of these services, or any other services given in Subsections
745 31A-11-102(1)(b) through (f).

746 [~~(108)~~] (111) "Mutual" means a mutual insurance corporation.

747 [~~(109)~~] (112) "Network plan" means health care insurance:

748 (a) that is issued by an insurer; and

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

752 [~~(110)~~] (113) "Nonparticipating" means a plan of insurance under which the insured is
753 not entitled to receive dividends representing shares of the surplus of the insurer.

754 [~~(111)~~] (114) "Ocean marine insurance" means insurance against loss of or damage to:

755 (a) ships or hulls of ships;

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

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

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

764 [~~(112)~~] (115) "Order" means an order of the commissioner.

765 [~~(113)~~] (116) "Outline of coverage" means a summary that explains an accident and
766 health insurance policy.

767 [~~(114)~~] (117) "Participating" means a plan of insurance under which the insured is
768 entitled to receive dividends representing shares of the surplus of the insurer.

769 [~~(115)~~] (118) "Participation," as used in a health benefit plan, means a requirement
770 relating to the minimum percentage of eligible employees that must be enrolled in relation to
771 the total number of eligible employees of an employer reduced by each eligible employee who

772 voluntarily declines coverage under the plan because the employee has other group health care
773 insurance coverage.

774 [~~(H6)~~] (119) "Person" includes an individual, partnership, corporation, incorporated or
775 unincorporated association, joint stock company, trust, limited liability company, reciprocal,
776 syndicate, or any similar entity or combination of entities acting in concert.

777 [~~(H7)~~] (120) "Personal lines insurance" means property and casualty insurance
778 coverage sold for primarily noncommercial purposes to:

779 (a) individuals; and

780 (b) families.

781 [~~(H8)~~] (121) "Plan sponsor" is as defined in 29 U.S.C. Sec. 1002(16)(B).

782 [~~(H9)~~] (122) "Plan year" means:

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

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

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

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

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

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

790 or

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

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

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

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

795 (c) in a case not described in Subsection [~~(H9)~~] (122)(a) or (b), the calendar year.

796 [~~(H0)~~] (123) (a) (i) "Policy" means any document, including attached endorsements

797 and riders, purporting to be an enforceable contract, which memorializes in writing some or all
798 of the terms of an insurance contract.

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

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

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

802 (C) a corporation licensed under:

803 (I) Chapter 7, Nonprofit Health Service Insurance Corporations; or
804 (II) Chapter 8, Health Maintenance Organizations and Limited Health Plans.
805 (iii) "Policy" does not include:
806 (A) a certificate under a group insurance contract; or
807 (B) a document that does not purport to have legal effect.

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

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

814 (c) "Blanket insurance policy" means a group policy covering classes of persons
815 without individual underwriting, where the persons insured are determined by definition of the
816 class with or without designating the persons covered.

817 ~~[(121)]~~ (124) "Policyholder" means the person who controls a policy, binder, or oral
818 contract by ownership, premium payment, or otherwise.

819 ~~[(122)]~~ (125) "Policy illustration" means a presentation or depiction that includes
820 nonguaranteed elements of a policy of life insurance over a period of years.

821 ~~[(123)]~~ (126) "Policy summary" means a synopsis describing the elements of a life
822 insurance policy.

823 ~~[(124)]~~ (127) "Preexisting condition," ~~[in connection]~~ with respect to a health benefit
824 plan[;]:

825 (a) means~~[-(a)]~~ a condition ~~[for which]~~ that was present before the effective date of
826 coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended
827 or received ~~[during the six months immediately preceding the earlier of:]~~ before that day; and
828 ~~[(i) the enrollment date; or]~~

829 ~~[(ii) the effective date of coverage; or]~~

830 ~~[(b) for an individual insurance policy, a pregnancy existing on the effective date of~~
831 ~~coverage.]~~

832 (b) does not include a condition indicated by genetic information unless an actual
833 diagnosis of the condition by a physician has been made.

834 [~~(125)~~] (128) (a) "Premium" means the monetary consideration for an insurance policy.

835 (b) "Premium" includes, however designated:

836 (i) assessments;

837 (ii) membership fees;

838 (iii) required contributions; or

839 (iv) monetary consideration.

840 (c) (i) Consideration paid to third party administrators for their services is not

841 "premium."

842 (ii) Amounts paid by third party administrators to insurers for insurance on the risks

843 administered by the third party administrators are "premium."

844 [~~(126)~~] (129) "Principal officers" of a corporation means the officers designated under

845 Subsection 31A-5-203(3).

846 [~~(127)~~] (130) "Proceedings" includes actions and special statutory proceedings.

847 [~~(128)~~] (131) "Professional liability insurance" means insurance against legal liability

848 incident to the practice of a profession and provision of any professional services.

849 [~~(129)~~] (132) "Property insurance" means insurance against loss or damage to real or

850 personal property of every kind and any interest in that property, from all hazards or causes,

851 and against loss consequential upon the loss or damage including vehicle comprehensive and

852 vehicle physical damage coverages, but excluding inland marine insurance and ocean marine

853 insurance as defined under Subsections [~~(77)~~] (78) and [~~(111)~~] (114).

854 [~~(130)~~] (133) "Qualified long-term care insurance contract" or "federally tax qualified

855 long-term care insurance contract" means:

856 (a) an individual or group insurance contract that meets the requirements of Section

857 7702B(b), Internal Revenue Code; or

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

859 (i) (A) by rider; or

860 (B) as a part of the contract; and

861 (ii) that satisfies the requirements of [~~Section~~] Sections 7702B(b) and (e), Internal

862 Revenue Code.

863 [~~(131)~~] (134) "Qualified United States financial institution" means an institution that:

864 (a) is:

- 865 (i) organized under the laws of the United States or any state; or
866 (ii) in the case of a United States office of a foreign banking organization, licensed
867 under the laws of the United States or any state;
- 868 (b) is regulated, supervised, and examined by United States federal or state authorities
869 having regulatory authority over banks and trust companies; and
- 870 (c) meets the standards of financial condition and standing that are considered
871 necessary and appropriate to regulate the quality of financial institutions whose letters of credit
872 will be acceptable to the commissioner as determined by:
- 873 (i) the commissioner by rule; or
874 (ii) the Securities Valuation Office of the National Association of Insurance
875 Commissioners.
- 876 [~~(132)~~] (135) (a) "Rate" means:
- 877 (i) the cost of a given unit of insurance; or
878 (ii) for property-casualty insurance, that cost of insurance per exposure unit either
879 expressed as:
- 880 (A) a single number; or
881 (B) a pure premium rate, adjusted before any application of individual risk variations
882 based on loss or expense considerations to account for the treatment of:
- 883 (I) expenses;
884 (II) profit; and
885 (III) individual insurer variation in loss experience.
- 886 (b) "Rate" does not include a minimum premium.
- 887 [~~(133)~~] (136) (a) Except as provided in Subsection [~~(133)~~] (136)(b), "rate service
888 organization" means any person who assists insurers in rate making or filing by:
- 889 (i) collecting, compiling, and furnishing loss or expense statistics;
890 (ii) recommending, making, or filing rates or supplementary rate information; or
891 (iii) advising about rate questions, except as an attorney giving legal advice.
- 892 (b) "Rate service organization" does not mean:
- 893 (i) an employee of an insurer;
894 (ii) a single insurer or group of insurers under common control;
895 (iii) a joint underwriting group; or

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

897 [~~(134)~~] (137) "Rating manual" means any of the following used to determine initial and
898 renewal policy premiums:

899 (a) a manual of rates;

900 (b) classifications;

901 (c) rate-related underwriting rules; and

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

904 [~~(135)~~] (138) "Received by the department" means:

905 (a) except as provided in Subsection [~~(135)~~] (138)(b), the date delivered to and
906 stamped received by the department, whether delivered:

907 (i) in person; or

908 (ii) electronically; and

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

911 (i) statute;

912 (ii) rule; or

913 (iii) a specific filing order.

914 [~~(136)~~] (139) "Reciprocal" or "interinsurance exchange" means any unincorporated
915 association of persons:

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

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

919 [~~(137)~~] (140) "Reinsurance" means an insurance transaction where an insurer, for
920 consideration, transfers any portion of the risk it has assumed to another insurer. In referring to
921 reinsurance transactions, this title sometimes refers to:

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

923 (b) the insurer assuming the risk as the:

924 (i) "assuming insurer"; or

925 (ii) "assuming reinsurer."

926 [~~(138)~~] (141) "Reinsurer" means any person licensed in this state as an insurer with the

927 authority to assume reinsurance.

928 ~~[(139)]~~ (142) "Residential dwelling liability insurance" means insurance against
929 liability resulting from or incident to the ownership, maintenance, or use of a residential
930 dwelling that is a detached single family residence or multifamily residence up to four units.

931 ~~[(140)]~~ (143) "Retrocession" means reinsurance with another insurer of a liability
932 assumed under a reinsurance contract. A reinsurer "retrocedes" when it reinsures with another
933 insurer part of a liability assumed under a reinsurance contract.

934 ~~[(141)]~~ (144) "Rider" means an endorsement to:

935 (a) an insurance policy; or

936 (b) an insurance certificate.

937 ~~[(142)]~~ (145) (a) "Security" means any:

938 (i) note;

939 (ii) stock;

940 (iii) bond;

941 (iv) debenture;

942 (v) evidence of indebtedness;

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

944 (vii) collateral-trust certificate;

945 (viii) preorganization certificate or subscription;

946 (ix) transferable share;

947 (x) investment contract;

948 (xi) voting trust certificate;

949 (xii) certificate of deposit for a security;

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

952 (xiv) commodity contract or commodity option;

953 (xv) any certificate of interest or participation in, temporary or interim certificate for,
954 receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed
955 in Subsections ~~[(142)]~~ (145)(a)(i) through (xiv); or

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

957 (b) "Security" does not include:

958 (i) any of the following under which an insurance company promises to pay money in a
959 specific lump sum or periodically for life or some other specified period:

- 960 (A) insurance;
- 961 (B) endowment policy; or
- 962 (C) annuity contract; or

963 (ii) a burial certificate or burial contract.

