Enrolled Copy **H.B. 195**

INSURANCE LAW AMENDMENTS

2005 GENERAL SESSION

STATE OF UTAH

Sponsor: James A. Dunnigan

LONG TITLE

General Description:

This bill modifies various provisions related to the Insurance Code.

Highlighted Provisions:

This bill:

- addresses general powers and duties of the commissioner;
- requires insurers to pay taxes required by Title 59, Revenue and Taxation, to the State Tax Commission;
- corrects citations;
- increases from three to five years the amount of time that insurers must maintain certain records;
- addresses termination of insurance policies by insurers;
- addresses reporting requirements;
- addresses unfair marketing practices;
- extends the sunset date for comparison tables;
- repeals a provision related to transitioning prior licensees; and
- makes technical changes.

Monies Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

31A-2-201, as last amended by Chapter 108, Laws of Utah 2004

31A-5-211, as last amended by Chapter 116, Laws of Utah 2001

31A-8-201, as enacted by Chapter 204, Laws of Utah 1986

31A-8-301, as last amended by Chapter 90, Laws of Utah 2004

31A-21-201, as last amended by Chapter 252, Laws of Utah 2003

31A-21-303, as last amended by Chapter 266, Laws of Utah 2004

31A-22-633, as enacted by Chapter 1, Laws of Utah 2002

31A-23a-402, as renumbered and amended by Chapter 298, Laws of Utah 2003

63-55-231, as last amended by Chapter 254, Laws of Utah 2003

ENACTS:

31A-3-205, Utah Code Annotated 1953

REPEALS:

31A-8-302, as enacted by Chapter 204, Laws of Utah 1986

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

Section 1. Section **31A-2-201** is amended to read:

31A-2-201. General duties and powers.

(1) The commissioner shall administer and enforce this title.

(2) The commissioner has all powers specifically granted, and all further powers that are reasonable and necessary to enable [~~him~~] the commissioner to perform the duties imposed by this title.

(3) (a) The commissioner may make rules to implement the provisions of this title according to the procedures and requirements of Title 63, Chapter 46a, Utah Administrative Rulemaking Act.

(b) In addition to the notice requirements of Section 63-46a-4, the commissioner shall provide notice under Section 31A-2-303 of hearings concerning insurance department rules.

(4) (a) The commissioner shall issue prohibitory, mandatory, and other orders as necessary to secure compliance with this title. An order by the commissioner is not effective unless the order:

(i) is in writing; and

(ii) is signed by the commissioner or under the commissioner's authority.

(b) On request of any person who would be affected by an order under Subsection (4)(a), the commissioner may issue a declaratory order to clarify the person's rights or duties.

(5) (a) The commissioner may hold informal adjudicative proceedings and public meetings, for the purpose of:

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

(ii) ascertainment of public sentiment[~~,~~]; or

(iii) informing the public.

(b) [~~No~~] An effective rule or order may not result from informal hearings and meetings unless the requirement of a hearing under [~~Section 31A-2-301~~] this section is satisfied.

(6) The commissioner shall inquire into violations of this title and may conduct any examinations and investigations of insurance matters, in addition to examinations and investigations expressly authorized, that [~~he~~] the commissioner considers proper to determine:

(a) whether or not any person has violated any provision of this title; or

(b) to secure information useful in the lawful administration of [~~any provision of~~] this title.

(7) (a) Each year, the commissioner shall:

(i) conduct an evaluation of the state's health insurance market;

(ii) report the findings of the evaluation to the Health and Human Services Interim Committee before October 1; and

(iii) publish the findings of the evaluation [~~of~~] on the department website.

