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H.B. 342

INSURANCE CODE AMENDMENTS

2008 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: Sheldon L. Killpack

LONG TITLE

General Description:

This bill modifies the Insurance Code to make various amendments.

Highlighted Provisions:

This bill:

- modifies definition provisions;
- addresses the timing of examinations;
- changes the requirements for appointments to the Title and Escrow Commission;
- addresses requirements to conduct an insurance business in Utah;
- addresses filing of evidence of preemption;
- addresses service contract providers and service contract reimbursement insurance policies including:
  - prohibiting a captive insurance company from writing certain reimbursement policies for service contract providers;
  - requiring registration;
  - requiring disclosures; and
  - addressing prohibited acts;
- addresses how to calculate monies paid a beneficiary in certain circumstances where a suicide occurs;
- addresses certain circumstances related to annuity payments;
- addresses the Basic Health Care Plan;

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- clarifies language related to catastrophic coverage of mental health conditions;
- provides for the payment of interest on life insurance proceeds;
- provides for special enrollment for individuals receiving premium assistance;
- clarifies circumstances when the commissioner can prohibit a policy, contract, certificate, or form;
- requires submission to criminal background checks in certain circumstances;
- modifies the contents of a form used in a license;
- addresses grounds involving a viatical settlement for action against a licensee;
- makes technical changes regarding delinquency proceedings;
- expands the purposes of the Individual, Small Employer, and Group Health Insurance Act;
- addresses when individual carriers must accept individuals; and
- makes additional technical amendments.

Monies Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

31A-1-301, as last amended by Laws of Utah 2007, Chapter 307

31A-2-203, as last amended by Laws of Utah 2007, Chapter 309

31A-2-403, as last amended by Laws of Utah 2007, Chapter 325

31A-4-102, as last amended by Laws of Utah 1998, Chapter 293

31A-4-106, as last amended by Laws of Utah 2003, Chapter 298

31A-6a-103, as last amended by Laws of Utah 2005, Chapter 124

31A-6a-104, as enacted by Laws of Utah 1992, Chapter 203

31A-6a-105, as enacted by Laws of Utah 1992, Chapter 203

31A-22-404, as last amended by Laws of Utah 2002, Chapter 308

31A-22-409, as last amended by Laws of Utah 2005, Chapter 125

31A-22-613.5, as last amended by Laws of Utah 2007, Chapter 307

31A-22-625, as last amended by Laws of Utah 2002, Chapter 308

31A-22-807, as last amended by Laws of Utah 2001, Chapter 116
31A-23a-105, as last amended by Laws of Utah 2007, Chapter 307
31A-23a-110, as renumbered and amended by Laws of Utah 2003, Chapter 298
31A-23a-111, as last amended by Laws of Utah 2006, Chapter 312
31A-23a-116, as renumbered and amended by Laws of Utah 2003, Chapter 298
31A-25-203, as last amended by Laws of Utah 2006, Chapter 312
31A-26-203, as last amended by Laws of Utah 2006, Chapter 312
31A-27a-513, as enacted by Laws of Utah 2007, Chapter 309
31A-27a-515, as enacted by Laws of Utah 2007, Chapter 309
31A-27a-516, as enacted by Laws of Utah 2007, Chapter 309
31A-30-102, as last amended by Laws of Utah 1997, Chapter 265
31A-30-108, as last amended by Laws of Utah 2004, Chapters 2 and 329
31A-30-112, as last amended by Laws of Utah 2007, Chapter 307

ENACTS:

31A-22-428, Utah Code Annotated 1953
31A-22-610.6, Utah Code Annotated 1953

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

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

31A-1-301. Definitions.

As used in this title, unless otherwise specified:

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

(i) a medical condition including:

(A) a medical care [~~expenses~~] expense; or

(B) the risk of disability;

(ii) accident; or

(iii) sickness.

(b) "Accident and health insurance":

(i) includes a contract with disability contingencies including:

(A) an income replacement contract;

(B) a health care contract;

(C) an expense reimbursement contract;

(D) a credit accident and health contract;

(E) a continuing care contract; and

(F) a long-term care contract; and

(ii) may provide:

(A) hospital coverage;

(B) surgical coverage;

(C) medical coverage; [~~or~~]

(D) loss of income coverage[~~.~~];

(E) prescription drug coverage;

(F) dental coverage; or

(G) vision coverage.

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

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

(3) "Administrator" is defined in Subsection [~~(157)~~] (159).

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

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

(6) "Agency" means:

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

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

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

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

(9) "Annuity" means an agreement to make periodical payments for a period certain or over the lifetime of one or more natural persons if the making or continuance of all or some of

the series of the payments, or the amount of the payment, is dependent upon the continuance of human life.

(10) "Application" means a document:

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

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

(A) insure the risk under:

(I) the [~~coverages~~] coverage as originally offered; or

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

(B) decline to insure the risk; or

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

(11) "Articles" or "articles of incorporation" means:

(a) the original articles[~~,~~];

(b) a special [~~laws, charters, amendments,~~] law;

(c) a charter;

(d) an amendment;

(e) restated articles[~~,~~];

(f) articles of merger or consolidation[~~, trust instruments, and other constitutive documents for trusts and other entities that are not corporations, and amendments to any of these.~~];

(g) a trust instrument;

(h) another constitutive document for a trust or other entity that is not a corporation; and

(i) an amendment to an item listed in Subsections (11)(a) through (h).

(12) "Bail bond insurance" means a guarantee that a person will attend court when required, up to and including surrender of the person in execution of [~~any~~] a sentence imposed under Subsection 77-20-7(1), as a condition to the release of that person from confinement.

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

(14) "Blanket insurance policy" means a group policy covering [~~classes~~] a defined class

of persons:

(a) without individual underwriting[, where the persons insured are] or application; and

(b) that is determined by definition [of the class] with or without designating [the persons] each person covered.

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

(16) "Business entity" means:

(a) a corporation[,];

(b) an association[,];

(c) a partnership[,];

(d) a limited liability company[,];

(e) a limited liability partnership[,]; or [other]

(f) another legal entity.

(17) "Business of insurance" is defined in Subsection [(84)] (85).

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

(a) Section 31A-7-201;

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

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

(19) (a) "Bylaws" means the rules adopted for the regulation or management of a corporation's affairs, however designated [and].

(b) "Bylaws" includes comparable rules for [trusts and other entities that are not corporations] a trust or other entity that is not a corporation.

(20) "Captive insurance company" means:

(a) an [insurance company] insurer:

(i) owned by another organization; and

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

(b) in the case of [groups and associations, an insurance organization] a group or association, an insurer:

(i) owned by the insureds; and

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

(A) a member [~~organizations~~] organization;

(B) a group [~~members; and~~] member; or

(C) [~~affiliates~~] an affiliate of:

(I) a member [~~organizations~~] organization; or

(II) a group [~~members~~] member.

(21) "Casualty insurance" means liability insurance as defined in Subsection [~~(96)~~] (97).

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

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

(b) a third party.

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

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

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

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

(b) When appropriate, the terms listed in Subsection (26)(a) apply to the equivalent supervisory official of another jurisdiction.

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

(i) provides board and lodging;

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

(A) a personal [~~services~~] service;

(B) a nursing [~~services~~] service;

(C) a medical [~~services~~] service; or

(D) any other health-related [~~services~~] service; and

(iii) provides the coverage described in Subsection (27)(a)(i) under an agreement effective:

(A) for the life of the insured; or

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

(b) Insurance is continuing care insurance regardless of whether or not the board and lodging are provided at the same location as [~~the services~~] a service described in Subsection (27)(a)(ii).

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

(i) by contract;

(ii) by common management;

(iii) through the ownership of voting securities; or

(iv) by a means other than those described in Subsections (28)(a)(i) through (iii).

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

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

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

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

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

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

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

(i) a corporation doing business:

(A) as:

(I) an insurance producer;

(II) a limited line producer;

(III) a consultant;

(IV) a managing general agent;

(V) a reinsurance intermediary;

(VI) a third party administrator; or

(VII) an adjuster; and

(B) under:

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

(II) Chapter 25, Third Party Administrators; or

(III) Chapter 26, Insurance Adjusters; or

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

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

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

(33) "Creditable coverage" has the same meaning as provided in federal regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936.

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

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

(b) "Credit insurance" includes:

(i) credit accident and health insurance;

(ii) credit life insurance;

(iii) credit property insurance;

(iv) credit unemployment insurance;

(v) guaranteed automobile protection insurance;

(vi) involuntary unemployment insurance;

(vii) mortgage accident and health insurance;

(viii) mortgage guaranty insurance; and

(ix) mortgage life insurance.

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

(37) "Credit property insurance" means insurance:

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

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

(38) "Credit unemployment insurance" means insurance:

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

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

(i) specific loan; or

(ii) credit transaction.

(39) "Creditor" means a person, including an insured, having [~~any~~] a claim, whether:

(a) matured;

(b) unmatured;

(c) liquidated;

(d) unliquidated;

(e) secured;

(f) unsecured;

(g) absolute;

(h) fixed; or

(i) contingent.

(40) (a) "Customer service representative" means a person that provides an insurance [~~services~~] service and insurance product information:

(i) for the customer service representative's:

(A) producer; or

(B) consultant employer; and

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

(A) customer;

(B) client; or

(C) organization.

(b) A customer service representative may only operate within the scope of authority of

the customer service representative's producer or consultant employer.

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

(a) imposed by:

(i) statute;

(ii) rule; or

(iii) order; and

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

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

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

(44) "Department" means the Insurance Department.

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

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

(a) perform the duties of:

(i) that individual's occupation; or

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

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

(i) eating;

(ii) toileting;

(iii) transferring;

(iv) bathing; or

(v) dressing.

(47) "Disability income insurance" is defined in Subsection [~~(75)~~] (76).

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

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

(a) is incorporated;

(b) is organized; or

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

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

(i) an employee who:

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

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

[~~(ii) a person described in Subsection (50) (b).~~]

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

[~~(i)~~] (ii) a sole proprietor;

[~~(ii)~~] (iii) a partner in a partnership; or

[~~(iii)~~] (iv) an independent contractor.

[~~(c)~~] (b) "Eligible employee" does not include[~~, unless eligible under Subsection (50)(b): (i)~~] an individual who works on a temporary or substitute basis for a small employer[~~;~~].

[~~(ii) an employer's spouse; or~~]

[~~(iii) a dependent of an employer.~~]

(51) "Employee" means [~~any~~] an individual employed by an employer.

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

(a) [~~employees~~] an employee; or

(b) [~~dependents of employees~~] a dependent of an employee.

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

(i) established or maintained, whether directly or through [~~trustees~~] a trustee, by:

(A) one or more employers;

(B) one or more labor organizations; or

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

(ii) that provides employee benefits paid or contracted to be paid, other than income from investments of the fund[~~;~~]:

(A) by or on behalf of an employer doing business in this state; or

(B) for the benefit of [~~any~~] a person employed in this state.

(b) "Employee welfare fund" includes a plan funded or subsidized by a user [~~fees~~] fee

or tax revenues.

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

(55) "Enrollment date," with respect to a health benefit plan, means:

(a) the first day of coverage; or[;]

(b) if there is a waiting period, the first day of the waiting period.

(56) (a) "Escrow" means:

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

(ii) a settlement or closing involving:

(A) a mobile home;

(B) a grazing right;

(C) a water right; or

(D) other personal property authorized by the commissioner.

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

(i) real estate settlement; or

(ii) real estate closing.

(57) "Escrow agent" means:

(a) an insurance producer with:

(i) a title insurance line of authority; and

(ii) an escrow subline of authority; or

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

(58) (a) "Excludes" is not exhaustive and does not mean that [~~other things are~~] another thing is not also excluded.

(b) The items listed in a list using the term "excludes" are representative examples for use in interpretation of this title.

(59) "Exclusion" means for the purposes of accident and health insurance that an insurer does not provide insurance coverage, for whatever reason, for one of the following:

(a) a specific physical condition;

(b) a specific medical procedure;

(c) a specific disease or disorder; or

(d) a specific prescription drug or class of prescription drugs.

[~~(59)~~] (60) "Expense reimbursement insurance" means insurance:

(a) written to provide [~~payments for expenses~~] a payment for an expense relating to hospital [~~confinements~~] confinement resulting from illness or injury; and

(b) written:

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

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

[~~(60)~~] (61) "Fidelity insurance" means insurance guaranteeing the fidelity of [~~persons~~] a person holding [~~positions~~] a position of public or private trust.

[~~(61)~~] (62) (a) "Filed" means that a filing is:

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

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

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

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

(B) rule.

(b) "Filed" does not include a filing that is rejected by the department because it is not submitted in accordance with Subsection [~~(61)~~] (62)(a).

[~~(62)~~] (63) "Filing," when used as a noun, means an item required to be filed with the department including:

(a) a policy;

(b) a rate;

(c) a form;

(d) a document;

(e) a plan;

(f) a manual;

(g) an application;

(h) a report;

(i) a certificate;

(j) an endorsement;

(k) an actuarial certification;

(l) a licensee annual statement;

(m) a licensee renewal application; [~~or~~]

(n) an advertisement; or

(o) an outline of coverage.

[~~(63)~~] (64) "First party insurance" means an insurance policy or contract in which the insurer agrees to pay [~~claims~~] a claim submitted to it by the insured for the insured's losses.

[~~(64)~~] (65) "Foreign insurer" means an insurer domiciled outside of this state, including an alien insurer.

[~~(65)~~] (66) (a) "Form" means one of the following prepared for general use:

(i) a policy;

(ii) a certificate;

(iii) an application; [~~or~~]

(iv) an outline of coverage; or

(v) an endorsement.

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

[~~(66)~~] (67) "Franchise insurance" means an individual insurance [~~policies~~] policy provided through a mass marketing arrangement involving a defined class of persons related in some way other than through the purchase of insurance.

[~~(67)~~] (68) "General lines of authority" include:

(a) the general lines of insurance in Subsection [~~(68)~~] (69);

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

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

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

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

(iv) title marketing representative only;

(c) surplus lines;

(d) workers' compensation; and

(e) any other line of insurance that the commissioner considers necessary to recognize

in the public interest.