964 ~~[(143)]~~ (146) "Self-insurance" means any arrangement under which a person provides
965 for spreading its own risks by a systematic plan.

966 (a) Except as provided in this Subsection ~~[(143)]~~ (146), "self-insurance" does not
967 include an arrangement under which a number of persons spread their risks among themselves.

968 (b) "Self-insurance" includes:

969 (i) an arrangement by which a governmental entity undertakes to indemnify its
970 employees for liability arising out of the employees' employment; and

971 (ii) an arrangement by which a person with a managed program of self-insurance and
972 risk management undertakes to indemnify its affiliates, subsidiaries, directors, officers, or
973 employees for liability or risk which is related to the relationship or employment.

974 (c) "Self-insurance" does not include any arrangement with independent contractors.

975 ~~[(144)]~~ (147) "Sell" means to exchange a contract of insurance:

- 976 (a) by any means;
- 977 (b) for money or its equivalent; and
- 978 (c) on behalf of an insurance company.

979 ~~[(145)]~~ (148) "Short-term care insurance" means any insurance policy or rider
980 advertised, marketed, offered, or designed to provide coverage that is similar to long-term care
981 insurance but that provides coverage for less than 12 consecutive months for each covered
982 person.

983 (149) "Significant break in coverage" means a period of 63 consecutive days during
984 each of which an individual does not have any creditable coverage.

985 ~~[(146)]~~ (150) "Small employer," in connection with a health benefit plan, means an
986 employer who, with respect to a calendar year and to a plan year:

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

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

990 (151) "Special enrollment period," in connection with a health benefit plan, has the
991 same meaning as provided in federal regulations adopted pursuant to the Health Insurance
992 Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936.

993 [~~(147)~~] (152) (a) "Subsidiary" of a person means an affiliate controlled by that person
994 either directly or indirectly through one or more affiliates or intermediaries.

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

999 [~~(148)~~] (153) Subject to Subsection [~~(79)~~] (80)(b), "surety insurance" includes:

1000 (a) a guarantee against loss or damage resulting from failure of principals to pay or
1001 perform their obligations to a creditor or other obligee;

1002 (b) bail bond insurance; and

1003 (c) fidelity insurance.

1004 [~~(149)~~] (154) (a) "Surplus" means the excess of assets over the sum of paid-in capital
1005 and liabilities.

1006 (b) (i) "Permanent surplus" means the surplus of a mutual insurer that has been
1007 designated by the insurer as permanent.

1008 (ii) Sections 31A-5-211, 31A-7-201, 31A-8-209, 31A-9-209, and 31A-14-209 require
1009 that mutuals doing business in this state maintain specified minimum levels of permanent
1010 surplus.

1011 (iii) Except for assessable mutuals, the minimum permanent surplus requirement is
1012 essentially the same as the minimum required capital requirement that applies to stock insurers.

1013 (c) "Excess surplus" means:

1014 (i) for life or accident and health insurers, health organizations, and property and
1015 casualty insurers as defined in Section 31A-17-601, the lesser of:

1016 (A) that amount of an insurer's or health organization's total adjusted capital, as defined
1017 in Subsection [~~(152)~~] (157), that exceeds the product of:

1018 (I) 2.5; and

1019 (II) the sum of the insurer's or health organization's minimum capital or permanent

1020 surplus required under Section 31A-5-211, 31A-9-209, or 31A-14-205; or
1021 (B) that amount of an insurer's or health organization's total adjusted capital, as defined
1022 in Subsection [~~(152)~~] (157), that exceeds the product of:
1023 (I) 3.0; and
1024 (II) the authorized control level RBC as defined in Subsection 31A-17-601(8)(a); and
1025 (ii) for monoline mortgage guaranty insurers, financial guaranty insurers, and title
1026 insurers, that amount of an insurer's paid-in-capital and surplus that exceeds the product of:
1027 (A) 1.5; and
1028 (B) the insurer's total adjusted capital required by Subsection 31A-17-609(1).
1029 [~~(150)~~] (155) "Third party administrator" or "administrator" means any person who
1030 collects charges or premiums from, or who, for consideration, adjusts or settles claims of
1031 residents of the state in connection with insurance coverage, annuities, or service insurance
1032 coverage, except:
1033 (a) a union on behalf of its members;
1034 (b) a person administering any:
1035 (i) pension plan subject to the federal Employee Retirement Income Security Act of
1036 1974;
1037 (ii) governmental plan as defined in Section 414(d), Internal Revenue Code; or
1038 (iii) nonelecting church plan as described in Section 410(d), Internal Revenue Code;
1039 (c) an employer on behalf of the employer's employees or the employees of one or
1040 more of the subsidiary or affiliated corporations of the employer;
1041 (d) an insurer licensed under Chapter 5, 7, 8, 9, or 14, but only for a line of insurance
1042 for which the insurer holds a license in this state; or
1043 (e) a person:
1044 (i) licensed or exempt from licensing under:
1045 (A) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and
1046 Reinsurance Intermediaries; or
1047 (B) Chapter 26, Insurance Adjusters; and
1048 (ii) whose activities are limited to those authorized under the license the person holds
1049 or for which the person is exempt.
1050 [~~(151)~~] (156) "Title insurance" means the insuring, guaranteeing, or indemnifying of

1051 owners of real or personal property or the holders of liens or encumbrances on that property, or
1052 others interested in the property against loss or damage suffered by reason of liens or
1053 encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity
1054 or unenforceability of any liens or encumbrances on the property.

1055 ~~[(152)]~~ (157) "Total adjusted capital" means the sum of an insurer's or health
1056 organization's statutory capital and surplus as determined in accordance with:

1057 (a) the statutory accounting applicable to the annual financial statements required to be
1058 filed under Section 31A-4-113; and

1059 (b) any other items provided by the RBC instructions, as RBC instructions is defined in
1060 Section 31A-17-601.

1061 ~~[(153)]~~ (158) (a) "Trustee" means "director" when referring to the board of directors of
1062 a corporation.

1063 (b) "Trustee," when used in reference to an employee welfare fund, means an
1064 individual, firm, association, organization, joint stock company, or corporation, whether acting
1065 individually or jointly and whether designated by that name or any other, that is charged with
1066 or has the overall management of an employee welfare fund.

1067 ~~[(154)]~~ (159) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted
1068 insurer" means an insurer:

1069 (i) not holding a valid certificate of authority to do an insurance business in this state;
1070 or

1071 (ii) transacting business not authorized by a valid certificate.

1072 (b) "Admitted insurer" or "authorized insurer" means an insurer:

1073 (i) holding a valid certificate of authority to do an insurance business in this state; and

1074 (ii) transacting business as authorized by a valid certificate.

1075 ~~[(155)]~~ (160) "Underwrite" means the authority to accept or reject risk on behalf of the
1076 insurer.

1077 ~~[(156)]~~ (161) "Vehicle liability insurance" means insurance against liability resulting
1078 from or incident to ownership, maintenance, or use of any land vehicle or aircraft, exclusive of
1079 vehicle comprehensive and vehicle physical damage coverages under Subsection ~~[(129)]~~ (132).

1080 ~~[(157)]~~ (162) "Voting security" means a security with voting rights, and includes any
1081 security convertible into a security with a voting right associated with the security.

1082 (163) "Waiting period" for a health benefit plan means the period that must pass before
1083 coverage for an individual, who is otherwise eligible to enroll under the terms of the health
1084 benefit plan, can become effective.

1085 ~~[(158)]~~ (164) "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 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-8-402.7** is amended to read:

1095 **31A-8-402.7. Discontinuance and nonrenewal limitations.**

1096 (1) Subject to Section 31A-4-115, an insurer that elects to discontinue offering a health
1097 benefit plan under Subsections 31A-8-402.3(3)(e) and 31A-8-402.5(3)(e) is prohibited from
1098 writing new business:

1099 (a) in the market in this state for which the insurer discontinues or does not renew; and

1100 (b) for a period of five years beginning on the date of discontinuation of the last
1101 coverage that is discontinued.

1102 (2) If an insurer is doing business in one established geographic service area of the
1103 state, Sections 31A-8-402.3 and 31A-8-402.5 apply only to the insurer's operations in that
1104 service area.

1105 ~~[(3) Notwithstanding whether Chapter 22, Part 7, Group Accident and Health~~
1106 ~~Insurance, requires a conversion policy be available for certain persons who are no longer~~
1107 ~~entitled to group coverage, an organization may not be required to provide a conversion policy~~
1108 ~~to a person residing outside of the organization's service area.]~~

1109 ~~[(4)]~~ (3) The commissioner may, by rule or order, define the scope of service area.

1110 Section 3. Section **31A-22-605** is amended to read:

1111 **31A-22-605. Accident and health insurance standards.**

1112 (1) The purposes of this section include:

1113 (a) reasonable standardization and simplification of terms and coverages of individual
1114 and franchise accident and health insurance policies, including accident and health insurance
1115 contracts of insurers licensed under Chapters 7 and 8, to facilitate public understanding and
1116 comparison in purchasing;

1117 (b) elimination of provisions contained in individual and franchise accident and health
1118 insurance contracts that may be misleading or confusing in connection with either the purchase
1119 of those types of coverages or the settlement of claims; and

1120 (c) full disclosure in the sale of individual and franchise accident and health insurance
1121 contracts.

1122 (2) As used in this section:

1123 (a) "Direct response insurance policy" means an individual insurance policy solicited
1124 and sold without the policyholder having direct contact with a natural person intermediary.