(b) The evaluation required by Subsection (7)(a) shall:

(i) analyze the effectiveness of the insurance regulations and statutes in promoting a healthy, competitive health insurance market that meets the needs of Utahns by assessing such things as:

(A) the availability and marketing of individual and group products[~~,~~];

(B) rate charges[~~,~~];

(C) coverage and demographic changes[~~,~~];

(D) benefit trends[~~,~~];

(E) market share changes[~~,~~]; and

(F) accessibility;

(ii) assess complaint ratios and trends within the health insurance market, which assessment shall integrate complaint data from the Office of Consumer Health Assistance within the department;

(iii) contain recommendations for action to improve the overall effectiveness of the health insurance market, administrative rules, and statutes; and

(iv) include claims loss ratio data for each insurance company doing business in the state.

(c) When preparing the evaluation required by this [~~section~~] Subsection (7), the commissioner may seek the input of insurers, employers, insured persons, providers, and others with an interest in the health insurance market.

Section 2. Section **31A-3-205** is enacted to read:

31A-3-205. Taxation of insurance companies.

An admitted insurer shall pay to the State Tax Commission taxes imposed on the admitted insurer by Title 59, Revenue and Taxation.

Section 3. Section **31A-5-211** is amended to read:

31A-5-211. Minimum capital or permanent surplus requirements.

(1) (a) Except as provided in Subsections (4) and (5), insurers being organized or operating under this chapter shall maintain minimum capital or permanent surplus for a mutual, in amounts specified in Subsection (2).

(b) The certificate of authority issued under Section 31A-5-212 does not permit an insurer to transact types of insurance for which the insurer does not have the required minimum capital or permanent surplus for a mutual, in at least the amounts specified under Subsection (2).

(c) [~~The types of insurance under this section are defined in Section 31A-1-301.~~] Minimum capital and permanent surplus requirements under this section are based upon all types of insurance transacted by the insurer in any and all areas which it operates, whether or not only a

portion of those types of insurance is or is to be transacted in this state.

(2) The minimum capital, or permanent surplus for a nonassessable mutual, is as follows for the indicated types of insurance:

(a) life, annuity, accident and health, or any combination of these $400,000

(b) subject to an aggregate maximum of $1,000,000 for more than one of the following types of coverages:

(i) property insurance 200,000

(ii) surety insurance 300,000

(iii) bail bonds insurance only 100,000

(iv) marine and transportation insurance 200,000

(v) vehicle liability insurance, residential dwelling liability insurance, or both 400,000

(vi) liability insurance 600,000

(vii) workers' compensation insurance 300,000

(c) title insurance 200,000

(d) professional liability insurance, excluding medical malpractice 700,000

(e) professional liability, including medical malpractice 1,000,000

(f) all types of insurance, except life, annuity, or title 2,000,000

(3) Prior to beginning operations, an insurer licensed under this chapter shall have total adjusted capital in excess of the company action level RBC as defined in Subsection 31A-17-601(8)(b).

(4) (a) Subject to Subsections (4)(b) and (4)(c), an insurer holding a valid certificate of authority to transact insurance in this state prior to July 1, 1986, continues to be authorized to transact the same kinds of insurance as permitted by that certificate of authority, if the insurer maintains not less than the amount of minimum capital or permanent surplus required for that authority under the laws of this state in force immediately prior to July 1, 1986.

(b) If, after July 1, 1986, an insurer ever has minimum capital or permanent surplus that meets or exceeds the requirements of Subsections (2) and (3), then Subsection (4)(a) is

inapplicable to that insurer and it shall comply with Subsections (2) and (3).

(c) Any insurer satisfying the minimum capital or permanent surplus requirement through application of Subsection (4)(a) shall comply with Subsections (2) and (3) by July 1, 1990.

(d) Beginning July 1, 1987, former county mutuals shall comply with the capital and surplus requirements of this section.

(5) (a) (i) An assessable mutual may be organized under this chapter, but it may not issue life insurance or annuities.

(ii) An assessable mutual need not have a permanent surplus if the assessment liability of its policyholders is unlimited and all insurance policies clearly state that.

(iii) If assessments are limited to a specified amount or a specified multiple of annual advance premiums, the minimum permanent surplus is the amount that would be required under Subsections (2) and (3) if the corporation were not assessable, reduced by an amount that reasonably reflects the value of the policyholders' assessment liability in satisfying the financial needs of the corporation.