[~~(68)~~] (69) "General lines of insurance" include:

(a) accident and health;

(b) casualty;

(c) life;

(d) personal lines;

(e) property; and

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

[~~(69)~~] (70) "Group health plan" means an employee welfare benefit plan to the extent that the plan provides medical care:

(a) (i) to [~~employees~~] an employee; or

(ii) to a dependent of an employee; and

(b) (i) directly;

(ii) through insurance reimbursement; or

(iii) through [~~any other~~] another method.

[~~(70)~~] (71) (a) "Group insurance policy" means a policy covering a group of persons that is issued:

(i) to a policyholder on behalf of the group; and

(ii) for the benefit of [~~group members who are~~] a member of the group who is selected under [~~procedures~~] a procedure defined in:

(A) the policy; or

(B) [~~agreements which are~~] an agreement that is collateral to the policy.

(b) A group insurance policy may include [~~members~~] a member of the policyholder's family or [~~dependents~~] a dependent.

[~~(71)~~] (72) "Guaranteed automobile protection insurance" means insurance offered in connection with an extension of credit that pays the difference in amount between the insurance settlement and the balance of the loan if the insured automobile is a total loss.

[~~(72)~~] (73) (a) Except as provided in Subsection [~~(72)~~] (73)(b), "health benefit plan" means a policy or certificate that:

(i) provides health care insurance;

(ii) provides major medical expense insurance; or

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

(A) a hospital confinement indemnity; or

(B) a limited benefit plan.

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

(i) provides benefits solely for:

(A) accident;

(B) dental;

(C) income replacement;

(D) long-term care;

(E) a Medicare supplement;

(F) a specified disease;

(G) vision; or

(H) a short-term limited duration; or

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

[~~(73)~~] (74) "Health care" means any of the following intended for use in the diagnosis, treatment, mitigation, or prevention of a human ailment or impairment:

(a) a professional [~~services~~] service;

(b) a personal [~~services~~] service;

(c) [~~facilities~~] a facility;

(d) equipment;

(e) [~~devices~~] a device;

(f) supplies; or

(g) medicine.

[~~(74)~~] (75) (a) "Health care insurance" or "health insurance" means insurance providing:

(i) a health care [~~benefits~~] benefit; or

(ii) payment of an incurred health care [~~expenses~~] expense.

(b) "Health care insurance" or "health insurance" does not include accident and health insurance providing [~~benefits~~] a benefit for:

(i) replacement of income;

(ii) short-term accident;

(iii) fixed indemnity;

(iv) credit accident and health;

(v) supplements to liability;

(vi) workers' compensation;

(vii) automobile medical payment;

(viii) no-fault automobile;

(ix) equivalent self-insurance; or

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

[~~(75)~~] (76) "Income replacement insurance" or "disability income insurance" means insurance written to provide payments to replace income lost from accident or sickness.

[~~(76)~~] (77) "Indemnity" means the payment of an amount to offset all or part of an insured loss.

[~~(77)~~] (78) "Independent adjuster" means an insurance adjuster required to be licensed under Section 31A-26-201 who engages in insurance adjusting as a representative of [~~insurers~~] an insurer.

[~~(78)~~] (79) "Independently procured insurance" means insurance procured under Section 31A-15-104.

[~~(79)~~] (80) "Individual" means a natural person.

[~~(80)~~] (81) "Inland marine insurance" includes insurance covering:

(a) property in transit on or over land;

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

(c) bailee liability;

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

(e) personal and commercial property floaters.

[~~(81)~~] (82) "Insolvency" means that:

(a) an insurer is unable to pay its debts or meet its obligations as [~~they~~] the debts and obligations mature;

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

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

[~~(82)~~] (83) (a) "Insurance" means:

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

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

(b) "Insurance" includes:

(i) a risk distributing [~~arrangements~~] arrangement providing for compensation or replacement for damages or loss through the provision of [~~services or benefits~~] a service or a benefit in kind;

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

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

[~~(83)~~] (84) "Insurance adjuster" means a person who directs the investigation, negotiation, or settlement of a claim under an insurance policy other than life insurance or an annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.

[~~(84)~~] (85) "Insurance business" or "business of insurance" includes:

(a) providing health care insurance, as defined in Subsection [~~(74)~~] (75), by [~~organizations that are~~] an organization that is or should be licensed under this title;

(b) providing [~~benefits to employees~~] a benefit to an employee in the event of [~~contingencies~~] a contingency not within the control of the [~~employees~~] employee, in which the [~~employees are~~] employee is entitled to the [~~benefits~~] benefit as a right, which [~~benefits~~] benefit may be provided either:

(i) by a single [~~employers~~] employer or by multiple employer groups; or

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

(c) providing [~~annuities,~~] an annuity:

(i) including [~~those~~] an annuity issued in return for [~~gifts,~~] a gift; and

(ii) except [~~those~~] an annuity provided by [~~persons~~] a person specified in Subsections 31A-22-1305(2) and (3);

(d) providing the characteristic services of a motor [~~clubs~~] club as outlined in Subsection [~~(112)~~] (113);

(e) providing [~~other persons~~] another person with insurance as defined in Subsection [~~(82)~~] (83);

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

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

(i) solicitation;

(ii) negotiation preliminary to execution;

(iii) execution of a contract of title insurance;

(iv) insuring; and

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

(h) doing, or proposing to do, any business in substance equivalent to Subsections [~~(84)~~] (85)(a) through (g) in a manner designed to evade the provisions of this title.

[~~(85)~~] (86) "Insurance consultant" or "consultant" means a person who:

(a) advises [~~other persons~~] another person about insurance needs and coverages;

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

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

[~~(86)~~] (87) "Insurance holding company system" means a group of two or more affiliated persons, at least one of whom is an insurer.

[~~(87)~~] (88) (a) "Insurance producer" or "producer" means a person licensed or required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

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

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

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

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

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

[~~(88)~~] (89) (a) "Insured" means a person to whom or for whose benefit an insurer makes a promise in an insurance policy and includes:

(i) [~~policyholders~~] a policyholder;

(ii) [~~subscribers~~] a subscriber;

(iii) [~~members~~] a member; and

(iv) [~~beneficiaries~~] a beneficiary.

(b) The definition in Subsection [~~(88)~~] (89)(a):

(i) applies only to this title; and

(ii) does not define the meaning of this word as used in an insurance [~~policies or certificates~~] policy or certificate.

[~~(89)~~] (90) (a) (i) "Insurer" means [~~any~~] a person doing an insurance business as a principal including:

(A) a fraternal benefit [~~societies~~] society;

(B) [~~issuers of gift annuities other than those~~] an issuer of a gift annuity other than an annuity specified in Subsections 31A-22-1305(2) and (3);

(C) a motor [~~clubs~~] club;

(D) an employee welfare [~~plans~~] plan; and

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

(ii) "Insurer" does not include a governmental entity to the extent [~~it~~] the governmental entity is engaged in [~~the activities~~] an activity described in Section 31A-12-107.

(b) "Admitted insurer" is defined in Subsection [~~(161)~~] (163)(b).

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

(d) "Authorized insurer" is defined in Subsection [~~(161)~~] (163)(b).

(e) "Domestic insurer" is defined in Subsection (48).

(f) "Foreign insurer" is defined in Subsection [~~(64)~~] (65).

(g) "Nonadmitted insurer" is defined in Subsection [~~(161)~~] (163)(a).

(h) "Unauthorized insurer" is defined in Subsection [~~(161)~~] (163)(a).

[~~(90)~~] (91) "Interinsurance exchange" is defined in Subsection [~~(141)~~] (142).

[~~(91)~~] (92) "Involuntary unemployment insurance" means insurance:

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

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

(i) specific loan; or

(ii) credit transaction.

[~~(92)~~] (93) "Large employer," in connection with a health benefit plan, means an employer who, with respect to a calendar year and to a plan year:

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

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

[~~(93)~~] (94) "Late enrollee," with respect to an employer health benefit plan, means an individual whose enrollment is a late enrollment.

[~~(94)~~] (95) "Late enrollment," with respect to an employer health benefit plan, means enrollment of an individual other than:

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

(b) through special enrollment.

[~~(95)~~] (96) (a) Except for a retainer contract or legal assistance described in Section 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for a specified legal [~~expenses~~] expense.

(b) "Legal expense insurance" includes [~~arrangements that create~~] an arrangement that creates a reasonable [~~expectations of~~] expectation of an enforceable [~~rights~~] right.

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

[~~(96)~~] (97) (a) "Liability insurance" means insurance against liability:

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

(A) Subsection [~~(106)~~] (107) for medical malpractice insurance;

(B) Subsection [~~(133)~~] (134) for professional liability insurance; and

(C) Subsection [~~(166)~~] (168) for workers' compensation insurance;

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

(A) Subsection [~~(106)~~] (107) for medical malpractice insurance;

(B) Subsection [~~(133)~~] (134) for professional liability insurance; and

(C) Subsection [~~(166)~~] (168) for workers' compensation insurance;

(iii) for loss or damage to property resulting from [~~accidents to or explosions of boilers, pipes, pressure containers~~] an accident to or explosion of a boiler, pipe, pressure container, machinery, or apparatus;

(iv) for loss or damage to [~~any~~] property caused by:

(A) the breakage or leakage of [~~sprinklers, water pipes and containers, or by~~] a sprinkler, water pipe, or water container; or

(B) water entering through [~~leaks or openings in buildings~~] a leak or opening in a building; or

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

(b) "Liability insurance" includes:

(i) vehicle liability insurance as defined in Subsection [~~(163)~~] (165);

(ii) residential dwelling liability insurance as defined in Subsection [~~(144)~~] (145); and

(iii) making inspection of, and issuing [~~certificates~~] a certificate of inspection upon, [~~elevators, boilers~~] an elevator, boiler, machinery, [~~and~~] or apparatus of any kind when done in connection with insurance on [~~them~~] the elevator, boiler, machinery, or apparatus.

[~~(97)~~] (98) (a) "License" means the authorization issued by the commissioner to engage in [~~some~~] an activity that is part of or related to the insurance business.

(b) "License" includes [~~certificates~~] a certificate of authority issued to [~~insurers~~] an insurer.

[~~(98)~~] (99) (a) "Life insurance" means:

(i) insurance on a human [~~lives~~] life; and [~~insurances~~]

(ii) insurance pertaining to or connected with human life.

(b) The business of life insurance includes:

(i) granting a death [~~benefits~~] benefit;

(ii) granting an annuity [~~benefits~~] benefit;

(iii) granting an endowment [~~benefits~~] benefit;

(iv) granting an additional [~~benefits~~] benefit in the event of death by accident;

(v) granting an additional [~~benefits~~] benefit to safeguard the policy against lapse; and

(vi) providing an optional [~~methods~~] method of settlement of proceeds.

[~~(99)~~] (100) "Limited license" means a license that:

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

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

[~~(100)~~] (101) "Limited line credit insurance" includes the following forms of insurance:

(a) credit life;

(b) credit accident and health;

(c) credit property;

(d) credit unemployment;

(e) involuntary unemployment;

(f) mortgage life;

(g) mortgage guaranty;

(h) mortgage accident and health;

(i) guaranteed automobile protection; and

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

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

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

[~~(101)~~] (102) "Limited line credit insurance producer" means a person who sells, solicits, or negotiates one or more forms of limited line credit insurance coverage to [~~individuals~~] an individual through a master, corporate, group, or individual policy.

[~~(102)~~] (103) "Limited line insurance" includes:

(a) bail bond;

(b) limited line credit insurance;

(c) legal expense insurance;

(d) motor club insurance;

(e) rental car-related insurance;

(f) travel insurance; and

(g) [~~any other~~] another form of limited insurance that the commissioner determines by rule should be designated a form of limited line insurance.

[~~(103)~~] (104) "Limited lines authority" includes:

(a) the lines of insurance listed in Subsection [~~(102)~~] (103); and

(b) a customer service representative.

[~~(104)~~] (105) "Limited lines producer" means a person who sells, solicits, or negotiates limited lines insurance.

[~~(105)~~] (106) (a) "Long-term care insurance" means an insurance policy or rider advertised, marketed, offered, or designated to provide coverage:

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

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

(A) expenses incurred;

(B) indemnity;

(C) prepayment; or

(D) another method;

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

(A) diagnostic;

(B) preventative;

(C) therapeutic;

(D) rehabilitative;

(E) maintenance; or

(F) personal care; and

(iv) that may be issued by:

(A) an insurer;

(B) a fraternal benefit society;

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

(II) a medical service corporation;

(D) a prepaid health plan;

(E) a health maintenance organization; or

(F) an entity similar to the entities described in Subsections [~~(105)~~] (106)(a)(iv)(A) through (E) to the extent that the entity is otherwise authorized to issue life or health care insurance.

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

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

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

(B) a life insurance policy or rider;

(ii) a policy or rider that provides for payment of benefits [~~based on~~] on the basis of:

(A) cognitive impairment; or

(B) functional capacity; or

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

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

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

(ii) basic hospital expense coverage;

(iii) basic medical/surgical expense coverage;

(iv) hospital confinement indemnity coverage;

(v) major medical expense coverage;

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

(vii) accident only coverage;

(viii) coverage for a specified:

(A) disease; or

(B) accident;

(ix) limited benefit health coverage; or

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

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

(I) benefits; or

(II) eligibility; and

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

(I) terminal illness;

(II) medical conditions requiring extraordinary medical intervention; or

(III) permanent institutional confinement.

[~~(106)~~] (107) "Medical malpractice insurance" means insurance against legal liability incident to the practice and provision of a medical [~~services~~] service other than the practice and provision of a dental [~~services~~] service.

[~~(107)~~] (108) "Member" means a person having membership rights in an insurance corporation.

[~~(108)~~] (109) "Minimum capital" or "minimum required capital" means the capital that must be constantly maintained by a stock insurance corporation as required by statute.

[~~(109)~~] (110) "Mortgage accident and health insurance" means insurance offered in connection with an extension of credit that provides indemnity for payments coming due on a mortgage while the debtor is disabled.

[~~(110)~~] (111) "Mortgage guaranty insurance" means surety insurance under which [~~mortgagees and other creditors are~~] a mortgagee or other creditor is indemnified against losses caused by the default of [~~debtors~~] a debtor.

[~~(111)~~] (112) "Mortgage life insurance" means insurance on the life of a debtor in connection with an extension of credit that pays if the debtor dies.