1125 (b) "Medicare" is defined in Subsection 31A-22-620(1)(e).

1126 (c) "Medicare supplement policy" is defined in Subsection 31A-22-620(1)(f).

1127 (3) This section applies to all individual and franchise accident and health policies.

1128 (4) The commissioner shall adopt rules relating to the following matters:

1129 (a) standards for the manner and content of policy provisions, and disclosures to be
1130 made in connection with the sale of policies covered by this section, dealing with at least the
1131 following matters:

1132 (i) terms of renewability;

1133 (ii) initial and subsequent conditions of eligibility;

1134 (iii) nonduplication of coverage provisions;

1135 (iv) coverage of dependents;

1136 (v) preexisting conditions;

1137 (vi) termination of insurance;

1138 (vii) probationary periods;

1139 (viii) limitations;

1140 (ix) exceptions;

1141 (x) reductions;

1142 (xi) elimination periods;

1143 (xii) requirements for replacement;

- 1144 (xiii) recurrent conditions;
- 1145 (xiv) coverage of persons eligible for Medicare; and
- 1146 (xv) definition of terms;
- 1147 (b) minimum standards for benefits under each of the following categories of coverage
- 1148 in policies covered in this section:
 - 1149 (i) basic hospital expense coverage;
 - 1150 (ii) basic medical-surgical expense coverage;
 - 1151 (iii) hospital confinement indemnity coverage;
 - 1152 (iv) major medical expense coverage;
 - 1153 (v) income replacement coverage;
 - 1154 (vi) accident only coverage;
 - 1155 (vii) specified disease or specified accident coverage;
 - 1156 (viii) limited benefit health coverage; and
 - 1157 (ix) nursing home and long-term care coverage;
- 1158 (c) the content and format of the outline of coverage, in addition to that required under
- 1159 Subsection (6);
 - 1160 (d) the method of identification of policies and contracts based upon coverages
 - 1161 provided; and
 - 1162 (e) rating practices.
- 1163 (5) Nothing in Subsection (4)(b) precludes the issuance of policies that combine
- 1164 categories of coverage in that subsection provided that any combination of categories meets the
- 1165 standards of a component category of coverage.
- 1166 (6) The commissioner may adopt rules relating to the following matters:
 - 1167 (a) establishing disclosure requirements for insurance policies covered in this section,
 - 1168 designed to adequately inform the prospective insured of the need for and extent of the
 - 1169 coverage offered, and requiring that this disclosure be furnished to the prospective insured with
 - 1170 the application form, unless it is a direct response insurance policy;
 - 1171 (b) (i) prescribing caption or notice requirements designed to inform prospective
 - 1172 insureds that particular insurance coverages are not Medicare Supplement coverages;
 - 1173 (ii) the requirements of Subsection (6)(b)(i) apply to all insurance policies and
 - 1174 certificates sold to persons eligible for Medicare; and

1175 (c) requiring the disclosures or information brochures to be furnished to the
1176 prospective insured on direct response insurance policies, upon his request or, in any event, no
1177 later than the time of the policy delivery.

1178 (7) A policy covered by this section may be issued only if it meets the minimum
1179 standards established by the commissioner under Subsection (4), an outline of coverage
1180 accompanies the policy or is delivered to the applicant at the time of the application, and,
1181 except with respect to direct response insurance policies, an acknowledged receipt is provided
1182 to the insurer. The outline of coverage shall include:

1183 (a) a statement identifying the applicable categories of coverage provided by the policy
1184 as prescribed under Subsection (4);

1185 (b) a description of the principal benefits and coverage;

1186 (c) a statement of the exceptions, reductions, and limitations contained in the policy;

1187 (d) a statement of the renewal provisions, including any reservation by the insurer of a
1188 right to change premiums;

1189 (e) a statement that the outline is a summary of the policy issued or applied for and that
1190 the policy should be consulted to determine governing contractual provisions; and

1191 (f) any other contents the commissioner prescribes.

1192 (8) If a policy is issued on a basis other than that applied for, the outline of coverage
1193 shall accompany the policy when it is delivered and it shall clearly state that it is not the policy
1194 for which application was made.

1195 ~~[(9) (a) Notwithstanding Subsection 31A-22-609(2), and except as provided under~~
1196 ~~Subsection (9)(b), an insurer that elects to use an application form without questions~~
1197 ~~concerning the insured's health history or medical treatment history, shall provide coverage~~
1198 ~~under the policy for any loss which occurs more than 12 months after the effective date of the~~
1199 ~~policy due to a preexisting condition which is not specifically excluded from coverage.]~~

1200 ~~[(b) (i) An insurer that issues a specified disease policy, regardless of whether the basis~~
1201 ~~of issuance is a detailed application form, a simplified application form, or an enrollment form,~~
1202 ~~may not deny a claim for loss due to a preexisting condition which occurs more than six~~
1203 ~~months after the effective date of coverage.]~~

1204 ~~[(ii) A specified disease policy may not define a preexisting condition more~~
1205 ~~restrictively than a condition which first manifested itself within six months prior to the~~

1206 ~~effective date of coverage or which was diagnosed by a physician at any time prior to the~~
1207 ~~effective date of coverage.]~~

1208 ~~[(iii) A specified disease policy may not include wording that provides a defense based~~
1209 ~~upon a preexisting condition except as allowed under this Subsection (9).]~~

1210 ~~[(10)]~~ (9) Notwithstanding Subsection 31A-22-606(1), limited accident and health
1211 policies or certificates issued to persons eligible for Medicare shall contain a notice
1212 prominently printed on or attached to the cover or front page which states that the policyholder
1213 or certificate holder has the right to return the policy for any reason within 30 days after its
1214 delivery and to have the premium refunded.

1215 Section 4. Section **31A-22-605.1** is enacted to read:

1216 **31A-22-605.1. Preexisting condition limitations.**

1217 (1) Any provision dealing with preexisting conditions shall be consistent with this
1218 section, Section 31A-22-609, and rules adopted by the commissioner.

1219 (2) Except as provided in this section, an insurer that elects to use an application form
1220 without questions concerning the insured's health or medical treatment history shall provide
1221 coverage under the policy for any loss which occurs more than 12 months after the effective
1222 date of coverage due to a preexisting condition which is not specifically excluded from
1223 coverage.

1224 (3) (a) An insurer that issues a specified disease policy may not deny a claim for loss
1225 due to a preexisting condition that occurs more than six months after the effective date of
1226 coverage.

1227 (b) A specified disease policy may impose a preexisting condition exclusion only if the
1228 exclusion relates to a preexisting condition which first manifested itself within six months prior
1229 to the effective date of coverage or which was diagnosed by a physician at any time prior to the
1230 effective date of coverage.

1231 (4) (a) Except as provided in this Subsection (4), a health benefit plan may impose a
1232 preexisting condition exclusion only if:

1233 (i) the exclusion relates to a preexisting condition for which medical advice, diagnosis,
1234 care, or treatment was recommended or received within the six-month period ending on the
1235 enrollment date from an individual licensed or similarly authorized to provide those services
1236 under state law and operating within the scope of practice authorized by state law;

1237 (ii) the exclusion period ends no later than 12 months after the enrollment date, or in
 1238 the case of a late enrollee, 18 months after the enrollment date; and

1239 (iii) the exclusion period is reduced by the number of days of creditable coverage the
 1240 enrollee has as of the enrollment date, in accordance with Subsection (4)(b).

1241 (b) (i) The amount of creditable coverage allowed under Subsection (4)(a)(iii) is
 1242 determined by counting all the days on which the individual has one or more types of creditable
 1243 coverage.

1244 (ii) Days of creditable coverage that occur before a significant break in coverage are
 1245 not required to be counted.

1246 (A) Days in a waiting period or affiliation period are not taken into account in
 1247 determining whether a significant break in coverage has occurred.

1248 (B) For an individual who elects federal COBRA continuation coverage during the
 1249 second election period provided under the federal Trade Act of 2002, the days between the date
 1250 the individual lost group health plan coverage and the first day of the second COBRA election
 1251 period are not taken into account in determining whether a significant break in coverage has
 1252 occurred.

1253 ~~H→ [(C) In the case of an individual whose coverage ceases, if a certificate of creditable~~
 1254 ~~coverage with respect to that cessation is not provided on or before the date coverage ceases;~~
 1255 ~~then the period that begins on the first date that an individual has no creditable coverage and~~
 1256 ~~that continues through the earlier of the following two dates is not taken into account in~~
 1257 ~~determining whether a significant break in coverage has occurred:~~

1258 ~~—— (I) the date that a certificate of creditable coverage with respect to that cessation is~~
 1259 ~~provided; or~~

1260 ~~—— (H) the date 44 days after coverage ceases.] ←H~~

1261 (c) A group health benefit plan may not impose a preexisting condition exclusion
 1262 relating to pregnancy.

1263 (d) (i) An insurer imposing a preexisting condition exclusion shall provide a written
 1264 general notice of preexisting condition exclusion as part of any written application materials.

1265 (ii) The general notice shall include:

1266 (A) a description of the existence and terms of any preexisting condition exclusion
 1267 under the plan, including the six-month period ending on the enrollment date, the maximum

- 1268 preexisting condition exclusion period, and how the insurer will reduce the maximum
1269 preexisting condition exclusion period by creditable coverage;
1270 (B) a description of the rights of individuals:
1271 (I) to demonstrate creditable coverage, including any applicable waiting periods,
1272 through a certificate of creditable coverage or through other means; and
1273 (II) to request a certificate of creditable coverage from a prior plan;
1274 (C) a statement that the current plan will assist in obtaining a certificate of creditable
1275 coverage from any prior plan or issuer if necessary; and
1276 (D) a person to contact, and an address and telephone number for the person, for
1277 obtaining additional information or assistance regarding the preexisting condition exclusion.
1278 (e) An insurer may not impose any limit on the amount of time that an individual has to
1279 present a certificate or other evidence of creditable coverage.
1280 (f) This Subsection (4) does not preclude application of any waiting period applicable
1281 to all new enrollees under the plan.