(iv) The liability of members in an assessable mutual is joint and several up to the limits provided by:

(A) the articles of incorporation of the assessable mutual; or

(B) this title.

(b) (i) Except as provided in Subsections (5)(c) and (d), [~~no~~] a certificate of authority may not be issued to an assessable mutual until it has at least 400 bona fide applications for insurance from not less than 400 separate applicants, on separate risks located in this state, in each of the classes of business upon which assessments may be separately levied. A full year's premium shall be paid with each application and the aggregate premium is at least $50,000 for each class.

(ii) If at any time while the corporation is an assessable mutual, the business plan is amended to include an additional class of business on which assessments may be separately levied, identical requirements of Subsection (5)(b)(i) are applicable to each additional class.

(c) Five or more employers may join in the formation of an assessable mutual to write only workers' compensation insurance if, instead of the requirements of Subsection (5)(b), policies are simultaneously put into effect that cover at least 1,500 employees, with no single employer having more than 1/5 of the employees insured by the assessable mutual. A full year's premium shall be paid by each employer, aggregating at least $200,000.

(d) (i) The number and amount of required initial applications and premium payments may be reduced by substituting surplus for the applications or premium payments.

(ii) The commissioner shall determine the reduction in required initial applications and premium payments that is appropriate for a given amount of surplus.

(iii) The insurer shall continue to be assessable until conversion under Subsection [~~31A-5-508~~] 31A-5-507(1) to a nonassessable mutual.

(6) (a) The capital or permanent surplus requirements of Subsection (2) apply to persons seeking certificates of authority under this chapter to write reinsurance.

(b) This Subsection (6) may not be construed as requiring reinsurers to obtain a certificate of authority. [~~However,~~]

(c) Section 31A-17-404 imposes alternate safety prerequisites to reserve credit being granted for reinsurance ceded to a reinsurer without a certificate of authority.

Section 4. Section **31A-8-201** is amended to read:

31A-8-201. Scope of part.

This part applies to all organizations doing business in this state[~~, including foreign organizations subject to the transition provision provided in Section 31A-8-302~~].

Section 5. Section **31A-8-301** is amended to read:

31A-8-301. Requirements for doing business in state.

(1) [~~Except as provided in Section 31A-8-302, only corporations~~] Only a corporation incorporated and licensed under Part 2, Domestic Organizations, may do business in this state as an organization.

(2) To do business in this state as an organization, foreign corporations doing a similar business in other states shall incorporate a subsidiary and license if under Part 2, Domestic

Organizations, for its Utah business. Except as to Chapter 16, Insurance Holding Companies, the laws applicable to domestic organizations apply only to the organization and not to its foreign parent corporation.

Section 6. Section **31A-21-201** is amended to read:

31A-21-201. Filing of forms.

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

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

(i) the form;

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

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

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

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

(i) the form is:

(A) inequitable;

(B) unfairly discriminatory;

(C) misleading;

(D) deceptive;

(E) obscure;

(F) unfair;

(G) encourages misrepresentation; or

(H) not in the public interest;

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

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

(A) the exact name of the insurer;

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

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

(iv) the form violates a statute or a rule adopted by the commissioner; or

(v) the form is otherwise contrary to law.

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

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

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

(iii) Whenever the commissioner prohibits the use of a form under Subsection (3)(a), the commissioner may require the insurer to disclose contract deficiencies to existing policyholders.

(d) If the commissioner prohibits use of a form under this Subsection (3), the prohibition shall:

(i) be in writing;

(ii) constitute an order; and

(iii) state the reasons for the prohibition.

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

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

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

(i) a form for a particular class of insurance;

(ii) a form for a specific line of insurance;

(iii) a specific type of form; or

(iv) a form for a specific market segment.

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

(i) any form:

(A) filed under this section for use; and

(B) that is in use; and

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

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

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

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

Section 7. Section **31A-21-303** is amended to read:

31A-21-303. Termination of insurance policies by insurers.