[~~(112)~~] (113) "Motor club" means a person:

(a) licensed under:

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

(ii) Chapter 11, Motor Clubs; or

(iii) Chapter 14, Foreign Insurers; and

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

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

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

(iii) (A) trip reimbursement;

(B) towing services;

(C) emergency road services;

(D) stolen automobile services;

(E) a combination of the services listed in Subsections [~~(112)~~] (113)(b)(iii)(A) through (D); or

(F) [~~any~~] other services given in Subsections 31A-11-102(1)(b) through (f).

[~~(113)~~] (114) "Mutual" means a mutual insurance corporation.

[~~(114)~~] (115) "Network plan" means health care insurance:

(a) that is issued by an insurer; and

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

[~~(115)~~] (116) "Nonparticipating" means a plan of insurance under which the insured is not entitled to receive [~~dividends~~] a dividend representing [~~shares~~] a share of the surplus of the insurer.

[~~(116)~~] (117) "Ocean marine insurance" means insurance against loss of or damage to:

(a) ships or hulls of ships;

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

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

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

[~~(117)~~] (118) "Order" means an order of the commissioner.

[~~(118)~~] (119) "Outline of coverage" means a summary that explains an accident and health insurance policy.

[~~(119)~~] (120) "Participating" means a plan of insurance under which the insured is entitled to receive [~~dividends~~] a dividend representing [~~shares~~] a share of the surplus of the insurer.

[~~(120)~~] (121) "Participation," as used in a health benefit plan, means a requirement relating to the minimum percentage of eligible employees that must be enrolled in relation to

the total number of eligible employees of an employer reduced by each eligible employee who voluntarily declines coverage under the plan because the employee:

(a) has other group health care insurance coverage[~~,~~]; or

(b) receives:

(i) Medicare, under the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965; or

(ii) another government health benefit.

[~~(121)~~] (122) "Person" includes:

(a) an individual[~~,~~];

(b) a partnership[~~,~~];

(c) a corporation[~~,~~];

(d) an incorporated or unincorporated association[~~,~~];

(e) a joint stock company[~~,~~];

(f) a trust[~~,~~];

(g) a limited liability company[~~,~~];

(h) a reciprocal[~~,~~];

(i) a syndicate[~~,~~]; or [~~any~~]

(j) another similar entity or combination of entities acting in concert.

[~~(122)~~] (123) "Personal lines insurance" means property and casualty insurance coverage sold for primarily noncommercial purposes to:

(a) [~~individuals; and~~] an individual; or

(b) [~~families~~] a family.

[~~(123)~~] (124) "Plan sponsor" is as defined in 29 U.S.C. Sec. 1002(16)(B).

[~~(124)~~] (125) "Plan year" means:

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

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

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

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

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

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

or

(iii) the employer's taxable year if:

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

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

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

(c) in a case not described in Subsection [~~(124)~~] (125)(a) or (b), the calendar year.

[~~(125)~~] (126) (a) "Policy" means [~~any~~] a document, including any attached [~~endorsements and riders, purporting~~] endorsement or application that:

(i) purports to be an enforceable contract[~~, which~~]; and

(ii) memorializes in writing some or all of the terms of an insurance contract.

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

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

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

(iii) a corporation licensed under:

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

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

(c) "Policy" does not include:

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

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

[~~(126)~~] (127) "Policyholder" means the person who controls a policy, binder, or oral contract by ownership, premium payment, or otherwise.

[~~(127)~~] (128) "Policy illustration" means a presentation or depiction that includes nonguaranteed elements of a policy of life insurance over a period of years.

[~~(128)~~] (129) "Policy summary" means a synopsis describing the elements of a life insurance policy.

[~~(129)~~] (130) "Preexisting condition," with respect to a health benefit plan:

(a) means a condition that was present before the effective date of coverage, whether or not [~~any~~] medical advice, diagnosis, care, or treatment was recommended or received before that day; and

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

[~~(130)~~] (131) (a) "Premium" means the monetary consideration for an insurance policy.

(b) "Premium" includes, however designated:

(i) [~~assessments~~] an assessment;

(ii) a membership [~~fees~~] fee;

(iii) a required [~~contributions~~] contribution; or

(iv) monetary consideration.

(c) (i) [~~Consideration~~] "Premium" does not include consideration paid to a third party [~~administrators for their services is not "premium."~~] administrator for the third party administrator's services.

(ii) [~~Amounts~~] "Premium" includes an amount paid by a third party [~~administrators to insurers~~] administrator to an insurer for insurance on the risks administered by the third party [~~administrators are "premium."~~] administrator.

[~~(131)~~] (132) "Principal officers" of a corporation means the officers designated under Subsection 31A-5-203(3).

[~~(132) "Proceedings"~~] (133) "Proceeding" includes [~~actions and~~] an action or special statutory [~~proceedings~~] proceeding.

[~~(133)~~] (134) "Professional liability insurance" means insurance against legal liability incident to the practice of a profession and provision of [~~any~~] a professional [~~services~~] service.

[~~(134)~~] (135) (a) Except as provided in Subsection [~~(134)~~] (135)(b), "property insurance" means insurance against loss or damage to real or personal property of every kind and any interest in that property:

(i) from all hazards or causes; and

(ii) against loss consequential upon the loss or damage including vehicle comprehensive and vehicle physical damage coverages.

(b) "Property insurance" does not include:

(i) inland marine insurance as defined in Subsection [~~(80)~~] (81); and

(ii) ocean marine insurance as defined under Subsection [~~(116)~~] (117).

[~~(135)~~] (136) "Qualified long-term care insurance contract" or "federally tax qualified long-term care insurance contract" means:

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

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

(i) (A) by rider; or

(B) as a part of the contract; and

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

[~~(136)~~] (137) "Qualified United States financial institution" means an institution that:

(a) is:

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

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

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

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

(i) the commissioner by rule; or

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

[~~(137)~~] (138) (a) "Rate" means:

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

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

(A) a single number; or

(B) a pure premium rate, adjusted before [~~any~~] the application of individual risk variations based on loss or expense considerations to account for the treatment of:

(I) expenses;

(II) profit; and

(III) individual insurer variation in loss experience.

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

[~~(138)~~] (139) (a) Except as provided in Subsection [~~(138)~~] (139)(b), "rate service

organization" means [~~any~~] a person who assists [~~insurers~~] an insurer in rate making or filing by:

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

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

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

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

(i) an employee of an insurer;

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

(iii) a joint underwriting group; or

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

[~~(139)~~] (140) "Rating manual" means any of the following used to determine initial and renewal policy premiums:

(a) a manual of rates;

(b) [~~classifications~~] a classification;

(c) a rate-related underwriting [~~rules~~] rule; and

(d) a rating [~~formulas that describe~~] formula that describes steps, policies, and procedures for determining initial and renewal policy premiums.

[~~(140)~~] (141) "Received by the department" means:

(a) except as provided in Subsection [~~(140)~~] (141)(b), the date delivered to and stamped received by the department, whether delivered:

(i) in person; or

(ii) electronically; and

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

(i) statute;

(ii) rule; or

(iii) a specific filing order.

[~~(141)~~] (142) "Reciprocal" or "interinsurance exchange" means [~~any~~] an unincorporated association of persons:

(a) operating through an attorney-in-fact common to all of [~~them~~] the persons; and

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

[~~(142)~~] (143) "Reinsurance" means an insurance transaction where an insurer, for consideration, transfers any portion of the risk it has assumed to another insurer. In referring to reinsurance transactions, this title sometimes refers to:

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

(b) the insurer assuming the risk as the:

(i) "assuming insurer"; or

(ii) "assuming reinsurer."

[~~(143)~~] (144) "Reinsurer" means [~~any~~] a person licensed in this state as an insurer with the authority to assume reinsurance.

[~~(144)~~] (145) "Residential dwelling liability insurance" means insurance against liability resulting from or incident to the ownership, maintenance, or use of a residential dwelling that is a detached single family residence or multifamily residence up to four units.

[~~(145)~~] (146) (a) "Retrocession" means reinsurance with another insurer of a liability assumed under a reinsurance contract.

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

[~~(146)~~] (147) "Rider" means an endorsement to:

(a) an insurance policy; or

(b) an insurance certificate.

[~~(147)~~] (148) (a) "Security" means [~~any~~] a:

(i) note;

(ii) stock;

(iii) bond;

(iv) debenture;

(v) evidence of indebtedness;

(vi) certificate of interest or participation in [~~any~~] a profit-sharing agreement;

(vii) collateral-trust certificate;

(viii) preorganization certificate or subscription;

(ix) transferable share;

(x) investment contract;

(xi) voting trust certificate;

(xii) certificate of deposit for a security;

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

(xiv) commodity contract or commodity option;

(xv) certificate of interest or participation in, temporary or interim certificate for, receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed in Subsections [~~(147)~~] (148)(a)(i) through (xiv); or

(xvi) [~~other~~] another interest or instrument commonly known as a security.

(b) "Security" does not include:

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

(A) insurance;

(B) endowment policy; or

(C) annuity contract; or

(ii) a burial certificate or burial contract.

(149) "Secondary medical condition" means a complication related to an exclusion from coverage in accident and health insurance.

[~~(148)~~] (150) "Self-insurance" means [~~any~~] an arrangement under which a person provides for spreading its own risks by a systematic plan.

(a) Except as provided in this Subsection [~~(148)~~] (150), "self-insurance" does not include an arrangement under which a number of persons spread their risks among themselves.

(b) "Self-insurance" includes:

(i) an arrangement by which a governmental entity undertakes to indemnify [~~its employees~~] an employee for liability arising out of the [~~employees'~~] employee's employment; and

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

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

[~~(149)~~] (151) "Sell" means to exchange a contract of insurance:

(a) by any means;

(b) for money or its equivalent; and

(c) on behalf of an insurance company.

[~~(150)~~] (152) "Short-term care insurance" means [~~any~~] an insurance policy or rider advertised, marketed, offered, or designed to provide coverage that is similar to long-term care insurance, but that provides coverage for less than 12 consecutive months for each covered person.

[~~(151)~~] (153) "Significant break in coverage" means a period of 63 consecutive days during each of which an individual does not have [~~any~~] creditable coverage.

[~~(152)~~] (154) "Small employer," in connection with a health benefit plan, means an employer who, with respect to a calendar year and to a plan year:

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

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

[~~(153)~~] (155) "Special enrollment period," in connection with a health benefit plan, has the same meaning as provided in federal regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936.

[~~(154)~~] (156) (a) "Subsidiary" of a person means an affiliate controlled by that person either directly or indirectly through one or more affiliates or intermediaries.

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

[~~(155)~~] (157) Subject to Subsection [~~(82)~~] (83)(b), "surety insurance" includes:

(a) a guarantee against loss or damage resulting from the failure of [~~principals~~] a principal to pay or perform [~~their~~] the principal's obligations to a creditor or other obligee;

(b) bail bond insurance; and

(c) fidelity insurance.

[~~(156)~~] (158) (a) "Surplus" means the excess of assets over the sum of paid-in capital and liabilities.

(b) (i) "Permanent surplus" means the surplus of a mutual insurer that [~~has been~~] is

designated by the insurer as permanent.

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

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

(c) "Excess surplus" means:

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

(A) that amount of an insurer's or health organization's total adjusted capital, as defined in Subsection [~~(159)~~] (161), that exceeds the product of:

(I) 2.5; and

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

(B) that amount of an insurer's or health organization's total adjusted capital, as defined in Subsection [~~(159)~~] (161), that exceeds the product of:

(I) 3.0; and

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

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

(A) 1.5; and

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

[~~(157)~~] (159) "Third party administrator" or "administrator" means [~~any~~] a person who collects charges or premiums from, or who, for consideration, adjusts or settles claims of residents of the state in connection with insurance coverage, annuities, or service insurance coverage, except:

(a) a union on behalf of its members;

(b) a person administering [~~any~~] a:

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

1974;

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

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

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

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

(e) a person:

(i) licensed or exempt from licensing under:

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

(B) Chapter 26, Insurance Adjusters; and

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

[~~(158)~~] (160) "Title insurance" means the insuring, guaranteeing, or indemnifying of [~~owners~~] an owner of real or personal property or the [~~holders~~] holder of liens or encumbrances on that property, or others interested in the property against loss or damage suffered by reason of liens or encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity or unenforceability of any liens or encumbrances on the property.

[~~(159)~~] (161) "Total adjusted capital" means the sum of an insurer's or health organization's statutory capital and surplus as determined in accordance with:

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

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

[~~(160)~~] (162) (a) "Trustee" means "director" when referring to the board of directors of a corporation.

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

[~~(161)~~] (163) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted insurer" means an insurer:

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

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

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

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

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

[~~(162)~~] (164) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

[~~(163)~~] (165) "Vehicle liability insurance" means insurance against liability resulting from or incident to ownership, maintenance, or use of [~~any~~] a land vehicle or aircraft, exclusive of a vehicle comprehensive [~~and~~] or vehicle physical damage [~~coverages~~] coverage under Subsection [~~(134)~~] (135).

[~~(164)~~] (166) "Voting security" means a security with voting rights, and includes [~~any~~] a security convertible into a security with a voting right associated with the security.

[~~(165)~~] (167) "Waiting period" for a health benefit plan means the period that must pass before coverage for an individual, who is otherwise eligible to enroll under the terms of the health benefit plan, can become effective.

[~~(166)~~] (168) "Workers' compensation insurance" means:

(a) insurance for indemnification of [~~employers~~] an employer against liability for compensation based on:

(i) a compensable accidental [~~injuries~~] injury; and

(ii) occupational disease disability;

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

(c) insurance assuring to [~~the persons~~] a person entitled to workers' compensation benefits the compensation provided by law.

Section 2. Section **31A-2-203** is amended to read:

31A-2-203. Examinations and alternatives.

(1) (a) Whenever the commissioner [~~considers it necessary in order to inform the~~

~~commissioner about any~~] determines that information is needed about a matter related to the enforcement of this title, the commissioner may examine the affairs and condition of:

(i) a licensee under this title;

(ii) an applicant for a license under this title;

(iii) a person or organization of persons doing or in process of organizing to do an insurance business in this state; or

(iv) a person who is not, but should be, licensed under this title.