1282 Section 5. Section **31A-22-606** is amended to read:

1283 **31A-22-606. Policy examination period.**

1284 (1) (a) Except as provided in Subsection (2), all accident and health policies shall
1285 contain a notice prominently printed on or attached to the cover or front page stating that the
1286 policyholder has the right to return the policy for any reason within ten days after its delivery.

1287 (b) "Return" means delivery to the insurer or its agent or mailing of the policy to either,
1288 properly addressed and stamped for first class handling, with a written statement on the policy
1289 or an accompanying communication that it is being returned for termination of coverage. A
1290 policy returned under this Subsection (1) is void from the beginning and a policyholder
1291 returning his policy is entitled to a refund of any premium paid.

1292 (2) This section does not apply to:

1293 (a) group policies;

1294 (b) policies issued to persons entitled to a 30-day examination period under Subsection
1295 31A-22-605[~~(10)~~](9);

1296 (c) single premium nonrenewable policies issued for terms not longer than 60 days;

1297 (d) policies covering accidents only or accidental bodily injury only; and

1298 (e) other classes of policies which the commissioner by rule specifies after a finding

1299 that a right to return those policies would be impracticable or unnecessary to protect the
1300 policyholder's interests.

1301 Section 6. Section **31A-22-609** is amended to read:

1302 **31A-22-609. Incontestability for accident and health insurance.**

1303 (1) (a) A statement made by an applicant [~~in the application for individual or franchise~~
1304 ~~accident and health insurance coverage or statement made~~] relating to the person's insurability
1305 [~~by a person insured under a group policy~~], except fraudulent misrepresentation, may not be a
1306 basis for avoidance of [~~the~~] a policy, coverage, or denial of a claim for loss incurred or
1307 disability commencing after the coverage has been in effect for two years.

1308 (b) The insurer has the burden of proving fraud by clear and convincing evidence.

1309 [~~(c) The policy may provide for incontestability even for fraudulent misstatements.~~]

1310 (2) Except as [~~otherwise~~] provided under Subsection [~~31A-22-605(9)~~] 31A-22-605.1, a
1311 claim for loss incurred or disability commencing after two years from the date of issue of the
1312 policy may not be reduced or denied on the ground that a disease or physical condition existed
1313 prior to the effective date of coverage, unless the condition was excluded from coverage by
1314 name or specific description in a provision that was in effect on the date of loss.

1315 (3) Except as provided in Subsection (1)(a), a specified disease policy may not include
1316 wording that provides a defense based upon a disease or physical condition that existed prior to
1317 the effective date of coverage except as allowed under Subsection 31A-22-605.1(2).

1318 Section 7. Section **31A-22-613** is amended to read:

1319 **31A-22-613. Permitted provisions for accident and health insurance policies.**

1320 The following provisions may be contained in an accident and health insurance policy,
1321 but if they are in that policy, they shall conform to at least the minimum requirements for the
1322 policyholder in this section.

1323 (1) Any provision respecting change of occupation may provide only for a lower
1324 maximum benefit payment and for reduction of loss payments proportionate to the change in
1325 appropriate premium rates, if the change is to a higher rated occupation, and this provision
1326 shall provide for retroactive reduction of premium rates from the date of change of occupation
1327 or the last policy anniversary date, whichever is the more recent, if the change is to a lower
1328 rated occupation.

1329 (2) Section 31A-22-405 applies to misstatement of age in accident and health policies,

1330 with the appropriate modifications of terminology.

1331 (3) Any policy which contains a provision establishing, as an age limit or otherwise, a
1332 date after which the coverage provided by the policy is not effective, and if that date falls
1333 within a period for which a premium is accepted by the insurer or if the insurer accepts a
1334 premium after that date, the coverage provided by the policy continues in force, subject to any
1335 right of cancellation, until the end of the period for which the premium was accepted. This
1336 Subsection (3) does not apply if the acceptance of premium would not have occurred but for a
1337 misstatement of age by the insured.

1338 ~~[(4) Any provision dealing with preexisting conditions shall be consistent with~~
1339 ~~Subsections 31A-22-605(9)(a) and 31A-22-609(2), and any applicable rule adopted by the~~
1340 ~~commissioner.]~~

1341 ~~[(5)]~~ (4) (a) If an insured is otherwise eligible for maternity benefits, a policy may not
1342 contain language which requires an insured to obtain any additional preauthorization or
1343 preapproval for customary and reasonable maternity care expenses or for the delivery of the
1344 child after an initial preauthorization or preapproval has been obtained from the insurer for
1345 prenatal care. A requirement for notice of admission for delivery is not a requirement for
1346 preauthorization or preapproval, however, the maternity benefit may not be denied or
1347 diminished for failure to provide admission notice. The policy may not require the provision of
1348 admission notice by only the insured patient.

1349 (b) This Subsection ~~[(5)]~~ (4) does not prohibit an insurer from:

1350 (i) requiring a referral before maternity care can be obtained;

1351 (ii) specifying a group of providers or a particular location from which an insured is
1352 required to obtain maternity care; or

1353 (iii) limiting reimbursement for maternity expenses and benefits in accordance with the
1354 terms and conditions of the insurance contract so long as such terms do not conflict with
1355 Subsection ~~[(5)]~~ (4)(a).

1356 ~~[(6)]~~ (5) An insurer may only represent that a policy:

1357 (a) offers a vision benefit if the policy:

1358 (i) charges a premium for the benefit; and

1359 (ii) provides reimbursement for materials or services provided under the policy; and

1360 (b) covers laser vision correction, whether photorefractive keratectomy, laser assisted

1361 in-situ keratomelasis, or related procedure, if the policy:

1362 (i) charges a premium for the benefit; and

1363 (ii) the procedure is at least a partially covered benefit.

1364 Section 8. Section **31A-22-620** is amended to read:

1365 **31A-22-620. Medicare Supplement Insurance Minimum Standards Act.**

1366 (1) As used in this section:

1367 (a) "Applicant" means:

1368 (i) in the case of an individual Medicare supplement policy, the person who seeks to

1369 contract for insurance benefits; and

1370 (ii) in the case of a group Medicare supplement policy, the proposed certificate holder.

1371 (b) "Certificate" means any certificate delivered or issued for delivery in this state

1372 under a group Medicare supplement policy.

1373 (c) "Certificate form" means the form on which the certificate is delivered or issued for

1374 delivery by the issuer.

1375 (d) "Issuer" includes insurance companies, fraternal benefit societies, health care

1376 service plans, health maintenance organizations, and any other entity delivering, or issuing for

1377 delivery in this state, Medicare supplement policies or certificates.

1378 (e) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the

1379 Social Security Amendments of 1965, as then constituted or later amended.

1380 (f) "Medicare Supplement Policy":

1381 (i) means a group or individual policy of disability insurance, other than a policy issued

1382 pursuant to a contract under Section 1876 of the federal Social Security Act, 42 U.S.C. Section

1383 1395 et seq., or an issued policy under a demonstration project specified in 41 U.S.C. Section

1384 1395ss(g)(1), that is advertised, marketed, or designed primarily as a supplement to

1385 reimbursements under Medicare for the hospital, medical, or surgical expenses of persons

1386 eligible for Medicare[-]; and

1387 (ii) does not include Medicare Advantage plans established under Medicare Part C,

1388 outpatient prescription drug plans established under Medicare Part D, or any health care

1389 prepayment plan that provides benefits pursuant to an agreement under Section 1833(a)(1)(A)

1390 of the Social Security Act.

1391 (g) "Policy form" means the form on which the policy is delivered or issued for

1392 delivery by the issuer.

1393 (2) (a) Except as otherwise specifically provided, this section applies to:

1394 (i) all Medicare supplement policies delivered or issued for delivery in this state on or
1395 after the effective date of this section;

1396 (ii) all certificates issued under group Medicare supplement policies, that have been
1397 delivered or issued for delivery in this state on or after the effective date of this section; and

1398 (iii) policies or certificates that were in force prior to the effective date of this section,
1399 with respect to requirements for benefits, claims payment, and policy reporting practice under
1400 Subsection (3)(d), and loss ratios under Subsection (4).

1401 (b) This section does not apply to a policy of one or more employers or labor
1402 organizations, or of the trustees of a fund established by one or more employers or labor
1403 organizations, or a combination of employers and labor unions, for employees or former
1404 employees or a combination of employees and former employees, or for members or former
1405 members of the labor organizations, or a combination of members and former members of
1406 labor organizations.

1407 (c) This section does not prohibit, nor does it apply to insurance policies or health care
1408 benefit plans, including group conversion policies, provided to Medicare eligible persons that
1409 are not marketed or held out to be Medicare supplement policies or benefit plans.

1410 (3) (a) A Medicare supplement policy or certificate in force in the state may not contain
1411 benefits that duplicate benefits provided by Medicare.

1412 (b) Notwithstanding any other provision of law of this state, a Medicare supplement
1413 policy or certificate may not exclude or limit benefits for loss incurred more than six months
1414 from the effective date of coverage because it involved a preexisting condition. The policy or
1415 certificate may not define a preexisting condition more restrictively than: "A condition for
1416 which medical advice was given or treatment was recommended by or received from a
1417 physician within six months before the effective date of coverage."