(1) (a) Except as otherwise provided in this section, in other statutes, or by rule under Subsection (1)(c), this section applies to all policies of insurance [~~other than~~]:

(i) except for:

(A) life[~~,~~] insurance;

(B) accident and health insurance[~~,~~]; and

(C) annuities[~~,~~]; and

(ii) if the policies of insurance are issued on forms that are subject to filing [~~and approval~~] under Subsection 31A-21-201(1).

(b) A policy may provide terms more favorable to insureds than this section requires.

(c) The commissioner may by rule totally or partially exempt from this section classes of insurance policies in which the insureds do not need protection against arbitrary or unannounced termination.

(d) The rights provided by this section are in addition to and do not prejudice any other rights the insureds may have at common law or under other statutes.

(2) (a) As used in this Subsection (2), "grounds" means:

(i) material misrepresentation;

(ii) substantial change in the risk assumed, unless the insurer should reasonably have foreseen the change or contemplated the risk when entering into the contract;

(iii) substantial breaches of contractual duties, conditions, or warranties;

(iv) attainment of the age specified as the terminal age for coverage, in which case the insurer may cancel by notice under Subsection (2)(c), accompanied by a tender of proportional return of premium; or

(v) in the case of automobile insurance, revocation or suspension of the driver's license of:

(A) the named insured; or

(B) any other person who customarily drives the car.

(b) (i) Except as provided in Subsection (2)(e) or unless the conditions of Subsection (2)(b)(ii) are met, an insurance policy may not be canceled by the insurer before the earlier of:

(A) the expiration of the agreed term; or

(B) one year from the effective date of the policy or renewal.

(ii) Notwithstanding Subsection (2)(b)(i), an insurance policy may be canceled by the insurer for:

(A) nonpayment of a premium when due; or

(B) on grounds defined in Subsection (2)(a).

(c) (i) The cancellation provided by Subsection (2)(b), except cancellation for nonpayment of premium, is effective no sooner than 30 days after the delivery or first-class mailing of a written notice to the policyholder.

(ii) Cancellation for nonpayment of premium is effective no sooner than ten days after delivery or first class mailing of a written notice to the policyholder.

(d) (i) Notice of cancellation for nonpayment of premium shall include a statement of the reason for cancellation.

(ii) Subsection (6) applies to the notice required for grounds of cancellation other than nonpayment of premium.

(e) (i) Subsections (2)(a) through (d) do not apply to any insurance contract that has not been previously renewed if the contract has been in effect less than 60 days when the written notice of cancellation is mailed or delivered.

(ii) A cancellation under this Subsection (2)(e) may not be effective until at least ten days after the delivery to the insured of a written notice of cancellation.

(iii) If the notice required by this Subsection (2)(e) is sent by first-class mail, postage prepaid, to the insured at the insured's last-known address, delivery is considered accomplished after the passing, since the mailing date, of the mailing time specified in the Utah Rules of Civil Procedure.

(iv) A policy cancellation subject to this Subsection (2)(e) is not subject to the procedures described in Subsection (6).

(3) A policy may be issued for a term longer than one year or for an indefinite term if the policy includes a clause providing for cancellation by the insurer by giving notice as provided in Subsection (4)(b)(i) 30 days prior to any anniversary date.

(4) (a) Subject to Subsections (2), (3), and (4)(b), a policyholder has a right to have the policy renewed:

(i) on the terms then being applied by the insurer to similar risks; and

(ii) (A) for an additional period of time equivalent to the expiring term if the agreed term is one year or less; or

(B) for one year if the agreed term is longer than one year.