(b) When reasonably necessary for an examination under Subsection (1)(a), the commissioner may examine:

(i) so far as [~~they relate~~] it relates to the examinee, [~~the accounts, records, documents, or evidences of transactions~~] an account, record, document, or evidence of a transaction of:

(A) the insurer or other licensee;

(B) [~~any~~] an officer or other person who has executive authority over or is in charge of any segment of the examinee's affairs; or

(C) [~~any~~] an affiliate of the examinee; or

(ii) [~~any~~] a third party model or product used by the examinee.

(c) (i) On demand, [~~each~~] an examinee under Subsection (1)(a) shall make available to the commissioner for examination:

(A) [~~any of~~] the examinee's own [~~accounts, records, files, documents, or evidences of transactions~~] account, record, file, document, or evidence of a transaction; and

(B) to the extent reasonably necessary for an examination, [~~the accounts, records, files, documents, or evidences of transactions of any persons~~] an account, record, file, document, or evidence of a transaction of a person described under Subsection (1)(b).

(ii) Except as provided in Subsection (1)(c)(iii), failure to make [~~the documents~~] an item described in Subsection (1)(c)(i) available is concealment of records under Subsection 31A-27a-207(1)(e).

(iii) If the examinee is unable to obtain [~~accounts, records, files, documents, or evidences of transactions from persons~~] an account, record, file, document, or evidence of a transaction from a person described under Subsection (1)(b), that failure is not concealment of records if the examinee immediately terminates the relationship with the other person.

(d) (i) Neither the commissioner nor an examiner may remove [~~any~~] an account,

record, file, document, evidence of a transaction, or other property of the examinee from the examinee's offices unless:

(A) the examinee consents in writing; or

(B) a court grants permission.

(ii) The commissioner may make and remove [~~copies or abstracts~~] a copy or abstract of the following described in Subsection (1)(d)(i):

(A) an account;

(B) a record;

(C) a file;

(D) a document;

(E) evidence of a transaction; or

(F) other property.

(2) (a) Subject to the other provisions of this section, the commissioner shall examine as needed and as otherwise provided by law:

(i) every insurer, both domestic and nondomestic;

(ii) every licensed rate service organization; and

(iii) any other licensee.

(b) The commissioner shall examine [~~insurers~~] an insurer, both domestic and nondomestic, no less frequently than once every five years, but the commissioner may use in lieu [~~examinations~~] an examination under Subsection (4) to satisfy this requirement.

(c) The commissioner shall revoke the certificate of authority of an insurer or the license of a rate service organization that has not been examined, or submitted an acceptable in lieu report under Subsection (4), within the past five years.

(d) (i) Any 25 persons who are policyholders, shareholders, or creditors of a domestic insurer may by verified petition demand a hearing under Section 31A-2-301 to determine whether the commissioner should conduct an unscheduled examination of the insurer.

(ii) Persons demanding the hearing under this Subsection (2)(d) shall be given an opportunity in the hearing to present evidence that an examination of the insurer is necessary.

(iii) If the evidence justifies an examination, the commissioner shall order an examination.

(e) (i) [~~When~~] If the board of directors of a domestic insurer requests that the

commissioner examine the insurer, the commissioner shall examine the insurer as soon as reasonably possible.

(ii) If the examination requested under this Subsection (2)(e) is conducted within two years after completion of a comprehensive examination by the commissioner, costs of the requested examination may not be deducted from premium taxes under Section 59-9-102 unless the commissioner's order specifically provides for the deduction.

(f) [~~Bail~~] A bail bond surety [~~companies~~] company, as defined in Section 31A-35-102, [~~are exempted~~] is exempt from:

(i) the five-year examination requirement in Subsection (2)(b);

(ii) the revocation under Subsection (2)(c); and

(iii) Subsections (2)(d) and (2)(e).

(3) (a) The commissioner may order an independent audit or examination by one or more technical experts, including a certified public [~~accountants and actuaries~~] accountant or actuary:

(i) in lieu of all or part of an examination under Subsection (1) or (2); or

(ii) in addition to an examination under Subsection (1) or (2).

(b) [~~Any~~] An audit or evaluation under this Subsection (3) is subject to Subsection (5), Section 31A-2-204, and Subsection 31A-2-205(4).

(4) (a) In lieu of all or [~~any~~] a part of an examination under this section, the commissioner may accept the report of an examination made by:

(i) the insurance department of another state; or

(ii) another government agency in:

(A) this state;

(B) the federal government; or

(C) another state.

(b) An examination by the commissioner under Subsection (1) or (2) or accepted by the commissioner under this Subsection (4) may use:

(i) an audit already made by a certified public accountant; or

(ii) an actuarial evaluation made by an actuary approved by the commissioner.

(5) (a) An examination may be comprehensive or limited with respect to the examinee's affairs and condition. The commissioner shall determine the nature and scope of

each examination, taking into account all relevant factors, including:

(i) the length of time the examinee has been licensed in this state;

(ii) the nature of the business being examined;

(iii) the nature of the accounting or other records available;

(iv) one or more reports from:

(A) independent auditors; and

(B) self-certification entities; and

(v) the nature of examinations performed elsewhere.

(b) The examination of an alien insurer [~~shall be~~] is limited to one or more insurance transactions and assets in the United States, unless the commissioner orders otherwise after finding that extraordinary circumstances necessitate a broader examination.

(6) To effectively administer this section, the commissioner:

(a) shall:

(i) maintain one or more effective financial condition and market regulation surveillance systems including:

(A) financial and market analysis; and

(B) a review of insurance regulatory information system reports;

(ii) employ a priority scheduling method that focuses on insurers and other licensees most in need of examination; and

(iii) use examination management techniques similar to those outlined in the Financial Condition Examination Handbook of the National Association of Insurance Commissioners; and

(b) in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, may make rules pertaining to [~~the~~] a financial condition and market regulation surveillance [~~systems~~] system.

Section 3. Section **31A-2-403** is amended to read:

31A-2-403. Title and Escrow Commission created.

(1) [~~(a)~~] There is created within the department the Title and Escrow Commission that is comprised of five members appointed by the governor with the consent of the Senate as follows:

[~~(i)~~] (a) four members shall each:

[~~(A)~~] (i) be or have been licensed under the title insurance line of authority; [~~and~~]

[~~(B)~~] (ii) as of the day on which the member is appointed, be or have been licensed with the search or escrow subline of authority for at least five years; and

(iii) as of the day on which the member is appointed, not be from the same county as another member appointed under this Subsection (1)(a); and

[~~(ii)~~] (b) one member shall be a member of the general public from any county in the state.

[~~(b) No more than one commission member may be appointed from:~~]

[~~(i) any county in the state; or~~]

[~~(ii) any single company.~~]

(2) (a) Subject to Subsection (2)(c), [~~each~~] a member of the commission shall file with the department a disclosure of any position of employment or ownership interest that the member of the commission has with respect to [~~any~~] a person that is subject to the jurisdiction of the department.

(b) The disclosure statement required by this Subsection (2) shall be:

(i) filed by no later than the day on which the person begins that person's appointment; and

(ii) amended when a significant change occurs in any matter required to be disclosed under this Subsection (2).

(c) A member of the commission is not required to disclose an ownership interest that the member of the commission has if the ownership interest is held as part of a mutual fund, trust, or similar investment.

(3) (a) Except as required by Subsection (3)(b), as terms of current commission members expire, the governor shall appoint each new member to a four-year term ending on June 30.

(b) Notwithstanding the requirements of Subsection (3)(a), the governor shall, at the time of appointment, adjust the length of terms to ensure that the terms of the commission members are staggered so that approximately half of the commission is appointed every two years.

(c) A commission member may not serve more than one consecutive term.

(d) When a vacancy occurs in the membership for any reason, the governor, with the

consent of the Senate, shall appoint a replacement [~~shall be appointed~~] for the unexpired term.

(4) (a) A member of the commission may not receive compensation or benefits for the member's services, but may receive per diem and expenses incurred in the performance of the member's official duties at the rates established by the Division of Finance under Sections 63A-3-106 and 63A-3-107.

(b) A member may decline to receive per diem and expenses for the member's service.

(5) Members of the commission shall annually select one member to serve as chair.

(6) (a) The commission shall meet at least monthly.

(b) The commissioner may call additional meetings:

(i) at the commissioner's discretion;

(ii) upon the request of the chair of the commission; or

(iii) upon the written request of three or more commission members.

(c) (i) Three members of the commission constitute a quorum for the transaction of business.

(ii) The action of a majority of the members when a quorum is present is the action of the commission.

(7) The department shall staff the commission.

Section 4. Section **31A-4-102** is amended to read:

31A-4-102. Qualified insurers.

(1) A person may not conduct an insurance business in Utah[~~, either~~] in person, through [~~agents or brokers, or~~] an agent, through a broker, through the mail, or [~~any other~~] through another method of communication, except:

(a) an insurer:

(i) authorized to do business in Utah under [~~Title 31A,~~] Chapter 5, 7, 8, 9, 10, 11, 13, or 14[~~,~~]; and

(ii) within the limits of its certificate of authority;

(b) a joint underwriting group under Section 31A-2-214 or 31A-20-102;

(c) an insurer doing business under Section 31A-15-103;

(d) a person who[~~, pursuant to Section 31A-1-105,~~] submits to the commissioner a certificate from the United States Department of Labor, or such other evidence as satisfies the commissioner, that the laws of Utah are preempted with respect to specified activities of that

person by Section 514 of the Employee Retirement Income Security Act of 1974 or other federal law; or

(e) a person exempt from [~~the application of the Insurance Code~~] this title under Section 31A-1-103 [~~and all other applicable statutes~~] or another applicable statute.

(2) As used in this section, "insurer" includes a bail bond surety company, as defined in Section 31A-35-102.

Section 5. Section **31A-4-106** is amended to read:

31A-4-106. Provision of health care.

(1) As used in this section, "health care provider" has the same definition as in Section 78-14-3.

(2) Except under Subsection (3) or (4), unless authorized to do so or employed by someone authorized to do so under Chapter 5, 7, 8, 9, or 14, a person may not:

(a) directly or indirectly provide health care[~~, or~~];

(b) arrange for[~~,~~] health care;

(c) manage[~~,~~] or administer the provision or arrangement of[~~,~~] health care;

(d) collect advance payments for[~~,~~] health care; or

(e) compensate [~~providers~~] a provider of health care [~~unless authorized to do so or employed by someone authorized to do so under Chapter 5, 7, 8, 9, or 14~~].

(3) Subsection (2) does not apply to:

(a) a natural person or professional corporation that alone or with others professionally associated with the natural person or professional corporation, and without receiving consideration for services in advance of the need for a particular service, provides the service personally with the aid of nonprofessional assistants;

(b) a health care facility as defined in Section 26-21-2 [~~which~~] that:

(i) is licensed or exempt from licensing under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; and

(ii) does not engage in health care insurance as defined under Section 31A-1-301;

(c) a person who files with the commissioner [~~under Section 31A-1-105~~] a certificate from the United States Department of Labor, or other evidence satisfactory to the commissioner, showing that the laws of Utah are preempted under Section 514 of the Employee Retirement Income Security Act of 1974 or other federal law;

(d) a person licensed under Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries, who [~~has arranged~~]:

(i) arranges for the insurance of all services under:

[~~(i)~~] (A) Subsection (2) by an insurer authorized to do business in Utah; or

[~~(ii)~~] (B) Section 31A-15-103; or

[~~(iii)~~] (ii) works for an uninsured employer that complies with Chapter 13, Employee Welfare Funds and Plans; or

(e) an employer that self-funds its obligations to provide health care services or indemnity for its employees if the employer complies with Chapter 13, Employee Welfare Funds and Plans.

(4) A person may not provide administrative or management services for [~~any other~~] another person subject to Subsection (2) and not exempt under Subsection (3) unless the person:

(a) is an authorized insurer under Chapter 5, 7, 8, 9, or 14[~~;~~]; or

(b) complies with Chapter 25, Third Party Administrators.

(5) [~~It is unlawful for any~~] An insurer or person [~~providing, administering, or managing~~] who provides, administers, or manages health care insurance under Chapter 5, 7, 8, 9, or 14 [~~to~~] may not enter into a contract that limits a health care provider's ability to advise the health care provider's patients or clients fully about treatment options or other issues that affect the health care of the health care provider's patients or clients.

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

31A-6a-103. Requirements for doing business.

(1) A service contract may not be issued, sold, or offered for sale in this state unless the service contract is insured under a service contract reimbursement insurance policy issued by:

(a) an insurer authorized to do business in this state; or

(b) a recognized surplus lines carrier.

(2) A captive insurance company may not write a reimbursement policy for a service contract provider that is subject to this chapter.

[~~(2)~~] (3) (a) A service contract may not be issued, sold, or offered for sale unless [~~a true and correct copy of the service contract and the provider's reimbursement insurance policy have been filed with the commissioner. A copy of a contract and policy must be filed~~] the service

contract provider completes the registration process described in this Subsection (3).

(b) To register, a service contract provider shall submit to the department the following:

(i) an application for registration;

(ii) a fee established in accordance with Section 31A-3-103;

(iii) a copy of any service contract that the service contract provider offers in this state; and

(iv) a copy of the service contract provider's reimbursement insurance policy.

(c) A service provider shall submit the information described in Subsection (3)(b) no less than 30 days [~~prior to the issuance, sale offering for sale, or use of the~~] before the day on which the service provider issues, sells, offers for sale, or uses a service contract or reimbursement insurance policy in this state.

[~~(b) Each~~] (d) A service provider shall file any modification of the terms of [~~any~~] a service contract or reimbursement insurance policy [~~must also be filed~~] 30 days [~~prior to its use~~] before the day on which it is used in this state.

[~~(c) Persons~~] (e) A person complying with this chapter [~~are~~] is not required to comply with:

(i) Subsections 31A-21-201(1) and 31A-23a-402(3); or

(ii) Chapter 19a, Utah Rate Regulation Act.

[~~(3)~~] (4) (a) Premiums collected on a service [~~contracts~~] contract are not subject to premium taxes.

(b) Premiums collected by [~~issuers~~] an issuer of a reimbursement insurance [~~policies~~] policy are subject to premium taxes.

[~~(4)~~] (5) A person marketing, selling, or offering to sell a service [~~contracts~~] contract for a service contract [~~providers~~] provider that complies with this chapter is exempt from the licensing requirements of this title.