1418 (c) The commissioner shall adopt rules to establish specific standards for policy
1419 provisions of Medicare supplement policies and certificates. The standards adopted shall be in
1420 addition to and in accordance with applicable laws of this state. A requirement of this title
1421 relating to minimum required policy benefits, other than the minimum standards contained in
1422 this section, may not apply to Medicare supplement policies and certificates. The standards

1423 may include:

- 1424 (i) terms of renewability;
- 1425 (ii) initial and subsequent conditions of eligibility;
- 1426 (iii) nonduplication of coverage;
- 1427 (iv) probationary periods;
- 1428 (v) benefit limitations, exceptions, and reductions;
- 1429 (vi) elimination periods;
- 1430 (vii) requirements for replacement;
- 1431 (viii) recurrent conditions; and
- 1432 (ix) definitions of terms.

1433 (d) The commissioner shall adopt rules establishing minimum standards for benefits,
1434 claims payment, marketing practices, compensation arrangements, and reporting practices for
1435 Medicare supplement policies and certificates.

1436 (e) The commissioner may adopt [~~such~~] rules [~~as are necessary~~] to conform Medicare
1437 supplement policies and certificates to the requirements of federal law and regulations
1438 [~~promulgated thereunder~~], including:

- 1439 (i) requiring refunds or credits if the policies do not meet loss ratio requirements;
- 1440 (ii) establishing a uniform methodology for calculating and reporting loss ratios;
- 1441 (iii) assuring public access to policies, premiums, and loss ratio information of issuers
1442 of Medicare supplement insurance;
- 1443 (iv) establishing a process for approving or disapproving policy forms and certificate
1444 forms and proposed premium increases;
- 1445 (v) establishing a policy for holding public hearings prior to approval of premium
1446 increases; and
- 1447 (vi) establishing standards for Medicare select policies and certificates.

1448 (f) The commissioner may adopt rules that prohibit policy provisions not otherwise
1449 specifically authorized by statute that, in the opinion of the commissioner, are unjust, unfair, or
1450 unfairly discriminatory to any person insured or proposed to be insured under a Medicare
1451 supplement policy or certificate.

1452 (4) Medicare supplement policies shall return to policyholders benefits that are
1453 reasonable in relation to the premium charged. The commissioner shall make rules to establish

1454 minimum standards for loss ratios of Medicare supplement policies on the basis of incurred
1455 claims experience, or incurred health care expenses where coverage is provided by a health
1456 maintenance organization on a service basis rather than on a reimbursement basis, and earned
1457 premiums in accordance with accepted actuarial principles and practices.

1458 (5) (a) To provide for full and fair disclosure in the sale of Medicare supplement
1459 policies, a Medicare supplement policy or certificate may not be delivered in this state unless
1460 an outline of coverage is delivered to the applicant at the time application is made.

1461 (b) The commissioner shall prescribe the format and content of the outline of coverage
1462 required by Subsection (5)(a).

1463 (c) For purposes of this section, "format" means style arrangements and overall
1464 appearance, including such items as the size, color, and prominence of type and arrangement of
1465 text and captions. The outline of coverage shall include:

1466 (i) a description of the principal benefits and coverage provided in the policy;

1467 (ii) a statement of the renewal provisions, including any reservation by the issuer of a
1468 right to change premiums; and disclosure of the existence of any automatic renewal premium
1469 increases based on the policyholder's age; and

1470 (iii) a statement that the outline of coverage is a summary of the policy issued or
1471 applied for and that the policy should be consulted to determine governing contractual
1472 provisions.

1473 (d) The commissioner may make rules for captions or notice if the commissioner finds
1474 that the rules are:

1475 (i) in the public interest; and

1476 (ii) designed to inform prospective insureds that particular insurance coverages are not
1477 Medicare supplement coverages, for all accident and health insurance policies sold to persons
1478 eligible for Medicare, other than:

1479 (A) a medicare supplement policy; or

1480 (B) a disability income policy.

1481 (e) The commissioner may prescribe by rule a standard form and the contents of an
1482 informational brochure for persons eligible for Medicare, that is intended to improve the
1483 buyer's ability to select the most appropriate coverage and improve the buyer's understanding of
1484 Medicare. Except in the case of direct response insurance policies, the commissioner may

1485 require by rule that the informational brochure be provided concurrently with delivery of the
1486 outline of coverage to any prospective insureds eligible for Medicare. With respect to direct
1487 response insurance policies, the commissioner may require by rule that the prescribed brochure
1488 be provided upon request to any prospective insureds eligible for Medicare, but in no event
1489 later than the time of policy delivery.

1490 (f) The commissioner may adopt reasonable rules to govern the full and fair disclosure
1491 of the information in connection with the replacement of accident and health policies,
1492 subscriber contracts, or certificates by persons eligible for Medicare.

1493 (6) Notwithstanding Subsection (1), Medicare supplement policies and certificates
1494 shall have a notice prominently printed on the first page of the policy or certificate, or attached
1495 to the front page, stating in substance that the applicant has the right to return the policy or
1496 certificate within 30 days of its delivery and to have the premium refunded if, after examination
1497 of the policy or certificate, the applicant is not satisfied for any reason. Any refund made
1498 pursuant to this section shall be paid directly to the applicant by the issuer in a timely manner.

1499 (7) Every issuer of Medicare supplement insurance policies or certificates in this state
1500 shall provide a copy of any Medicare supplement advertisement intended for use in this state,
1501 whether through written or broadcast medium, to the commissioner for review.

1502 Section 9. Section **31A-22-629** is amended to read:

1503 **31A-22-629. Adverse benefit determination review process.**

1504 (1) As used in this section:

1505 (a) (i) "Adverse benefit determination" means the:

1506 (A) denial of a benefit;

1507 (B) reduction of a benefit;

1508 (C) termination of a benefit; or

1509 (D) failure to provide or make payment, in whole or in part, for a benefit.

1510 (ii) "Adverse benefit determination" includes:

1511 (A) denial, reduction, termination, or failure to provide or make payment that is based
1512 on a determination of an insured's or a beneficiary's eligibility to participate in a plan;

1513 (B) with respect to individual or group health plans, and income replacement or
1514 disability income policies, a denial, reduction, or termination of, or a failure to provide or make
1515 payment, in whole or in part, for, a benefit resulting from the application of a utilization

1516 review; and
1517 (C) failure to cover an item or service for which benefits are otherwise provided
1518 because it is determined to be:
1519 (I) experimental;
1520 (II) investigational; or
1521 (III) not medically necessary or appropriate.
1522 (b) "Independent review" means a process that:
1523 (i) is a voluntary option for the resolution of an adverse benefit determination;
1524 (ii) is conducted at the discretion of the claimant;
1525 (iii) is conducted by an independent review organization designated by the insurer;
1526 (iv) renders an independent and impartial decision on an adverse benefit determination
1527 submitted by an insured; and
1528 (v) may not require the insured to pay a fee for requesting the independent review.
1529 (c) "Insured" is as defined in Section 31A-1-301 and includes a person who is
1530 authorized to act on the insured's behalf.
1531 (d) "Insurer" is as defined in Section 31A-1-301 and includes:
1532 (i) a health maintenance organization; and
1533 (ii) a third-party administrator that offers, sells, manages, or administers a health
1534 insurance policy or health maintenance organization contract that is subject to this title.
1535 (e) "Internal review" means the process an insurer uses to review an insured's adverse
1536 benefit determination before the adverse benefit determination is submitted for independent
1537 review.
1538 (2) This section applies generally to health insurance policies, health maintenance
1539 organization contracts, and income replacement or disability income policies.
1540 (3) (a) An insured may submit an adverse benefit determination to the insurer.
1541 (b) The insurer shall conduct an internal review of the insured's adverse benefit
1542 determination.
1543 (c) An insured who disagrees with the results of an internal review may submit the
1544 adverse benefit determination for an independent review if the adverse benefit determination
1545 involves payment of a claim regarding medical necessity or denial of [~~coverage~~] a claim
1546 regarding medical necessity.

1547 (4) Before October 1, 2000, the commissioner shall adopt rules that establish minimum
1548 standards for:

1549 (a) internal reviews;

1550 (b) independent reviews to ensure independence and impartiality;

1551 (c) the types of adverse benefit determinations that may be submitted to an independent
1552 review; and

1553 (d) the timing of the review process, including an expedited review when medically
1554 necessary.

1555 (5) Nothing in this section may be construed as:

1556 (a) expanding, extending, or modifying the terms of a policy or contract with respect to
1557 benefits or coverage;

1558 (b) permitting an insurer to charge an insured for the internal review of an adverse
1559 benefit determination;

1560 (c) restricting the use of arbitration in connection with or subsequent to an independent
1561 review; or

1562 (d) altering the legal rights of any party to seek court or other redress in connection
1563 with:

1564 (i) an adverse decision resulting from an independent review, except that if the insurer
1565 is the party seeking legal redress, the insurer shall pay for the reasonable attorneys' fees of the
1566 insured related to the action and court costs; or

1567 (ii) an adverse benefit determination or other claim that is not eligible for submission
1568 to independent review.

1569 Section 10. Section **31A-22-723** is amended to read:

1570 **31A-22-723. Group and blanket conversion coverage.**

1571 (1) Notwithstanding Subsection 31A-1-103(3)(f), and except as provided in Subsection
1572 (3), all policies of accident and health insurance offered on a group basis under this title, or
1573 Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act, shall provide that
1574 a person whose insurance under the group policy has been terminated is entitled to choose a
1575 converted individual policy of similar accident and health insurance.

1576 (2) A person who has lost group coverage may elect conversion coverage with the
1577 insurer that provided prior group coverage if the person:

1578 (a) has been continuously covered ~~H→~~ ~~[under a group policy]~~ ~~←H~~ for a period of six
 1578a months ~~H→~~ by the group policy or the group's preceding policies ~~←H~~
 1579 immediately prior to termination; ~~and~~

1580 (b) has exhausted either Utah mini-COBRA coverage as required in Section
 1581 31A-22-722 or federal COBRA coverage ~~H→~~ ~~[-if offered]~~ ~~←H~~ ; ~~H→~~ ~~[and]~~ ~~←H~~

1582 (c) has not acquired or is not covered under any other group coverage that covers all
 1583 preexisting conditions, including maternity, if the coverage exists ~~H→~~ ; and

1583a (d) resides in the insurer's service area ~~←H~~ .