(b) Except as provided in Subsection (4)(c), the right to renewal under Subsection (4)(a) is extinguished if:

(i) at least 30 days prior to the policy expiration or anniversary date a notice of intention not to renew the policy beyond the agreed expiration or anniversary date is delivered or sent by first-class mail by the insurer to the policyholder at the policyholder's last-known address;

(ii) not more than 45 nor less than 14 days prior to the due date of the renewal premium, the insurer delivers or sends by first-class mail a notice to the policyholder at the policyholder's last-known address, clearly stating:

(A) the renewal premium;

(B) how the renewal premium may be paid; and

(C) that failure to pay the renewal premium by the due date extinguishes the policyholder's right to renewal;

(iii) the policyholder has:

(A) accepted replacement coverage; or

(B) requested or agreed to nonrenewal; or

(iv) the policy is expressly designated as nonrenewable.

(c) Unless the conditions of Subsection (4)(b)(iii) or (iv) apply, an insurer may not fail to renew an insurance policy as a result of a telephone call or other inquiry that:

(i) references a policy coverage; and

(ii) does not result in the insured requesting payment of a claim.

(5) (a) (i) Subject to Subsection (5)(b), if the insurer offers or purports to renew the policy, but on less favorable terms or at higher rates, the new terms or rates take effect on the renewal date if the insurer delivered or sent by first-class mail to the policyholder notice of the new terms or rates at least 30 days prior to the expiration date of the prior policy.

(ii) If the insurer did not give the prior notification described in Subsection (5)(a)(i) to the policyholder, the new terms or rates do not take effect until 30 days after the notice is delivered or sent by first-class mail, in which case the policyholder may elect to cancel the renewal policy at any time during the 30-day period.

(iii) Return premiums or additional premium charges shall be calculated proportionately on the basis that the old rates apply.

(b) Subsection (5)(a) does not apply if the only change in terms that is adverse to the policyholder is:

(i) a rate increase generally applicable to the class of business to which the policy belongs;

(ii) a rate increase resulting from a classification change based on the altered nature or extent of the risk insured against; or

(iii) a policy form change made to make the form consistent with Utah law.

(6) (a) If a notice of cancellation or nonrenewal under Subsection (2)(c) does not state with reasonable precision the facts on which the insurer's decision is based, the insurer shall send by first-class mail or deliver that information within ten working days after receipt of a written request by the policyholder.

(b) A notice under Subsection (2)(c) is not effective unless it contains information about the policyholder's right to make the request.

(7) If a risk-sharing plan under Section 31A-2-214 exists for the kind of coverage provided by the insurance being cancelled or nonrenewed, a notice of cancellation or nonrenewal required under Subsection (2)(c) or (4)(b)(i) may not be effective unless it contains instructions to the policyholder for applying for insurance through the available risk-sharing plan.

(8) There is no liability on the part of, and no cause of action against, any insurer, its authorized representatives, agents, employees, or any other person furnishing to the insurer information relating to the reasons for cancellation or nonrenewal or for any statement made or information given by them in complying or enabling the insurer to comply with this section unless actual malice is proved by clear and convincing evidence.

(9) This section does not alter any common law right of contract rescission for material misrepresentation.

Section 8. Section **31A-22-633** is amended to read:

31A-22-633. Exemptions from standards.

Notwithstanding the provisions of Title 31A, Insurance Code, any accident and health insurer or health maintenance organization may offer a choice of coverage that is less or different than is otherwise required by applicable state law if:

(1) the Department of Health offers a choice of coverage as part of a Medicaid waiver under Title 26, Chapter 18, Medical Assistance Act, which includes:

(a) less or different coverage than the basic coverage;

(b) less or different coverage than is otherwise required in an insurance policy or health maintenance organization contract under applicable state law; or

(c) less or different coverage than required by Subsection 31A-22-605(4)(b); and

(2) the choice of coverage offered by the carrier:

(a) is the same or similar coverage as the coverage offered by the Department of Health under Subsection (1);

(b) is offered to the same or similar population as the coverage offered by the Department of Health under Subsection (1); and

(c) contains an explanation for each insured of coverage exclusions and limitations;

(3) the commissioner [~~as part of the requirements of Subsection 31A-2-201(7),~~] and the executive director of the Department of Health shall report to the Health and Human Services Interim Committee prior to November 15 of each year concerning:

(a) the number of lives covered under any policy offered under the provisions of this section or under the Medicaid waiver described in Subsection (1);

(b) the claims experienced under the policies or Medicaid programs described in Subsection (3)(a);

(c) any cost shifting to the private sector for care not covered under the programs or policies described in Subsection (3)(a); and

(d) efforts or agreements between the Department of Health, the commissioner, insurers regulated under this chapter, and health care providers regarding combining publicly funded coverage with private, employer-based coverage to increase benefits and health care coverage.