[~~(5) Service~~] (6) A service contract [~~providers~~] provider complying with this chapter [~~are~~] is not required to comply with:

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

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

(c) Chapter 8, Health Maintenance Organizations and Limited Health Plans;

(d) Chapter 9, Insurance Fraternals;

(e) Chapter 10, Annuities;

(f) Chapter 11, Motor Clubs;

(g) Chapter 12, State Risk Management Fund;

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

(i) Chapter 14, Foreign Insurers;

(j) Chapter 19a, Utah Rate Regulation Act;

(k) Chapter 25, Third Party Administrators; and

(l) Chapter 28, Guaranty Associations.

Section 7. Section **31A-6a-104** is amended to read:

31A-6a-104. Required disclosures.

(1) [~~All~~] A service contract reimbursement insurance [~~policies~~] policy insuring a service [~~contracts~~] contract that is issued, sold, or offered for sale in this state must conspicuously state that, upon failure of the service contract provider to perform under the contract, the issuer of the policy shall:

(a) pay on behalf of the service contract provider any sums the service contract provider is legally obligated to pay according to the service contract provider's contractual obligations under the service contract issued or sold by the service contract provider; or [~~shall~~]

(b) provide the service which the service contract provider is legally obligated to perform, according to the service contract provider's contractual obligations under the service [~~contracts~~] contract issued or sold by the service contract provider.

(2) (a) A service contract may not be issued, sold, or offered for sale in this state unless the service contract contains [~~a statement~~] the following statements in substantially the following form[~~,~~]:

(i) "Obligations of the provider under this service contract are guaranteed under a service contract reimbursement insurance policy. Should the provider fail to pay or provide service on any claim within 60 days after proof of loss has been filed, the contract holder is entitled to make a claim directly against the Insurance Company." [~~The~~]; and

(ii) "This service contract or warranty is subject to limited regulation by the Utah Insurance Department. To file a complaint, contact the Utah Insurance Department."

(b) A service contract or reimbursement insurance policy may not be issued, sold, or

offered for sale in this state unless the contract contains a statement in substantially the following form, "Coverage afforded under this contract is not guaranteed by the Property and Casualty Guaranty Association."

(3) A service contract shall [~~also~~]:

(a) conspicuously state the name [~~and~~], address, and a toll free claims service telephone number of the reimbursement insurer[~~.~~];

[~~(3) The contract must~~] (b) identify the service contract provider, the seller, and the service contract holder[~~.~~];

[~~(4) The contract must~~]

(c) conspicuously state the total purchase price and the terms under which [~~it~~] the service contract is to be paid[~~.~~];

(d) conspicuously state the existence of any deductible amount;

(e) specify the merchandise, service to be provided, and any limitation, exception, or exclusion;

(f) state a term, restriction, or condition governing the transferability of the service contract; and

(g) state a term, restriction, or condition that governs cancellation of the service contract as provided in Sections 31A-21-303 through 31A-21-305 by either the contract holder or service contract provider.

[~~(5)~~] (4) If prior approval of repair work is required, [~~the~~] a service contract must conspicuously state the procedure for obtaining prior approval and for making a claim, including:

(a) a toll free telephone number for claim service; and

(b) a procedure for obtaining reimbursement for emergency repairs performed outside of normal business hours.

[~~(6) The contract must conspicuously state the existence of any deductible amount.~~]

[~~(7) The contract must specify the merchandise, services to be provided and any limitations, exceptions, or exclusions. Any preexisting conditions clause~~]

(5) A preexisting condition clause in a service contract must specifically state which preexisting [~~conditions are~~] condition is excluded from coverage.

[~~(8) The~~] (6) (a) Except as provided in Subsection (6)(c), a service contract must state

the conditions upon which the use of a nonmanufacturers' [~~parts will be~~] part is allowed. [~~Conditions stated~~]

(b) A condition described in Subsection (6)(a) must comply with applicable state and federal laws.

[~~(9) The contract must state any terms, restrictions, or conditions governing the transferability of the service contract.~~]

[~~(10) The contract must state the terms, restrictions, or conditions governing cancellation of the contract by either the contract holder or provider, and must satisfy the provisions of Sections 31A-21-303 through 31A-21-305.~~]

(c) This Subsection (6) does not apply to a home warranty contract.

[~~(11) A service contract or reimbursement insurance policy may not be issued, sold, or offered for sale in this state unless the contract contains a statement in substantially the following form, "Coverage afforded under this contract is not guaranteed by the Property and Casualty Guaranty Association."~~]

Section 8. Section **31A-6a-105** is amended to read:

31A-6a-105. Prohibited acts.

(1) Except as provided in Subsection 31A-6a-104(2), a service contract provider may not use in its name, [~~contracts~~] a contract, or literature:

(a) any of the following words:

(i) "insurance[~~,~~]";

(ii) "casualty[~~,~~]";

(iii) "surety[~~,~~]";

(iv) "mutual[~~,~~]"; or [~~any other words~~]

(v) another word descriptive of the insurance, casualty, or surety business; or

(b) a name deceptively similar to the name or description of [~~any~~]:

(i) an insurance or surety corporation[~~,~~]; or [~~any other~~]

(ii) another service contract provider.

(2) A service contract provider or [~~his~~] the service contract provider's representative may not:

(a) make, permit, or cause to be made [~~any~~] a false or misleading statement[~~, or~~] in connection with the sale, offer to sell, or advertisement of a service contract; or

(b) deliberately omit [~~any~~] a material statement that would be considered misleading if omitted, in connection with the sale, offer to sell, or advertisement of a service contract.

(3) A bank, savings and loan association, insurance company, or other lending institution may not require the purchase of a service contract as a condition of a loan.

(4) A service contract provider may not sell, or be the obligated party for:

(a) a guaranteed asset protection waiver; or

(b) a debt cancellation agreement.

Section 9. Section **31A-22-404** is amended to read:

31A-22-404. Suicide.

(1) (a) Suicide is not a defense to a claim under a life insurance policy that [~~has been~~] is in force as to a policyholder or certificate holder for two years from the date of issuance of the later of:

(i) the policy; or

(ii) the certificate.

(b) Subsection (1)(a) applies whether:

(i) the suicide [~~was~~] is voluntary or involuntary; or

(ii) the insured [~~was~~] is sane or insane.

(c) If a suicide occurs within the two-year period described in Subsection (1)(a), the insurer shall pay to the beneficiary an amount not less than the premium paid [~~for the life insurance policy.~~] less the following:

(i) a dividend paid;

(ii) an indebtedness; and

(iii) a partial withdrawal.

(2) (a) If after a life insurance policy is in effect the policy allows the insured to obtain a death benefit that is larger than when the policy was originally effective for an additional premium, the payment of the additional increment of benefit may be limited in the event of a suicide within a two-year period beginning on the [~~date~~] day on which the increment increase takes effect.

(b) If a suicide occurs within the two-year period described in Subsection (2)(a), the insurer shall pay to the beneficiary an amount not less than the additional premium paid for the additional increment of benefit.

(3) This section does not apply to:

(a) a policy insuring against death by accident only; or

(b) [~~the~~] an accident or double indemnity [~~provisions~~] provision of an insurance policy.

Section 10. Section **31A-22-409** is amended to read:

31A-22-409. Standard Nonforfeiture Law for Individual Deferred Annuities.

(1) This section is known as the "Standard Nonforfeiture Law for Individual Deferred Annuities."

(2) This section does not apply to:

(a) [~~any~~] reinsurance;

(b) a group annuity purchased under a retirement plan or plan of deferred compensation:

(i) established or maintained by:

(A) an employer, including a partnership or sole proprietorship;

(B) an employee organization; or

(C) both an employer and an employee organization; and

(ii) other than a plan providing individual retirement accounts or individual retirement annuities under Section 408, Internal Revenue Code;

(c) a premium deposit fund;

(d) a variable annuity;

(e) an investment annuity;

(f) an immediate annuity;

(g) a deferred annuity contract after annuity payments have commenced;

(h) a reversionary annuity; or

(i) [~~any~~] a contract that [~~shall be~~] is delivered outside this state through an agent or other representative of the company issuing the contract.

(3) (a) If a policy is issued after this section takes effect as set forth in Subsection (15), a contract of annuity, except as stated in Subsection (2), may not be delivered or issued for delivery in this state unless the contract of annuity contains in substance:

(i) the provisions described in Subsection (3)(b); or

(ii) provisions corresponding to the provisions described in Subsection (3)(b) that in the opinion of the commissioner are at least as favorable to the contractholder, governing

cessation of payment of consideration under the contract.

(b) Subsection (3)(a)(i) requires the following provisions:

(i) the company shall grant a paid-up annuity benefit on a plan stipulated in the contract of such a value as specified in Subsections (7), (8), (9), (10), and (12):

(A) upon cessation of payment of consideration under a contract; or

(B) upon a written request of the contract owner;

(ii) if a contract provides for a lump-sum settlement at maturity, or at any other time, upon surrender of the contract at or before the commencement of any annuity payments, the company shall pay in lieu of any paid-up annuity benefit a cash surrender benefit of such amount as is specified in Subsections (7), (8), (10), and (12);

(iii) a statement of the mortality table, if any, and interest rates used in calculating any of the following that are guaranteed under the contract:

(A) minimum paid-up annuity [~~benefits~~] benefit;

(B) cash surrender [~~benefits~~] benefit; or

(C) death [~~benefits~~] benefit;

(iv) sufficient information to determine the amounts of the benefits described in Subsection (3)(b)(iii);

(v) a statement that any paid-up annuity, cash surrender, or death benefits that may be available under the contract are not less than the minimum benefits required by [~~any~~] a statute of the state in which the contract is delivered; and

(vi) an explanation of the manner in which [~~the benefits~~] a benefit described in Subsection (3)(b)(v) [~~are~~] is altered by the existence of any:

(A) additional amounts credited by the company to the contract;

(B) indebtedness to the company on the contract; or

(C) prior withdrawals from or partial surrender of the contract.

(c) Notwithstanding the requirements of this Subsection (3), [~~any~~] a deferred annuity contract may provide that if no consideration [~~has been~~] is received under a contract for a period of two full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from consideration paid before the period would be less than $20 monthly:

(i) the company may at the company's option terminate the contract by payment in cash

of the then present value of such portion of the paid-up annuity benefit, calculated on the basis of the mortality table specified in the contract, if any, and the interest rate specified in the contract for determining the paid-up annuity benefit; and

(ii) the payment described in Subsection (3)(c)(i), relieves the company of any further obligation under the contract.

(d) A company may reserve the right to defer the payment of cash surrender benefit for a period not to exceed six months after demand for the payment of the cash surrender benefit with surrender of the contract.

(4) For a policy issued before June 1, 2006, the minimum values as specified in Subsections (7), (8), (9), (10), and (12) of any paid-up annuity, cash surrender, or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as established in this Subsection (4).

(a) (i) With respect to [~~contracts~~] a contract providing for flexible considerations, the minimum nonforfeiture amount at any time at or before the commencement of any annuity payments shall be equal to an accumulation up to such time, at a rate of interest of 3% per annum of percentages of the net considerations paid prior to such time:

(A) decreased by the sum of:

(I) any prior withdrawals from or partial surrenders of the contract accumulated at a rate of interest of 3% per annum; and

(II) the amount of any indebtedness to the company on the contract, including interest due and accrued; and

(B) increased by any existing additional amounts credited by the company to the contract.

(ii) For purposes of this Subsection (4)(a), the net consideration for a given contract year used to define the minimum nonforfeiture amount shall be:

(A) an amount not less than zero; and

(B) equal to the corresponding gross considerations credited to the contract during that contract year less:

(I) an annual contract charge of $30; and

(II) a collection charge of $1.25 per consideration credited to the contract during that contract year.

(iii) The percentages of net considerations shall be:

(A) 65% of the net consideration for the first contract year; and

(B) 87-1/2% of the net considerations for the second and later contract years.

(iv) Notwithstanding Subsection (4)(a)(iii), the percentage shall be 65% of the portion of the total net consideration for any renewal contract year that exceeds by not more than two times the sum of those portions of the net considerations in all prior contract years for which the percentage was 65%.

(b) (i) Except as provided in Subsections (4)(b)(ii) and (iii), with respect to [~~contracts~~] a contract providing for fixed scheduled consideration, minimum nonforfeiture amounts shall be:

(A) calculated on the assumption that considerations are paid annually in advance; and

(B) defined as for contracts with flexible considerations that are paid annually.

(ii) The portion of the net consideration for the first contract year to be accumulated shall be equal to an amount that is the sum of:

(A) 65% of the net consideration for the first contract year; and

(B) 22-1/2% of the excess of the net consideration for the first contract year over the lesser of the net considerations for:

(I) the second contract year; and

(II) the third contract year.

(iii) The annual contract charge shall be the lesser of $30 or 10% of the gross annual consideration.

(c) With respect to [~~contracts~~] a contract providing for a single consideration payment, minimum nonforfeiture amounts shall be defined as for contracts with flexible considerations except that:

(i) the percentage of net consideration used to determine the minimum nonforfeiture amount shall be equal to 90%; and

(ii) the net consideration shall be the gross consideration less a contract charge of $75.

(5) For a policy issued on or after June 1, 2006, the minimum values as specified in Subsections (7), (8), (9), (10), and (12) of any paid-up annuity, cash surrender, or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as established in this Subsection (5).

(a) The minimum nonforfeiture amount at any time at or before the commencement of any annuity payments shall be equal to an accumulation up to such time, at rates of interest as indicated in Subsection (5)(b), of 87-1/2% of the gross considerations paid before such time decreased by the sum of:

(i) any prior withdrawals from or partial surrenders of the contract accumulated at rates of interest as indicated in Subsection (5)(b);

(ii) an annual contract charge of $50, accumulated at rates of interest as indicated in Subsection (5)(b);

(iii) any premium tax paid by the company for the contract, accumulated at rates of interest as indicated in Subsection (5)(b); and

(iv) the amount of any indebtedness to the company on the contract, including interest due and accrued.