1584 (3) This section does not apply if the person's prior group coverage:

1585 (a) is a stand alone policy that only provides one of the following:

- 1586 (i) catastrophic benefits;
- 1587 (ii) aggregate stop loss benefits;
- 1588 (iii) specific stop loss benefits;
- 1589 (iv) benefits for specific diseases;
- 1590 (v) accidental injuries only;
- 1591 (vi) dental; or

1592 (vii) vision;

1593 (b) is an income replacement policy; ~~or~~

1594 (c) was terminated because the insured:

- 1595 (i) failed to pay any required individual contribution;
- 1596 (ii) performed an act or practice that constitutes fraud in connection with the coverage;

1597 ~~H→~~ ~~[f]~~ ~~or~~ ~~[f]~~ ~~←H~~

1598 (iii) made intentional misrepresentation of material fact under the terms of coverage[-];

1599 or ~~H→~~ ~~[(iv) individual no longer resides in the service area; or]~~ ~~←H~~

1600 (d) was terminated pursuant to Subsection 31A-8-402.3(2)(a), 31A-22-721(2)(a), or
 1601 31A-30-107(2)(a).

1602 (4) (a) The employer shall provide written notification of the right to an individual
 1603 conversion policy within 30 days of the insured's termination of coverage to:

- 1604 (i) the terminated insured;
- 1605 (ii) the ex-spouse; or
- 1606 (iii) in the case of the death of the insured:

1607 (A) the surviving spouse; ~~or~~ and

1608 (B) the guardian of any dependents, if different from a surviving spouse.

- 1609 (b) The notification required by Subsection (4)(a) shall:
- 1610 (i) be sent by first class mail;
- 1611 (ii) contain the name, address, and telephone number of the insurer that will provide
- 1612 the conversion coverage; and
- 1613 (iii) be sent to the insured's last-known address as shown on the records of the
- 1614 employer of:
- 1615 (A) the insured;
- 1616 (B) the ex-spouse; and
- 1617 (C) if the policy terminates by reason of the death of the insured to:
- 1618 (I) the surviving spouse; ~~[or]~~ and
- 1619 (II) the guardian of any dependents, if different from a surviving spouse.
- 1620 (5) (a) An insurer is not required to issue a converted policy which provides benefits in
- 1621 excess of those provided under the group policy from which conversion is made.
- 1622 (b) Except as provided in Subsection (5)(c), if the conversion is made from a health
- 1623 benefit plan, the employee or member must be offered at least the basic benefit plan as
- 1624 provided in Subsection 31A-22-613.5(2)(a).
- 1625 (c) If the benefit levels required under Subsection (5)(b) exceed the benefit levels
- 1626 provided under the group policy, the conversion policy may offer benefits which are
- 1627 substantially similar to those provided under the group policy.
- 1628 (6) Written application for the converted policy shall be made and the first premium
- 1629 paid to the insurer no later than 60 days after termination of the group accident and health
- 1630 insurance.
- 1631 (7) The converted policy shall be issued without evidence of insurability.
- 1632 (8) (a) The initial premium for the converted policy for the first 12 months and
- 1633 subsequent renewal premiums shall be determined in accordance with premium rates
- 1634 applicable to age, class of risk of the person, and the type and amount of insurance provided.
- 1635 (b) The initial premium for the first 12 months may not be raised based on pregnancy
- 1636 of a covered insured.
- 1637 (c) The premium for converted policies shall be payable monthly or quarterly as
- 1638 required by the insurer for the policy form and plan selected, unless another mode or premium
- 1639 payment is mutually agreed upon.

1640 (9) The converted policy becomes effective at the time the insurance under the group
1641 policy terminates.

1642 (10) (a) A newly issued converted policy covers the employee or the member and must
1643 also cover all dependents covered by the group policy at the date of termination of the group
1644 coverage.

1645 (b) The only dependents that may be added after the policy has been issued are children
1646 and dependents as required by Section 31A-22-610 and Subsections 31A-22-610.5(6) and (7).

1647 (c) At the option of the insurer, a separate converted policy may be issued to cover any
1648 dependent.

1649 (11) (a) To the extent the group policy provided maternity benefits, the conversion
1650 policy shall provide maternity benefits equal to the lesser of the maternity benefits of the group
1651 policy or the conversion policy until termination of a pregnancy that exists on the date of
1652 conversion if one of the following is pregnant on the date of the conversion:

1653 (i) the insured;

1654 (ii) a spouse of the insured; or

1655 (iii) a dependent of the insured.

1656 (b) The requirements of this Subsection (11) do not apply to a pregnancy that occurs
1657 after the date of conversion.

1658 (12) Except as provided in this Subsection (12), a converted policy is renewable with
1659 respect to all individuals or dependents at the option of the insured. An insured may be
1660 terminated from a converted policy for the following reasons:

1661 (a) a dependent is no longer eligible under the policy;

1662 (b) for a network plan, if the individual no longer lives, resides, or works in:

1663 (i) the insured's service area; or

1664 (ii) the area for which the covered carrier is authorized to do business; or

1665 (c) the individual fails to pay premiums or contributions in accordance with the terms
1666 of the converted policy, including any timeliness requirements;

1667 (d) the individual performs an act or practice that constitutes fraud in connection with
1668 the coverage;

1669 (e) the individual makes an intentional misrepresentation of material fact under the
1670 terms of the coverage; or

1671 (f) coverage is terminated uniformly without regard to any health status-related factor
1672 relating to any covered individual.

1673 (13) Conditions pertaining to health may not be used as a basis for classification under
1674 this section.

1675 Section 11. Section **31A-29-103** is amended to read:

1676 **31A-29-103. Definitions.**

1677 As used in this chapter:

1678 (1) "Board" means the board of directors of the pool created in Section 31A-29-104.

1679 (2) (a) "Creditable coverage" has the same meaning as provided in [~~the Health~~
1680 ~~Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat. 1956, Sec.~~
1681 ~~2701(c)(1) and 45 C.F.R. Sec. 146.11(a)(1)] Section 31A-1-301.~~

1682 (b) "Creditable coverage" does not include a period of time in which there is a
1683 significant break in coverage [~~as described in the Health Insurance Portability and~~
1684 ~~Accountability Act, Pub. L. No. 104-191, 110 Stat. 1956, Sec. 2701(c)(2)], as defined in
1685 Section 31A-1-301.~~

1686 (3) "Domicile" means the place where an individual has a fixed and permanent home
1687 and principal establishment:

1688 (a) to which the individual, if absent, intends to return; and

1689 (b) in which the individual, and the individual's family voluntarily reside, not for a
1690 special or temporary purpose, but with the intention of making a permanent home.

1691 (4) "Enrollee" means an individual who has met the eligibility requirements of the pool
1692 and is covered by a pool policy under this chapter.

1693 (5) "Health care facility" means any entity providing health care services which is
1694 licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act.

1695 (6) "Health care provider" has the same meaning as provided in Section 78-14-3.

1696 (7) "Health care services" means:

1697 (a) any service or product:

1698 (i) used in furnishing to any individual medical care or hospitalization; or

1699 (ii) incidental to furnishing medical care or hospitalization; and

1700 (b) any other service or product furnished for the purpose of preventing, alleviating,
1701 curing, or healing human illness or injury.

- 1702 (8) (a) "Health insurance" means any:
- 1703 (i) hospital and medical expense-incurred policy;
- 1704 (ii) nonprofit health care service plan contract; or
- 1705 (iii) health maintenance organization subscriber contract.
- 1706 (b) "Health insurance" does not mean:
- 1707 (i) any insurance arising out of Title 34A, Chapter 2 or 3, or similar law;
- 1708 (ii) automobile medical payment insurance; or
- 1709 (iii) insurance under which benefits are payable with or without regard to fault and
- 1710 which is required by law to be contained in any liability insurance policy.
- 1711 (9) "Health maintenance organization" has the same meaning as provided in Section
- 1712 31A-8-101.
- 1713 (10) (a) "Health plan" means any arrangement by which an individual, including a
- 1714 dependent or spouse, covered or making application to be covered under the pool has:
- 1715 (i) access to hospital and medical benefits or reimbursement including group or
- 1716 individual insurance or subscriber contract;
- 1717 (ii) coverage through:
- 1718 (A) a health maintenance organization;
- 1719 (B) a preferred provider prepayment;
- 1720 (C) group practice; or
- 1721 (D) individual practice plan;
- 1722 (iii) coverage under an uninsured arrangement of group or group-type contracts
- 1723 including employer self-insured, cost-plus, or other benefits methodologies not involving
- 1724 insurance;
- 1725 (iv) coverage under a group type contract which is not available to the general public
- 1726 and can be obtained only because of connection with a particular organization or group; and
- 1727 (v) coverage by Medicare or other governmental benefit.
- 1728 (b) "Health plan" includes coverage through health insurance.
- 1729 (11) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996,
- 1730 Pub. L. [~~No.~~] 104-191, 110 Stat. [~~1962~~] 1936.
- 1731 (12) "HIPAA eligible" means an individual who is eligible under the provisions of the
- 1732 Health Insurance Portability and Accountability Act of 1996, Pub. L. [~~No.~~] 104-191, 110 Stat.

1733 [~~1979, Sec. 2741(b)~~] 1936.

1734 (13) "Insurer" means:

1735 (a) an insurance company authorized to transact accident and health insurance business
1736 in this state;

1737 (b) a health maintenance organization; and

1738 (c) a self-insurer not subject to federal preemption.