Section 9. Section **31A-23a-402** is amended to read:

31A-23a-402. Unfair marketing practices -- Communication -- Inducement -- Unfair Discrimination -- Coercion or intimidation -- Restriction on choice.

(1) (a) (i) Any of the following may not make or cause to be made any communication that contains false or misleading information, relating to an insurance product or contract, any insurer, or [~~other~~] any licensee under this title, including information that is false or misleading because it is incomplete:

(A) a person who is or should be licensed under this title;

(B) an employee or producer of a person described in Subsection (1)(a)(i)(A);

(C) a person whose primary interest is as a competitor of a person licensed under this title; and

(D) a person on behalf of any of the persons listed in this Subsection (1)(a)(i).

(ii) As used in this Subsection (1), "false or misleading information" includes:

(A) assuring the nonobligatory payment of future dividends or refunds of unused premiums in any specific or approximate amounts, but reporting fully and accurately past experience is not false or misleading information; and

(B) with intent to deceive a person examining it[~~,~~]:

(I) filing a report[~~,~~];

(II) making a false entry in a record[~~,~~]; or

(III) wilfully refraining from making a proper entry in a record.

(iii) A licensee under this title may not:

(A) use any business name, slogan, emblem, or related device that is misleading or likely to cause the insurer or other licensee to be mistaken for another insurer or other licensee already in business; or

(B) use any advertisement or other insurance promotional material that would cause a reasonable person to mistakenly believe that a state or federal government agency:

(I) is responsible for the insurance sales activities of the person;

(II) stands behind the credit of the person;

(III) guarantees any returns on insurance products of or sold by the person; or

(IV) is a source of payment of any insurance obligation of or sold by the person.

(iv) A person who is not an insurer may not assume or use any name that deceptively implies or suggests that it is an insurer.

(v) A person other than persons licensed as health maintenance organizations under Chapter 8 may not use the term "Health Maintenance Organization" or "HMO" in referring to itself.

(b) [~~If a~~] A licensee's violation creates a rebuttable presumption that the violation was also committed by the insurer if:

(i) the licensee under this title distributes cards or documents, exhibits a sign, or publishes an advertisement that violates Subsection (1)(a), with reference to a particular insurer:

(A) that the licensee represents[~~,~~]; or

(B) for whom the licensee processes claims[~~,~~]; and [~~if~~]

(ii) the cards, documents, signs, or advertisements are supplied or approved by that insurer[~~, the licensee's violation creates a rebuttable presumption that the violation was also committed by the insurer~~].

(2) (a) (i) A licensee under this title, or an officer or employee of a licensee may not induce any person to enter into or continue an insurance contract or to terminate an existing insurance contract by offering benefits not specified in the policy to be issued or continued, including premium or commission rebates.

(ii) An insurer may not make or knowingly allow any agreement of insurance that is not clearly expressed in the policy to be issued or renewed.

(iii) This Subsection (2)(a) does not preclude:

(A) insurers from reducing premiums because of expense savings;

(B) the usual kinds of social courtesies not related to particular transactions; or

(C) an insurer from receiving premiums under an installment payment plan.

(b) A licensee under this title may not absorb the tax under Section 31A-3-301.

(c) (i) A title insurer or producer or any officer or employee of either may not pay, allow, give, or offer to pay, allow, or give, directly or indirectly, as an inducement to obtaining any title insurance business[~~,~~]:

(A) any rebate, reduction, or abatement of any rate or charge made incident to the issuance of the insurance[~~,~~];

(B) any special favor or advantage not generally available to others[~~,~~]; or

(C) any money or other consideration or material inducement.