(b) (i) The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of interest determined as the lesser of:

(A) 3% per annum; and

(B) the five-year Constant Maturity Treasury Rate reported by the Federal Reserve, rounded to the nearest 1/20th of 1%, as of a date or average over a period no longer than 15 months prior to the contract issue date or redetermination date under Subsection (5)(b)(iii):

(I) reduced by 125 basis points; and

(II) where the resulting interest rate is not less than 1%.

(ii) The interest rate shall apply for an initial period and may be redetermined for additional periods.

(iii) (A) If the interest rate will be reset, the contract shall state:

(I) the initial period;

(II) the redetermination date;

(III) the redetermination basis; and

(IV) the redetermination period.

(B) The basis is the date or average over a specified period that produces the value of the five-year Constant Maturity Treasury Rate to be used at each redetermination date.

(c) (i) During the period or term that a contract provides substantive participation in an equity indexed benefit, the reduction described in Subsection (5)(b)(i)(B)(I) may be increased

by up to an additional 100 basis points to reflect the value of the equity index benefit.

(ii) The present value of the additional reduction at the contract issue date and at each redetermination date may not exceed the market value of the benefit.

(iii) (A) The commissioner may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit.

(B) If the demonstration required under Subsection (5)(c)(iii)(A) is not made to the satisfaction of the commissioner, the commissioner may disallow or limit the additional reduction.

(6) Notwithstanding Subsection (4), for a policy issued on or after June 1, 2004 and before June 1, 2006, at the election of a company, on a contract form-by-contract form basis, the minimum values as specified in Subsections (7), (8), (9), (10), and (12) of any paid-up annuity, cash surrender, or death benefits available under an annuity contract may be based upon minimum nonforfeiture amounts as established in Subsection (5).

(7) (a) [~~Any~~] A paid-up annuity benefit available under a contract shall be such that the contract's present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date.

(b) The present value described in Subsection (7)(a) shall be computed using the mortality table, if any, and the interest rate specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

(8) (a) For [~~contracts~~] a contract that [~~provide~~] provides cash surrender benefits, the cash surrender benefits available before maturity may not be less than the present value as of the date of surrender of that portion of the cash surrender value that would be provided under the contract at maturity arising from considerations paid before the time of cash surrender:

(i) decreased by the amount appropriate to reflect any prior withdrawals from or partial surrender of the contract;

(ii) decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued; and

(iii) increased by any existing additional amounts credited by the company to the contract.

(b) For purposes of this Subsection (8), the present value [~~being~~] is to be calculated on the basis of an interest rate not more than 1% higher than the interest rate specified in the

contract for accumulating the net considerations to determine the maturity value.

(c) In no event shall [~~any~~] a cash surrender benefit be less than the minimum nonforfeiture amount at that time.

(d) The death benefit under a contract described in Subsection (8)(a) shall be at least equal to the cash surrender benefit.

(9) (a) For [~~contracts~~] a contract that [~~do~~] does not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity may not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid before the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity increased by any existing additional amounts credited by the company to the contract.

(b) For purposes of [~~this~~] Subsection (9)(a), the present value [~~being calculated~~] for the period prior to the maturity date is to be calculated on the basis of the interest rate specified in the contract for accumulating the net considerations to determine maturity value.

(c) For [~~contracts~~] a contract that [~~do~~] does not provide [~~any~~] a death [~~benefits~~] benefit before commencement of any annuity payments, the present values shall be calculated on the basis of the interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit.

(d) In no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.

(10) (a) For the purpose of determining the benefits calculated under Subsections (8) and (9), the maturity date shall be considered to be [~~the latest date~~]:

(i) in the case of an annuity contract issued on or before May 5, 2002, under which an election may be made to have an annuity payment commence at an optional maturity date, the latest date for which an election is permitted by the contract, except that it may not be considered to be later than the later of:

[~~(i)~~] (A) the anniversary of the contract next following the [~~annuitant's 70th birthday~~] day on which the annuitant becomes 70 years of age; or

[~~(ii)~~] (B) the tenth anniversary of the contract[~~.~~]; or

(ii) in the case of an annuity contract issued on or after May 6, 2002, the latest date permitted by the contract, except that it may not be considered to be later than the later of:

(A) the anniversary of the contract next following the day on which the annuitant becomes 70 years of age; or

(B) the tenth anniversary of the contract.

(b) In the case of an annuity contract issued on or after May 6, 2002:

[~~(b) For~~] (i) for a contract that provides cash surrender benefits, the cash surrender value on or past the maturity date shall be equal to the amount used to determine the annuity benefit payments[~~.~~]; and

[~~(c) A~~] (ii) a surrender charge may not be imposed on or past maturity.

(11) [~~Any~~] A contract that does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount before the commencement of any annuity payments shall include a statement in a prominent place in the contract that these benefits are not provided.

(12) [~~Any~~] A paid-up annuity, cash surrender, or death [~~benefits~~] benefit available at any time, other than on the contract anniversary under [~~any~~] a contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

(13) (a) For [~~any~~] a contract that provides, within the same contract by rider or supplemental contract provisions, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall:

(i) be equal to the sum of:

(A) the minimum nonforfeiture benefits for the annuity portion; and

(B) the minimum nonforfeiture benefits, if any, for the life insurance portion; and

(ii) computed as if each portion were a separate contract.

(b) (i) Notwithstanding Subsections (7), (8), (9), (10), and (12), additional benefits payable, as described in Subsection (13)(b)(ii), and consideration for the additional benefits payable, shall be disregarded in ascertaining, if required by this section:

(A) the minimum nonforfeiture amounts;

(B) paid-up annuity;

(C) cash surrender; and

(D) death benefits.

(ii) For purposes of this Subsection (13), an additional benefit is a benefit payable:

(A) in the event of total and permanent disability;

(B) as reversionary annuity or deferred reversionary annuity benefits; or

(C) as other policy benefits additional to life insurance, endowment, and annuity benefits.

(iii) The inclusion of the additional benefits described in this Subsection (13) may not be required in any paid-up benefits, unless the additional benefits separately would require:

(A) minimum nonforfeiture amounts;

(B) paid-up annuity;

(C) cash surrender; and

(D) death benefits.

(14) In accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, the commissioner may adopt rules necessary to implement this section, including:

(a) ensuring that any additional reduction under Subsection (5)(c) is consistent with the requirements imposed by Subsection (5)(c); and

(b) providing for adjustments in addition to the adjustments allowed under Subsection (5)(c) to the calculation of minimum nonforfeiture amounts for:

(i) [~~contracts~~] a contract that [~~provide~~] provides substantive participation in an equity index benefit; and

(ii) [~~other contracts~~] a contract for which the commissioner determines adjustments are justified.

(15) (a) After this section takes effect, [~~any~~] a company may file with the commissioner a written notice of its election to comply with this section after a specified date before July 1, 1988.

(b) This section applies to annuity contracts of a company issued on or after the date the company specifies in the notice.

(c) If a company makes no election under Subsection (15)(a), the operative date of this section for such company is July 1, 1988.

Section 11. Section **31A-22-428** is enacted to read:

31A-22-428. Interest payable on life insurance proceeds.

(1) For a life insurance policy delivered or issued for delivery in this state on or after May 5, 2008, the insurer shall pay interest on the death proceeds payable upon the death of the insured.

(2) (a) For the period beginning on the date of death and ending the day before the day described in Subsection (3)(b), interest under Subsection (1) shall accrue at a rate no less than:

(i) the rate applicable to policy funds left on deposit; or

(ii) if there is no rate described in Subsection (2)(a)(i), at the Two Year Treasury Constant Maturity Rate as published by the Federal Reserve.

(b) The rate described in Subsection (2)(a) is the rate in effect on the day on which the death occurs.

(c) Interest is payable until the day on which the claim is paid.

(3) (a) Unless the claim is paid, beginning on the day described in Subsection (3)(b) and ending the day on which the claim is paid, interest shall accrue at the rate in Subsection (2) plus additional interest at the rate of 10% annually.

(b) Interest accrues under Subsection (3)(a) beginning with the day that is 31 days from the latest of:

(i) the day on which the insurer receives proof of death;

(ii) the day on which the insurer receives sufficient information to determine:

(A) liability;

(B) the extent of the liability; and

(C) the appropriate payee legally entitled to the proceeds; and

(iii) the day on which:

(A) legal impediments to payment of proceeds that depend on the action of parties other than the insurer are resolved; and

(B) the insurer receives sufficient evidence of the resolution of the legal impediments described in Subsection (3)(b)(iii)(A).

Section 12. Section **31A-22-610.6** is enacted to read:

31A-22-610.6. Special enrollment for individuals receiving premium assistance.

(1) As used in this section:

(a) "Premium assistance" means assistance under Title 26, Chapter 18, Medical Assistance Act, in the payment of premium.

(b) "Qualified beneficiary" means an individual who is approved to receive a premium assistance.

(2) Subject to the other provisions in this section, an individual may enroll under this section at a time outside of an employer health benefit plan open enrollment period, regardless of previously waiving coverage, if the individual is:

(a) a qualified beneficiary who is eligible for coverage as an employee under the employer health benefit plan; or

(b) a dependent of the qualified beneficiary who is eligible for coverage under the employer health benefit plan.

(3) To be eligible to enroll outside of an open enrollment period, an individual described in Subsection (2) shall enroll in the employer health benefit plan by no later than 30 days from the day on which the qualified beneficiary receives written notification that the qualified beneficiary is eligible to receive premium assistance.

(4) An individual described in Subsection (2) may enroll under this section only in an employer health benefit plan that is available at the time of enrollment to similarly situated eligible employees or dependents of eligible employees.

(5) Coverage under an employer health benefit plan for an individual described in Subsection (2) may begin as soon as the first day of the month immediately following enrollment of the individual in accordance with this section.

(6) This section does not modify any requirement related to premiums that applies under an employer health benefit plan to a similarly situated eligible employee or dependent of an eligible employee under the employer health benefit plan.

(7) An employer health benefit plan may require an individual described in Subsection (2) to satisfy a preexisting condition waiting period that:

(a) is allowed under the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936; and

(b) is not longer than 12 months.

Section 13. Section **31A-22-613.5** is amended to read:

31A-22-613.5. Price and value comparisons of health insurance -- Basic Health Care Plan.

(1) This section applies generally to all health insurance policies and health

maintenance organization contracts.

(2) The commissioner shall adopt a Basic Health Care Plan consistent with this section to be offered under the open enrollment provisions of Chapter 30, Individual, Small Employer, and Group Health Insurance Act.

(3) (a) The commissioner shall promote informed consumer behavior and responsible health insurance and health plans by requiring an insurer issuing health insurance policies or health maintenance organization contracts to provide to all enrollees, prior to enrollment in the health benefit plan or health insurance policy, written disclosure of:

(i) restrictions or limitations on prescription drugs and biologics including the use of a formulary and generic substitution; and

(ii) coverage limits under the plan.

(b) In addition to the requirements of Subsections (3)(a) and (d), an insurer described in Subsection (3)(a) shall submit the written disclosure required by this Subsection (3) to the commissioner:

(i) upon commencement of operations in the state; and

(ii) anytime the insurer amends any of the following described in Subsection (3)(a):

(A) treatment policies;

(B) practice standards;

(C) restrictions; or

(D) coverage limits of the insurer's health benefit plan or health insurance policy.

(c) The commissioner may adopt rules to implement the disclosure requirements of this Subsection (3), taking into account:

(i) business confidentiality of the insurer;

(ii) definitions of terms; and

(iii) the method of disclosure to enrollees.

(d) If under Subsection (3)(a)(i) a formulary is used, the insurer shall make available to prospective enrollees and maintain evidence of the fact of the disclosure of:

(i) the drugs included;

(ii) the patented drugs not included; and

(iii) any conditions that exist as a precedent to coverage.

(4) The Basic Health Care Plan adopted by the commissioner under this section shall

provide for:

(a) a lifetime maximum benefit per person not to exceed $1,000,000;

(b) an annual maximum benefit per person not to exceed $300,000;

(c) an out-of-pocket maximum [~~per person not to exceed $5,000,~~] of cost-sharing features:

(i) including [~~the~~]:

(A) a deductible;

(B) a copayment; and

(C) coinsurance;

(ii) not to exceed $5,000 per person; and

(iii) for family coverage, not to exceed three times the per person out-of-pocket maximum provided in Subsection (4)(c)(ii);

(d) in relation to its cost-sharing features:

(i) a deductible of:

(A) not less than $1,500 per person for major medical expenses; and

(B) for family coverage, not to exceed three times the per person deductible for major medical expenses under Subsection (4)(d)(i)(A); and

(ii) (A) a copayment of not less than:

(I) $25 per visit for office services; and

(II) $150 per visit to an emergency room; or

(B) coinsurance of not less than:

(I) 20% per visit for office services; and

(II) 20% per visit for an emergency room; and

(e) in relation to cost-sharing features for prescription drugs:

(i) (A) a deductible of not less than $500 per person; and

(B) for family coverage, not to exceed three times the per person deductible provided in Subsection (4)(e)(i)(A); and

(ii) (A) a copayment of not less than:

(I) the lesser of the cost of the prescription drug or $15 for the lowest level of cost for prescription drugs;

(II) the lesser of the cost of the prescription drug or $30 for the second level of cost for

prescription drugs; and

(III) the lesser of the cost of the prescription drug or $60 for the highest level of cost for prescription drugs; or

(B) coinsurance of not less than:

(I) the lesser of the cost of the prescription drug or 25% for the lowest level of cost for prescription drugs;

(II) the lesser of the cost of the prescription drug or 40% for the second level of cost for prescription drugs; and

(III) the lesser of the cost of the prescription drug or 60% for the highest level of cost for prescription drugs.

Section 14. Section **31A-22-625** is amended to read:

31A-22-625. Catastrophic coverage of mental health conditions.

(1) As used in this section:

(a) (i) "Catastrophic mental health coverage" means coverage in a health [~~insurance policy~~] benefit plan or health maintenance organization contract that does not impose [~~any~~] a lifetime limit, annual payment limit, episodic limit, inpatient or outpatient service limit, or maximum out-of-pocket limit that places a greater financial burden on an insured for the evaluation and treatment of a mental health condition than for the evaluation and treatment of a physical health condition.

(ii) "Catastrophic mental health coverage" may include a restriction on cost sharing factors, such as deductibles, copayments, or coinsurance, prior to reaching any maximum out-of-pocket limit.