1739 (14) "Medicaid" means coverage under Title XIX of the Social Security Act, 42 U.S.C.
1740 Sec. 1396 et seq., as amended.

1741 (15) "Medicare" means coverage under both Part A and B of Title XVIII of the Social
1742 Security Act, 42 U.S.C. 1395 et seq., as amended.

1743 (16) "Plan of operation" means the plan developed by the board in accordance with
1744 Section 31A-29-105 and includes the articles, bylaws, and operating rules adopted by the board
1745 under Section 31A-29-106.

1746 (17) "Pool" means the Utah Comprehensive Health Insurance Pool created in Section
1747 31A-29-104.

1748 (18) "Pool fund" means the Comprehensive Health Insurance Pool Enterprise Fund
1749 created in Section 31A-29-120.

1750 (19) "Pool policy" means a health insurance policy issued under this chapter.

1751 (20) "Preexisting condition" [~~means a condition, regardless of the cause of the~~
1752 ~~condition, for which medical advice, diagnosis, care, or treatment was recommended or~~
1753 ~~received within the six-month period immediately prior to the enrollment date]~~ has the same
1754 meaning as defined in Section 31A-1-301.

1755 (21) (a) "Resident" or "residency" means a person who is domiciled in this state.

1756 (b) A resident retains residency if that resident leaves this state:

1757 (i) to serve in the armed forces of the United States; or

1758 (ii) for religious or educational purposes.

1759 (22) "Third-party administrator" has the same meaning as provided in Section
1760 31A-1-301.

1761 Section 12. Section **31A-29-110** is amended to read:

1762 **31A-29-110. Pool administrator -- Selection -- Powers.**

1763 (1) The board shall select a pool administrator in accordance with Title 63, Chapter 56,

1764 Utah Procurement Code. The board shall evaluate bids based on criteria established by the
1765 board, which shall include:

- 1766 (a) ability to manage medical expenses;
- 1767 (b) proven ability to handle accident and health insurance;
- 1768 (c) efficiency of claim paying procedures;
- 1769 (d) marketing and underwriting;
- 1770 (e) proven ability for managed care and quality assurance;
- 1771 (f) provider contracting and discounts;
- 1772 (g) pharmacy benefit management;
- 1773 (h) an estimate of total charges for administering the pool; and
- 1774 (i) ability to administer the pool in a cost-efficient manner.

1775 (2) A pool administrator may be:

- 1776 (a) a health insurer;
- 1777 (b) a health maintenance organization;
- 1778 (c) a third-party administrator; or
- 1779 (d) any person or entity which has demonstrated ability to meet the criteria in

1780 Subsection (1).

1781 (3) (a) The pool administrator shall serve for a period of three years [~~subject to removal~~
1782 ~~for cause and~~], with two one-year extension options, subject to the terms, conditions, and
1783 limitations of the contract between the board and the administrator.

1784 (b) At least one year prior to the expiration of [~~each three-year period of service by~~] the
1785 contract between the board and the pool administrator, the board shall invite all interested
1786 parties, including the current pool administrator, to submit bids to serve as the pool
1787 administrator [~~for the succeeding three-year period~~].

1788 (c) Selection of the pool administrator for a succeeding period shall be made at least
1789 six months prior to the expiration of a three-year period of service by the pool administrator.

1790 (4) The pool administrator is responsible for all operational functions of the pool and
1791 shall:

- 1792 (a) have access to all nonpatient specific experience data, statistics, treatment criteria,
1793 and guidelines compiled or adopted by the Medicaid program, the Public Employees Health
1794 Plan, the Department of Health, or the Insurance Department, and which are not otherwise

1795 declared by statute to be confidential;

1796 (b) perform all marketing, eligibility, enrollment, member agreements, and
1797 administrative claim payment functions relating to the pool;

1798 (c) establish, administer, and operate a monthly premium billing procedure for
1799 collection of premiums from enrollees;

1800 (d) perform all necessary functions to assure timely payment of benefits to enrollees,
1801 including:

1802 (i) making information available relating to the proper manner of submitting a claim
1803 for benefits to the pool administrator and distributing forms upon which submission shall be
1804 made; and

1805 (ii) evaluating the eligibility of each claim for payment by the pool;

1806 (e) submit regular reports to the board regarding the operation of the pool, the
1807 frequency, content, and form of which reports shall be determined by the board;

1808 (f) following the close of each calendar year, determine net written and earned
1809 premiums, the expense of administration, and the paid and incurred losses for the year and
1810 submit a report of this information to the board, the commissioner, and the Division of Finance
1811 on a form prescribed by the commissioner; and

1812 (g) be paid as provided in the plan of operation for expenses incurred in the
1813 performance of the pool administrator's services.

1814 Section 13. Section **31A-29-111** is amended to read:

1815 **31A-29-111. Eligibility -- Limitations.**

1816 (1) (a) Except as provided in Subsections (1)(b) and (2), an individual who is not
1817 HIPAA eligible is eligible for pool coverage if the individual:

1818 (i) pays the established premium;

1819 (ii) is a resident of this state; and

1820 (iii) meets the health underwriting criteria under Subsection (5)(a).

1821 (b) Notwithstanding Subsection (1)(a), an individual who is not HIPAA eligible is not
1822 eligible for pool coverage if one or more of the following conditions apply:

1823 (i) the individual is eligible for health care benefits under Medicaid or Medicare,
1824 except as provided in Section 31A-29-112;

1825 (ii) the individual has terminated coverage in the pool, unless:

- 1826 (A) 12 months have elapsed since the termination date; or
- 1827 (B) the individual demonstrates that creditable coverage has been involuntarily
- 1828 terminated for any reason other than nonpayment of premium;
- 1829 (iii) the pool has paid the maximum lifetime benefit to or on behalf of the individual;
- 1830 (iv) the individual is an inmate of a public institution;
- 1831 (v) the individual is eligible for ~~[other]~~ a public ~~[programs for which medical care is~~
- 1832 ~~provided]~~ health plan, as defined in federal regulations adopted pursuant to 42 U.S.C. 300gg;
- 1833 (vi) the individual's health condition does not meet the criteria established under
- 1834 Subsection (5);
- 1835 (vii) the individual is eligible for coverage under an employer group that offers health
- 1836 insurance or a self-insurance arrangement to its eligible employees, dependents, or members as:
- 1837 (A) an eligible employee;
- 1838 (B) a dependent of an eligible employee; or
- 1839 (C) a member;
- 1840 (viii) the individual:
- 1841 (A) has coverage substantially equivalent to a pool policy, as established by the board
- 1842 in administrative rule, either as an insured or a covered dependent; or
- 1843 (B) would be eligible for the substantially equivalent coverage if the individual elected
- 1844 to obtain the coverage; or
- 1845 (ix) at the time of application, the individual has not resided in Utah for at least 12
- 1846 consecutive months preceding the date of application.
- 1847 (2) (a) Except as provided in Subsections (1) and (2)(b), an individual who is HIPAA
- 1848 eligible is eligible for pool coverage if the individual:
- 1849 (i) pays the established premium; and
- 1850 (ii) is a resident of this state.
- 1851 (b) Notwithstanding Subsections (1) and (2)(a), a HIPAA eligible individual is not
- 1852 eligible for pool coverage if one or more of the following conditions apply:
- 1853 (i) the individual is eligible for health care benefits under Medicaid or Medicare,
- 1854 except as provided in Section 31A-29-112;
- 1855 (ii) the individual is eligible for ~~[other public programs for which medical care is~~
- 1856 ~~provided]~~ a public health plan, as defined in federal regulations adopted pursuant to 42 U.S.C.

1857 300gg;

1858 (iii) the individual is covered under any other health insurance;

1859 (iv) the individual is eligible for coverage under an employer group that offers health
1860 insurance or self-insurance arrangements to its eligible employees, dependents, or members as:

1861 (A) an eligible employee;

1862 (B) a dependent of an eligible employee; or

1863 (C) a member;

1864 (v) the pool has paid the maximum lifetime benefit to or on behalf of the individual; or

1865 (vi) the individual is an inmate of a public institution.

1866 (3) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under Subsection

1867 (1)(a), an individual whose health insurance coverage from a state high risk pool with similar

1868 coverage is terminated because of nonresidency in another state [~~may apply~~] is eligible for

1869 coverage under the pool subject to the conditions of Subsections (1)(b)(i) through (viii).

1870 (b) Coverage sought under Subsection (3)(a) shall be applied for within 63 days after
1871 the termination date of the previous high risk pool coverage.

1872 (c) The effective date of this state's pool coverage shall be the date of termination of the
1873 previous high risk pool coverage.

1874 (d) The waiting period of an individual with a preexisting condition applying for
1875 coverage under this chapter shall be waived:

1876 (i) to the extent to which the waiting period was satisfied under a similar plan from
1877 another state; and

1878 (ii) if the other state's benefit limitation was not reached.

1879 (4) (a) If an eligible individual applies for pool coverage within 30 days of being
1880 denied coverage by an individual carrier, the effective date for pool coverage shall be no later
1881 than the first day of the month following the date of submission of the completed insurance
1882 application to the carrier.

1883 (b) Notwithstanding Subsection (4)(a), for individuals eligible for coverage under
1884 Subsection (3), the effective date shall be the date of termination of the previous high risk pool
1885 coverage.

1886 (5) (a) The board shall establish and adjust, as necessary, health underwriting criteria
1887 based on:

1888 (i) health condition; and
1889 (ii) expected claims so that the expected claims are anticipated to remain within
1890 available funding.

1891 (b) The board, with approval of the commissioner, may contract with one or more
1892 providers under Title 63, Chapter 56, Utah Procurement Code, to develop underwriting criteria
1893 under Subsection (5)(a).