(ii) "Charge made incident to the issuance of the insurance" includes escrow charges, and any other services that are prescribed by the commissioner.

(iii) An insured or any other person connected, directly or indirectly, with the transaction,

including a mortgage lender, real estate broker, builder, attorney, or any officer, employee, or agent of any of them, may not knowingly receive or accept, directly or indirectly, any benefit referred to in Subsection (2)(c)(i).

(3) (a) An insurer may not unfairly discriminate among policyholders by charging different premiums or by offering different terms of coverage, except on the basis of classifications related to the nature and the degree of the risk covered or the expenses involved.

(b) Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, blanket, or franchise policy, and the terms of those policies are not unfairly discriminatory merely because they are more favorable than in similar individual policies.

(4) [~~A~~] (a) This Subsection (4) applies to:

(i) a person who is or should be licensed under this title[~~,~~];

(ii) an employee of that licensee or person who should be licensed[~~,~~];

(iii) a person whose primary interest is as a competitor of a person licensed under this title[~~,~~]; and

(iv) one acting on behalf of any [~~of these persons,~~] person described in Subsections (4)(a)(i) through (iii).

(b) A person described in Subsection (4)(a) may not commit or enter into any agreement to participate in any act of boycott, coercion, or intimidation that:

[~~(a)~~] (i) tends to produce:

[~~(i)~~] (A) an unreasonable restraint of the business of insurance; or

[~~(ii)~~] (B) a monopoly in that business; or

[~~(b)~~] (ii) results in an applicant purchasing or replacing an insurance contract.

(5) (a) [~~A~~] (i) Subject to Subsection (5)(a)(ii), a person may not restrict in the choice of an insurer or licensee under this chapter, another person who is required to pay for insurance as a condition for the conclusion of a contract or other transaction or for the exercise of any right under a contract. [~~The~~]

(ii) A person requiring [~~the~~] coverage may[~~, however,~~] reserve the right to disapprove the

insurer or the coverage selected on reasonable grounds.

(b) The form of corporate organization of an insurer authorized to do business in this state is not a reasonable ground for disapproval, and the commissioner may by rule specify additional grounds that are not reasonable. This Subsection (5) does not bar an insurer from declining an application for insurance.

(6) A person may not make any charge other than insurance premiums and premium financing charges for the protection of property or of a security interest in property, as a condition for obtaining, renewing, or continuing the financing of a purchase of the property or the lending of money on the security of an interest in the property.

(7) (a) A licensee under this title may not refuse or fail to return promptly all indicia of agency to the principal on demand.

(b) A licensee whose license is suspended, limited, or revoked under Section 31A-2-308, 31A-23a-111, or 31A-23a-112 may not refuse or fail to return the license to the commissioner on demand.

(8) A person may not engage in any other unfair method of competition or any other unfair or deceptive act or practice in the business of insurance, as defined by the commissioner by rule, after a finding that they are misleading, deceptive, unfairly discriminatory, provide an unfair inducement, or unreasonably restrain competition.

Section 10. Section **63-55-231** is amended to read:

63-55-231. Repeal dates, Title 31A.

(1) Section 31A-2-208.5, Comparison tables, is repealed July 1, [~~2005~~] 2010.

(2) Section 31A-2-217, Coordination with other states, is repealed July 1, 2013.

(3) Section 31A-3-104, Electronic [~~Commerce Dedicated Fees~~] commerce dedicated fees, is repealed July 1, 2006.

(4) Section 31A-22-315, Motor [~~Vehicle Insurance Reporting~~] vehicle insurance reporting, is repealed July 1, 2010.

(5) Section 31A-22-625, Catastrophic [~~Coverage of Mental Health Conditions~~] coverage of mental health conditions, is repealed July 1, 2011.

(6) Title 31A, Chapter 31, Insurance Fraud Act, is repealed July 1, 2007.

Section 11. **Repealer.**

This bill repeals:

Section **31A-8-302, Transition period for prior licensees.**