(iii) "Catastrophic mental health coverage" may include one maximum out-of-pocket limit for physical health conditions and another maximum out-of-pocket limit for mental health conditions, provided that, if separate out-of-pocket limits are established, the out-of-pocket limit for mental health conditions may not exceed the out-of-pocket limit for physical health conditions.

(b) (i) "50/50 mental health coverage" means coverage in a health [~~insurance policy~~] benefit plan or health maintenance organization contract that pays for at least 50% of covered services for the diagnosis and treatment of mental health conditions.

(ii) "50/50 mental health coverage" may include a restriction on episodic limits,

inpatient or outpatient service limits, or maximum out-of-pocket limits.

(c) "Large employer" is as defined in Section 31A-1-301.

(d) (i) "Mental health condition" means any condition or disorder involving mental illness that falls under any of the diagnostic categories listed in the Diagnostic and Statistical Manual, as periodically revised.

(ii) "Mental health condition" does not include the following when diagnosed as the primary or substantial reason or need for treatment:

(A) marital or family problem;

(B) social, occupational, religious, or other social maladjustment;

(C) conduct disorder;

(D) chronic adjustment disorder;

(E) psychosexual disorder;

(F) chronic organic brain syndrome;

(G) personality disorder;

(H) specific developmental disorder or learning disability; or

(I) mental retardation.

(e) "Small employer" is as defined in Section 31A-1-301.

(2) (a) At the time of purchase and renewal, an insurer shall offer to each small employer that it insures or seeks to insure a choice between catastrophic mental health coverage and 50/50 mental health coverage.

(b) In addition to Subsection (2)(a), an insurer may offer to provide:

(i) catastrophic mental health coverage, 50/50 mental health coverage, or both at levels that exceed the minimum requirements of this section; or

(ii) coverage that excludes benefits for mental health conditions.

(c) A small employer may, at its option, choose either catastrophic mental health coverage, 50/50 mental health coverage, or coverage offered under Subsection (2)(b), regardless of the employer's previous coverage for mental health conditions.

(d) An insurer is exempt from the 30% index rating restriction in Subsection 31A-30-106(1)(b) and, for the first year only that catastrophic mental health coverage is chosen, the 15% annual adjustment restriction in Subsection 31A-30-106(1)(c)(ii), for any small employer with 20 or less enrolled employees who chooses coverage that meets or

exceeds catastrophic mental health coverage.

(3) (a) At the time of purchase and renewal of a health benefit plan, an insurer shall offer catastrophic mental health coverage to each large employer that it insures or seeks to insure.

(b) In addition to Subsection (3)(a), an insurer may offer to provide catastrophic mental health coverage at levels that exceed the minimum requirements of this section.

(c) A large employer may, at its option, choose either catastrophic mental health coverage, coverage that excludes benefits for mental health conditions, or coverage offered under Subsection (3)(b).

(4) (a) An insurer may provide catastrophic mental health coverage through a managed care organization or system in a manner consistent with the provisions in Chapter 8, Health Maintenance Organizations and Limited Health Plans, regardless of whether the policy or contract uses a managed care organization or system for the treatment of physical health conditions.

(b) (i) Notwithstanding any other provision of this title, an insurer may:

(A) establish a closed panel of providers for catastrophic mental health coverage; and

(B) refuse to provide any benefit to be paid for services rendered by a nonpanel provider unless:

(I) the insured is referred to a nonpanel provider with the prior authorization of the insurer; and

(II) the nonpanel provider agrees to follow the insurer's protocols and treatment guidelines.

(ii) If an insured receives services from a nonpanel provider in the manner permitted by Subsection (4)(b)(i)(B), the insurer shall reimburse the insured for not less than 75% of the average amount paid by the insurer for comparable services of panel providers under a noncapitated arrangement who are members of the same class of health care providers.

(iii) Nothing in this Subsection (4)(b) may be construed as requiring an insurer to authorize a referral to a nonpanel provider.

(c) To be eligible for catastrophic mental health coverage, a diagnosis or treatment of a mental health condition must be rendered:

(i) by a mental health therapist as defined in Section 58-60-102; or

(ii) in a health care facility licensed or otherwise authorized to provide mental health services pursuant to Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act, or Title 62A, Chapter 2, Licensure of Programs and Facilities, that provides a program for the treatment of a mental health condition pursuant to a written plan.

(5) The commissioner may [~~disapprove any~~] prohibit a policy or contract that provides mental health coverage in a manner that is inconsistent with [~~the provisions of~~] this section.

(6) The commissioner shall:

(a) adopt rules as necessary to ensure compliance with this section; and

(b) provide general figures on the percentage of contracts and policies that include no mental health coverage, 50/50 mental health coverage, catastrophic mental health coverage, and coverage that exceeds the minimum requirements of this section.

(7) The Health and Human Services Interim Committee shall review:

(a) the impact of this section on insurers, employers, providers, and consumers of mental health services before January 1, 2004; and

(b) make a recommendation as to whether the provisions of this section should be modified and whether the cost-sharing requirements for mental health conditions should be the same as for physical health conditions.

(8) (a) An insurer shall offer catastrophic mental health coverage as part of a health maintenance organization contract that is governed by Chapter 8, Health Maintenance Organizations and Limited Health Plans, that is in effect on or after January 1, 2001.

(b) An insurer shall offer catastrophic mental health coverage as a part of a health [~~insurance policy~~] benefit plan that is not governed by Chapter 8, Health Maintenance Organizations and Limited Health Plans, that is in effect on or after July 1, 2001.

(c) This section does not apply to the purchase or renewal of an individual insurance policy or contract.

(d) Notwithstanding Subsection (8)(c), nothing in this section may be construed as discouraging or otherwise preventing insurers from continuing to provide mental health coverage in connection with an individual policy or contract.

(9) This section shall be repealed in accordance with Section 63-55-231.

Section 15. Section **31A-22-807** is amended to read:

31A-22-807. Filing and approval of forms -- Loss ratio standards.

(1) [~~All forms of policies, certificates of insurance, statements of insurance, endorsements, and riders~~] A policy, certificate of insurance, statement of insurance, or endorsement form intended for use in Utah [~~are~~] is subject to Section 31A-21-201.

(2) In addition to the grounds for [~~disapproval~~] prohibiting use of a form under Subsection 31A-21-201(3), it is a ground [~~for disapproval~~] to prohibit the use of a form that the benefits provided in the form are not reasonable in relation to the premium charge.

(3) (a) In ascertaining whether the benefits are reasonable in relation to the premium charged, the commissioner shall consider:

(i) the mortality cost of the life insurance [~~and~~];

(ii) the morbidity cost of the accident and health insurance[~~,~~]; and

(iii) the reserves set up for the payment of claims unreported or in the process of settlement. [~~The~~]

(b) For purposes of this section, benefits are considered reasonable in relation to the premium charged if, given the costs described in this Subsection (3), the premium rate charged develops or may reasonably be expected to develop a loss ratio of:

(i) not less than 50% for credit life insurance; and

(ii) not less than 55% for credit accident and health insurance [~~given the above costs~~].

(4) Benefits are considered reasonable in relation to premium charged if the ratio of claims incurred to premium earned during the most recent four-year period at the rates in use produces a loss ratio that is equal to or exceeds the minimum loss ratio standard specified in Subsection (3).

(5) If the minimum loss ratio test produces a loss ratio that exceeds [~~Subsection (4)'s~~] the minimum loss ratio standard in Subsection (4) by five percentage points or more, the insurer may file for approval and use [~~rates~~] a rate that [~~are~~] is higher than the prima facie [~~rates~~] rate, if it can be expected that the use of [~~those~~] the higher [~~rates~~] rate will continue to produce a loss ratio for [~~the accounts to which they are~~] an account to which it is applied that will satisfy the minimum loss ratio test.

(6) If the minimum loss ratio test produces a loss ratio that is lower than [~~Subsection (4)'s~~] the minimum loss standard in Subsection (4) by five percentage points or more, the commissioner may require that the insurer:

(a) file an adjusted [~~rates~~] rate that can be expected to produce a loss ratio that will

satisfy the minimum loss ratio test[~~,~~]; or [~~to~~]

(b) submit reasons acceptable to the commissioner why the insurer should not be required to file [~~these adjusted rates~~] an adjusted rate.

Section 16. Section **31A-23a-105** is amended to read:

31A-23a-105. General requirements for individual and agency license issuance and renewal.

(1) The commissioner shall issue or renew a license to act as a producer, limited line producer, customer service representative, consultant, managing general agent, or reinsurance intermediary to any person who, as to the license type and line of authority classification applied for under Section 31A-23a-106:

(a) [~~has satisfied~~] satisfies the application requirements under Section 31A-23a-104;

(b) [~~has satisfied~~] satisfies the character requirements under Section 31A-23a-107;

(c) [~~has satisfied~~] satisfies any applicable continuing education requirements under Section 31A-23a-202;

(d) [~~has satisfied~~] satisfies any applicable examination requirements under Section 31A-23a-108;

(e) [~~has satisfied~~] satisfies any applicable training period requirements under Section 31A-23a-203;

(f) if a nonresident:

(i) [~~has complied~~] complies with Section 31A-23a-109; and

(ii) holds an active similar license in that person's state of residence;

(g) if an applicant for a title insurance producer license, [~~has satisfied~~] satisfies the requirements of Sections 31A-23a-203 and 31A-23a-204;

(h) if an applicant for a license to act as a viatical settlement provider or viatical settlement producer, [~~has satisfied~~] satisfies the requirements of Section 31A-23a-117; and

(i) [~~has paid~~] pays the applicable fees under Section 31A-3-103.

(2) (a) This Subsection (2) applies to the following persons:

(i) an applicant for a pending:

(A) individual or agency producer license;

(B) limited line producer license;

(C) customer service representative license;

(D) consultant license;

(E) managing general agent license; or

(F) reinsurance intermediary license; or

(ii) a licensed:

(A) individual or agency producer;

(B) limited line producer;

(C) customer service representative;

(D) consultant;

(E) managing general agent; or

(F) reinsurance intermediary.

(b) A person described in Subsection (2)(a) shall report to the commissioner:

(i) any administrative action taken against the person:

(A) in another jurisdiction; or

(B) by another regulatory agency in this state; and

(ii) any criminal prosecution taken against the person in any jurisdiction.

(c) The report required by Subsection (2)(b) shall:

(i) be filed:

(A) at the time the person files the application for an individual or agency license; and

(B) for an action or prosecution that occurs on or after the day on which the person files the application:

(I) for an administrative action, within 30 days of the final disposition of the administrative action; or

(II) for a criminal prosecution, within 30 days of the initial [~~pretrial hearing date~~] appearance before a court; and

(ii) include a copy of the complaint or other relevant legal documents related to the action or prosecution described in Subsection (2)(b).

(3) (a) The department may [~~request:~~] require a person applying for a license, for renewal of a license, or for consent to engage in the business of insurance to submit to a criminal background check as a condition of receiving a license, renewal, or consent.

(b) A person, if required to submit to a criminal background check under Subsection (3)(a), shall:

(i) submit a fingerprint card in a form acceptable to the department; and

(ii) consent to a fingerprint background check by:

(A) the Utah Bureau of Criminal Identification; and

(B) the Federal Bureau of Investigation.

(c) For a person who submits a fingerprint card and consents to a fingerprint background check under Subsection (3)(b), the department may request:

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

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

[~~(b)~~] (d) Information obtained by the department from the review of criminal history records received under this Subsection (3)[~~(a)~~] shall be used by the department for the purposes of:

(i) determining if a person satisfies the character requirements under Section 31A-23a-107 for issuance or renewal of a license;

(ii) determining if a person has failed to maintain the character requirements under Section 31A-23a-107; and

(iii) preventing persons who violate the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Secs. 1033 and 1034, from engaging in the business of insurance in the state.

[~~(c)~~] (e) If the department requests the criminal background information, the department shall:

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

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

(iii) charge the person applying for a license [~~or~~], for renewal of a license, or for consent to engage in the business of insurance a fee equal to the aggregate of Subsections (3)[~~(c)~~](e)(i) and (ii).

(4) To become a resident licensee in accordance with Section 31A-23a-104 and this section, a person licensed as one of the following in another state who moves to this state shall apply within 90 days of establishing legal residence in this state:

(a) insurance producer;

(b) limited line producer;

(c) customer service representative;

(d) consultant;

(e) managing general agent; or

(f) reinsurance intermediary.

(5) Notwithstanding the other provisions of this section, the commissioner may:

(a) issue a license to an applicant for a license for a title insurance line of authority only with the concurrence of the Title and Escrow Commission; and

(b) renew a license for a title insurance line of authority only with the concurrence of the Title and Escrow Commission.

Section 17. Section **31A-23a-110** is amended to read:

31A-23a-110. Form and contents of license.

(1) [~~Licenses~~] A license issued under this chapter shall be in the form the commissioner prescribes and shall set forth:

(a) the name[~~,~~] and address[~~, and telephone number~~] of the licensee;

(b) the license types and lines of authority under Section 31A-23a-106;

(c) the date of license issuance; and

(d) any other information the commissioner considers necessary.

(2) A licensee under this chapter doing business under [~~any other~~] another name than the licensee's legal name shall notify the commissioner [~~prior to~~] before using the assumed name in this state.

Section 18. Section **31A-23a-111** is amended to read:

31A-23a-111. Revocation, suspension, surrender, lapsing, limiting, or otherwise terminating a license -- Rulemaking for renewal or reinstatement.

(1) A license type issued under this chapter remains in force until:

(a) revoked or suspended under Subsection (5);

(b) surrendered to the commissioner and accepted by the commissioner in lieu of

administrative action;

(c) the licensee dies or is adjudicated incompetent as defined under:

(i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

(ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and Minors;

(d) lapsed under Section 31A-23a-113; or

(e) voluntarily surrendered.

(2) The following may be reinstated within one year after the day on which the license is inactivated:

(a) a lapsed license; or

(b) a voluntarily surrendered license.

(3) Unless otherwise stated in the written agreement for the voluntary surrender of a license, submission and acceptance of a voluntary surrender of a license does not prevent the department from pursuing additional disciplinary or other action authorized under:

(a) this title; or

(b) rules made under this title in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act.