1894 (c) If an individual is denied coverage by the pool under the criteria established in
1895 Subsection (5)(a), the pool shall issue a certificate of insurability to the individual for coverage
1896 under Subsection 31A-30-108(3).

1897 Section 14. Section **31A-29-113** is amended to read:

1898 **31A-29-113. Benefits -- Additional types of pool insurance -- Preexisting**
1899 **conditions -- Waiver -- Maximum benefits.**

1900 (1) (a) The pool policy shall pay for eligible medical expenses rendered or furnished
1901 for the diagnoses or treatment of illness or injury that:

1902 (i) exceed the deductible and copayment amounts applicable under Section
1903 31A-29-114; and

1904 (ii) are not otherwise limited or excluded.

1905 (b) Eligible medical expenses are the allowed charges established by the board for the
1906 health care services and items rendered during times for which benefits are extended under the
1907 pool policy.

1908 (2) The coverage to be issued by the pool, its schedule of benefits, exclusions, and
1909 other limitations shall be established by the board.

1910 (3) The commissioner shall approve the benefit package developed by the board to
1911 ensure its compliance with this chapter.

1912 (4) The pool shall offer at least one benefit plan through a managed care program as
1913 authorized under Section 31A-29-106.

1914 (5) This chapter may not be construed to prohibit the pool from issuing additional types
1915 of pool policies with different types of benefits which in the opinion of the board may be of
1916 benefit to the citizens of Utah.

1917 (6) (a) The board shall design and require an administrator to employ cost containment
1918 measures and requirements including preadmission certification and concurrent inpatient

1919 review for the purpose of making the pool more cost effective.

1920 (b) Sections 31A-22-617 and 31A-22-618 do not apply to coverage issued under this
1921 chapter.

1922 (7) (a) A pool policy may contain provisions under which coverage for a preexisting
1923 condition is excluded [~~during a~~] if:

1924 (i) the exclusion relates to a condition, regardless of the cause of the condition, for
1925 which medical advice, diagnosis, care, or treatment was recommended or received, from an
1926 individual licensed or similarly authorized to provide such services under state law and
1927 operating within the scope of practice authorized by state law, within the six-month period
1928 ending on the effective date of plan coverage; and

1929 (ii) except as provided in Subsection (8), the exclusion extends for a period no longer
1930 than the six-month period following the effective date of plan coverage for a given individual.

1931 (b) Subsection (7)(a) does not apply to a HIPAA eligible individual.

1932 (8) (a) A pool policy may contain provisions under which coverage for a preexisting
1933 pregnancy is excluded during a ten-month period following the effective date of plan coverage
1934 for a given individual.

1935 (b) Subsection (8)(a) does not apply to a HIPAA eligible individual.

1936 (9) (a) The pool will waive the preexisting condition exclusion described in
1937 Subsections (7)(a) and (8)(a) for an individual that is changing health coverage to the pool, to
1938 the extent to which similar exclusions have been satisfied under any prior health insurance
1939 coverage if the individual applies not later than 63 days following the date of involuntary
1940 termination, other than for nonpayment of premiums, from health coverage.

1941 (b) If this Subsection (9) applies, coverage in the pool shall be effective from the date
1942 on which the prior coverage was terminated.

1943 (10) Covered benefits available from the pool may not exceed a \$1,000,000 lifetime
1944 maximum, which includes a per enrollee calendar year maximum established by the board.

1945 Section 15. Section **31A-30-107.5** is amended to read:

1946 **31A-30-107.5. Preexisting condition exclusion -- Condition-specific exclusion**
1947 **riders -- Limitation periods.**

1948 (1) A health benefit plan may impose a preexisting condition exclusion only if[?] the
1949 provision complies with Subsection 31A-22-605.1(4).

1950 ~~[(a) the exclusion relates to a condition, regardless of the cause of the condition, for~~
1951 ~~which medical advice, diagnosis, care, or treatment was recommended or received within the~~
1952 ~~six-month period ending on the enrollment date;]~~

1953 ~~[(b) the exclusion extends for a period of:]~~

1954 ~~[(i) not more than 12 months after the enrollment date; or]~~

1955 ~~[(ii) in the case of a late enrollee, 18 months after the enrollment date; and]~~

1956 ~~[(c) the period described in Subsection (1)(b) is reduced by the aggregate of the periods~~
1957 ~~of creditable coverage applicable to the participant or beneficiary as of the enrollment date.]~~

1958 ~~[(2) Creditable coverage shall be provided for the period of time the individual was~~
1959 ~~previously covered by:]~~

1960 ~~[(a) public or private health insurance; or]~~

1961 ~~[(b) any other group health plan as defined in 42 U.S.C. Section 300gg-91.]~~

1962 ~~[(3) (a) The period of continuous coverage under Subsection (1)(c) may not include~~
1963 ~~any waiting period for the effective date of the new coverage applied by the employer or the~~
1964 ~~carrier.]~~

1965 ~~[(b) This Subsection (3) does not preclude application of any waiting period applicable~~
1966 ~~to all new enrollees under the plan.]~~

1967 ~~[(4) (a) Credit for previous coverage as provided under Subsection (1)(c) need not be~~
1968 ~~given for any condition that was previously excluded under a condition-specific exclusion rider~~
1969 ~~issued pursuant to Subsection (6).]~~

1970 ~~[(b) A new preexisting waiting period may be applied to any condition that was~~
1971 ~~excluded by a rider under the terms of previous individual coverage.]~~

1972 ~~[(5) (a) For purposes of Subsection (1)(c), a period of creditable coverage may not be~~
1973 ~~counted with respect to enrollment of an individual under a health benefit plan, if:]~~

1974 ~~[(i) after the period and before the enrollment date, there was a 63-day period during all~~
1975 ~~of which the individual was not covered under any creditable coverage; or]~~

1976 ~~[(ii) the insured fails to provide notification of previous coverage to the covered carrier~~
1977 ~~within 36 months of the coverage effective date if the covered carrier has previously requested~~
1978 ~~the notification.]~~

1979 ~~[(b) (i) Credit for previous coverage as provided under Subsection (1)(c) need not be~~
1980 ~~given for any condition that was previously excluded in compliance with Subsection (6).]~~

1981 [~~(ii)~~ A new preexisting waiting period may be applied to any condition that was
1982 excluded under the terms of previous individual coverage.]

1983 [~~(6)~~ (2) (a) An individual carrier:
1984 [~~(i)~~ shall offer a health benefit plan in compliance with Subsection (1);]
1985 [~~(ii)~~ (i) may, when the individual carrier and the insured mutually agree in writing to a
1986 condition-specific exclusion rider, offer to issue an individual policy that excludes all treatment
1987 and prescription drugs related to a specific physical condition, or any specific or class of
1988 prescription drugs consistent with Subsection [~~(6)~~ (2)(b); and
1989 [~~(iii)~~ (ii) may offer an individual policy that may establish separate cost sharing
1990 requirements including, deductibles and maximum limits that are specific to covered services
1991 and supplies, including specific drugs, when utilized for the treatment and care of the
1992 conditions listed in Subsection [~~(6)~~ (2)(b).

1993 (b) (i) The following may be the subject of a condition-specific exclusion rider except
1994 when a mastectomy has been performed or the condition is due to cancer:

1995 (A) conditions of the bones or joints of the ankle, arm, elbow, foot, hand, hip, knee,
1996 leg, wrist, shoulder, spine, and toes, including bone spurs, bunions, carpal tunnel syndrome,
1997 club foot, hammertoe, syndactylism, and treatment and prosthetic devices related to
1998 amputation;

1999 (B) anal fistula, breast implants, breast reduction, cystocele, rectocele enuresis,
2000 hemorrhoids, hydrocele, hypospadias, uterine leiomyoma, varicocele, spermatocoele,
2001 endometriosis;

2002 (C) deviated nasal septum, and other sinus related conditions;

2003 (D) goiter and other thyroid related conditions, hemangioma, hernia, keloids,
2004 migraines, scar revisions, varicose veins, abdominoplasty;

2005 (E) cataracts, cornea transplant, detached retina, glaucoma, keratoconus, macular
2006 degeneration, strabismus;

2007 (F) Baker's cyst;

2008 (G) allergies; and

2009 (H) any specific or class of prescription drugs.

2010 (ii) A condition-specific exclusion rider:
2011 (A) shall be limited to the excluded condition;

2012 (B) may not extend to any secondary medical condition that may or may not be directly
2013 related to the excluded condition; and

2014 (C) must include the following informed consent paragraph: "I agree by signing below,
2015 to the terms of this rider, which excludes coverage for all treatment, including medications,
2016 related to specific condition(s) stated herein and that if treatment or medications are received
2017 that I have the responsibility for payment for those services and items. I further understand that
2018 this rider does not extend to any secondary medical condition that may or may not be directly
2019 related to the excluded condition(s) herein.

2020 [~~7~~] (3) Notwithstanding the other provisions of this section, a health benefit plan may
2021 impose a limitation period if:

2022 (a) each policy that imposes a limitation period under the health benefit plan specifies
2023 the physical condition that is excluded from coverage during the limitation period;

2024 (b) the limitation period does not exceed 12 months;

2025 (c) the limitation period is applied uniformly; and

2026 (d) the limitation period is reduced in compliance with [~~Subsection (1)(c)] Subsections
2027 31A-22-605.1(4)(a) and (4)(b).~~

Legislative Review Note
as of 1-25-05 6:56 AM

Based on a limited legal review, this legislation has not been determined to have a high probability of being held unconstitutional.

Office of Legislative Research and General Counsel

Fiscal Note
Bill Number HB0236

Health Insurance Law Amendments

28-Jan-05

3:18 PM

State Impact

No fiscal impact.

Individual and Business Impact

No fiscal iimpact.

Office of the Legislative Fiscal Analyst