(4) A line of authority issued under this chapter remains in force until:

(a) the qualifications pertaining to a line of authority are no longer met by the licensee; or

(b) the supporting license type:

(i) is revoked or suspended under Subsection (5); or

(ii) is surrendered to the commissioner and accepted by the commissioner in lieu of administrative action.

(5) (a) If the commissioner makes a finding under Subsection (5)(b), after an adjudicative proceeding under Title 63, Chapter 46b, Administrative Procedures Act, the commissioner may:

(i) revoke:

(A) a license; or

(B) a line of authority;

(ii) suspend for a specified period of 12 months or less:

(A) a license; or

(B) a line of authority; or

(iii) limit in whole or in part:

(A) a license; or

(B) a line of authority.

(b) The commissioner may take an action described in Subsection (5)(a) if the commissioner finds that the licensee:

(i) is unqualified for a license or line of authority under Sections 31A-23a-104 and 31A-23a-105;

(ii) [~~has violated~~] violates:

(A) an insurance statute;

(B) a rule that is valid under Subsection 31A-2-201(3); or

(C) an order that is valid under Subsection 31A-2-201(4);

(iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other delinquency proceedings in any state;

(iv) fails to pay any final judgment rendered against the person in this state within 60 days after the day on which the judgment became final;

(v) fails to meet the same good faith obligations in claims settlement that is required of admitted insurers;

(vi) is affiliated with and under the same general management or interlocking directorate or ownership as another insurance producer that transacts business in this state without a license;

(vii) refuses:

(A) to be examined; or

(B) to produce its accounts, records, and files for examination;

(viii) has an officer who refuses to:

(A) give information with respect to the insurance producer's affairs; or

(B) perform any other legal obligation as to an examination;

(ix) provides information in the license application that is:

(A) incorrect;

(B) misleading;

(C) incomplete; or

(D) materially untrue;

(x) [~~has violated any~~] violates an insurance law, valid rule, or valid order of another state's insurance department;

(xi) [~~has obtained or attempted~~] obtains or attempts to obtain a license through misrepresentation or fraud;

(xii) [~~has improperly withheld, misappropriated, or converted~~] improperly withholds, misappropriates, or converts any monies or properties received in the course of doing insurance business;

(xiii) [~~has~~] intentionally [~~misrepresented~~] misrepresents the terms of an actual or proposed:

(A) insurance contract; [~~or~~]

(B) application for insurance; or

(C) viatical settlement;

(xiv) [~~has been~~] is convicted of a felony;

(xv) [~~has admitted or been~~] admits or is found to have committed [~~any~~] an insurance unfair trade practice or fraud;

(xvi) in the conduct of business in this state or elsewhere [~~has~~]:

(A) [~~used~~] uses fraudulent, coercive, or dishonest practices; or

(B) [~~demonstrated~~] demonstrates incompetence, untrustworthiness, or financial irresponsibility;

(xvii) has [~~had~~] an insurance license, or its equivalent, denied, suspended, or revoked in [~~any other~~] another state, province, district, or territory;

(xviii) [~~has forged~~] forges another's name to:

(A) an application for insurance; or

(B) a document related to an insurance transaction;

(xix) [~~has~~] improperly [~~used~~] uses notes or [~~any other~~] another reference material to complete an examination for an insurance license;

(xx) [~~has~~] knowingly [~~accepted~~] accepts insurance business from an individual who is not licensed;

(xxi) [~~has failed~~] fails to comply with an administrative or court order imposing a child

support obligation;

(xxii) [~~has failed~~] fails to:

(A) pay state income tax; or

(B) comply with [~~any~~] an administrative or court order directing payment of state income tax;

(xxiii) [~~has violated or permitted~~] violates or permits others to violate the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Secs. 1033 and 1034; or

(xxiv) [~~has engaged in methods and practices~~] engages in a method or practice in the conduct of business that [~~endanger~~] endangers the legitimate interests of customers and the public.

(c) For purposes of this section, if a license is held by an agency, both the agency itself and any natural person named on the license are considered to be the holders of the license.

(d) If a natural person named on the agency license commits [~~any~~] an act or fails to perform [~~any~~] a duty that is a ground for suspending, revoking, or limiting the natural person's license, the commissioner may suspend, revoke, or limit the license of:

(i) the natural person;

(ii) the agency, if the agency:

(A) is reckless or negligent in its supervision of the natural person; or

(B) knowingly [~~participated~~] participates in the act or failure to act that is the ground for suspending, revoking, or limiting the license; or

(iii) (A) the natural person; and

(B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).

(6) A licensee under this chapter is subject to the penalties for acting as a licensee without a license if:

(a) the licensee's license is:

(i) revoked;

(ii) suspended;

(iii) limited;

(iv) surrendered in lieu of administrative action;

(v) lapsed; or

(vi) voluntarily surrendered; and

(b) the licensee:

(i) continues to act as a licensee; or

(ii) violates the terms of the license limitation.

(7) A licensee under this chapter shall immediately report to the commissioner:

(a) a revocation, suspension, or limitation of the person's license in [~~any other~~] another state, the District of Columbia, or a territory of the United States;

(b) the imposition of a disciplinary sanction imposed on that person by [~~any other~~] another state, the District of Columbia, or a territory of the United States; or

(c) a judgment or injunction entered against that person on the basis of conduct involving:

(i) fraud;

(ii) deceit;

(iii) misrepresentation; or

(iv) a violation of an insurance law or rule.

(8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a license in lieu of administrative action may specify a time, not to exceed five years, within which the former licensee may not apply for a new license.

(b) If no time is specified in the order or agreement described in Subsection (8)(a), the former licensee may not apply for a new license for five years from the day on which the order or agreement is made without the express approval by the commissioner.

(9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of a license issued under this part if so ordered by a court.

(10) The commissioner shall by rule prescribe the license renewal and reinstatement procedures in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act.

Section 19. Section **31A-23a-116** is amended to read:

31A-23a-116. Services performed for unauthorized insurers.

(1) A person licensed under Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries, may not perform [~~any~~] an act that assists [~~any~~] a person not authorized as an insurer to act as an insurer.

(2) It is a violation of this section to assist [~~any~~] a person purporting to be exempt from state insurance regulation under Section 514 of the Employee Retirement Income Security Act

of 1974, unless that person [~~has rebutted the presumption of jurisdiction under Section 31A-1-105~~] submits to the commissioner a certificate from the United States Department of Labor, or other evidence satisfactory to the commissioner, showing that the laws of Utah are preempted under Section 514 of the Employee Retirement Income Security Act of 1974 or other federal law.

(3) It is not a violation of this section:

(a) to assist [~~persons~~] a person engaged in self insurance as defined under Section 31A-1-301; or

(b) for a surplus lines producer to engage in the placement of insurance under Section 31A-15-103.

Section 20. Section **31A-25-203** is amended to read:

31A-25-203. General requirements for license issuance.

(1) The commissioner shall issue a license to act as a third party administrator to [~~any~~] a person who [~~has~~]:

(a) [~~satisfied~~] satisfies the character requirements under Section 31A-25-204;

(b) [~~satisfied~~] satisfies the financial responsibility requirement under Section 31A-25-205;

(c) if a nonresident, [~~complied~~] complies with Section 31A-25-206; and

(d) [~~paid~~] pays the applicable fees under Section 31A-3-103.

(2) The license of [~~each~~] a third party administrator licensed under former Title 31, Chapter 15a, is continued under this chapter.

(3) (a) This Subsection (3) applies to the following persons:

(i) an applicant for a third party administrator's license; or

(ii) a licensed third party administrator.

(b) A person described in Subsection (3)(a) shall report to the commissioner:

(i) [~~any~~] an administrative action taken against the person:

(A) in another jurisdiction; or

(B) by another regulatory agency in this state; and

(ii) [~~any~~] a criminal prosecution taken against the person in any jurisdiction.

(c) The report required by Subsection (3)(b) shall:

(i) be filed:

(A) at the time the person applies for a third party administrator's license; and

(B) for an action or prosecution that occurs on or after the day on which the person applies for a third party administrator license:

(I) for an administrative action, within 30 days of the final disposition of the administrative action; or

(II) for a criminal prosecution, within 30 days of the initial [~~pretrial hearing~~] appearance before a court; and

(ii) include a copy of the complaint or other relevant legal documents related to the action or prosecution described in Subsection (3)(b).

(4) (a) The department may require a person applying for a license, for renewal of a license, or for consent to engage in the business of insurance to submit to a criminal background check as a condition of receiving a license, renewal, or consent.

(b) A person, if required to submit to a criminal background check under Subsection (4)(a), shall:

(i) submit a fingerprint card in a form acceptable to the department; and

(ii) consent to a fingerprint background check by:

(A) the Utah Bureau of Criminal Identification; and

(B) the Federal Bureau of Investigation.

[~~(4) (a) The~~] (c) For a person who submits a fingerprint card and consents to a fingerprint background check under Subsection (4)(b), the department may request concerning a person applying for a third party administrator's license:

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

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

[~~(b)~~] (d) Information obtained by the department from the review of criminal history records received under this Subsection (4)[~~(a)~~] shall be used by the department for the purposes of:

(i) determining if a person satisfies the character requirements under Section 31A-25-204 for issuance or renewal of a license;

(ii) determining if a person has failed to maintain the character requirements under

Section 31A-25-204; and

(iii) preventing persons who violate the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Secs. 1033 and 1034, from engaging in the business of insurance in the state.

[~~(c)~~] (e) If the department requests the criminal background information, the department shall:

(i) pay to the Department of Public Safety the costs incurred by the Department of Public Safety in providing the department criminal background information under Subsection (4)[~~(a)~~](c)(i);

(ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau of Investigation in providing the department criminal background information under Subsection (4)[~~(a)~~](c)(ii); and

(iii) charge the person applying for a license [~~or~~], for renewal of a license, or for consent to engage in the business of insurance a fee equal to the aggregate of Subsections (4)[~~(c)~~](e)(i) and (ii).

Section 21. Section **31A-26-203** is amended to read:

31A-26-203. Adjuster's license required.

(1) The commissioner shall issue a license to act as an independent adjuster or public adjuster to [~~any~~] a person who, as to the license classification applied for under Section 31A-26-204[~~, has~~]:

(a) [~~satisfied~~] satisfies the character requirements under Section 31A-26-205;

(b) [~~satisfied~~] satisfies the applicable continuing education requirements under Section 31A-26-206;

(c) [~~satisfied~~] satisfies the applicable examination requirements under Section 31A-26-207;

(d) if a nonresident, [~~complied~~] complies with Section 31A-26-208; and

(e) [~~paid~~] pays the applicable fees under Section 31A-3-103.

(2) (a) This Subsection (2) applies to the following persons:

(i) an applicant for:

(A) an independent adjuster's license; or

(B) a public adjuster's license;

(ii) a licensed independent adjuster; or

(iii) a licensed public adjuster.

(b) A person described in Subsection (2)(a) shall report to the commissioner:

(i) [~~any~~] an administrative action taken against the person:

(A) in another jurisdiction; or

(B) by another regulatory agency in this state; and

(ii) [~~any~~] a criminal prosecution taken against the person in any jurisdiction.

(c) The report required by Subsection (2)(b) shall:

(i) be filed:

(A) at the time the person applies for an adjustor's license; and

(B) for an action or prosecution that occurs on or after the day on which the person applies for an adjustor's license:

(I) for an administrative action, within 30 days of the final disposition of the administrative action; or

(II) for a criminal prosecution, within 30 days of the initial [~~pretrial hearing date~~] appearance before a court; and

(ii) include a copy of the complaint or other relevant legal documents related to the action or prosecution described in Subsection (2)(b).

(3) (a) The department may require a person applying for a license, for renewal of a license, or for consent to engage in the business of insurance to submit to a criminal background check as a condition of receiving a license, renewal, or consent.

(b) A person, if required to submit to a criminal background check under Subsection (3)(a), shall:

(i) submit a fingerprint card in a form acceptable to the department; and

(ii) consent to a fingerprint background check by:

(A) the Utah Bureau of Criminal Identification; and

(B) the Federal Bureau of Investigation.

[~~(3) (a) The~~] (c) For a person who submits a fingerprint card and consents to a fingerprint background check under Subsection (3)(b), the department may request concerning a person applying for an independent or public adjuster's license:

(i) criminal background information maintained pursuant to Title 53, Chapter 10, Part

2, Bureau of Criminal Identification, from the Bureau of Criminal Identification; and

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

[~~(b)~~] (d) Information obtained by the department from the review of criminal history records received under this Subsection (3)[~~(a)~~] shall be used by the department for the purposes of:

(i) determining if a person satisfies the character requirements under Section 31A-26-205 for issuance or renewal of a license;

(ii) determining if a person has failed to maintain the character requirements under Section 31A-25-204; and

(iii) preventing persons who violate the federal Violent Crime Control and Law Enforcement Act of 1994, 18 U.S.C. Secs. 1033 and 1034, from engaging in the business of insurance in the state.

[~~(c)~~] (e) If the department requests the criminal background information, the department shall:

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

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

(iii) charge the person applying for a license [~~or~~], for renewal of a license, or for consent to engage in the business of insurance a fee equal to the aggregate of Subsections (3)[~~(c)~~](e)(i) and (ii).

(4) Notwithstanding the other provisions of this section, the commissioner may:

(a) issue a license to an applicant for a license for a title insurance classification only with the concurrence of the Title and Escrow Commission; or

(b) renew a license for a title insurance classification only with the concurrence of the Title and Escrow Commission.

Section 22. Section **31A-27a-513** is amended to read:

31A-27a-513. Reinsurance continuation and termination.

(1) For purposes of this section:

(a) "Coverage date" is the day on which an order of liquidation is entered.

(b) "Election date" is the day on which an affected guaranty association elects to assume under this section the rights and obligations of a ceding insurer that relate to a policy or annuity covered, in whole or in part, by the affected guaranty association.

(2) A contract reinsuring a life insurance policy, disability income insurance policy, long-term care insurance policy, or an annuity issued by a ceding insurer that is placed in rehabilitation proceedings pursuant to this chapter shall be continued or terminated pursuant to:

(a) the terms or conditions of each contract; and

(b) this section.

(3) A contract reinsuring a life insurance policy, disability income insurance policy, long-term care insurance policy, or an annuity issued by a ceding insurer that is placed into liquidation pursuant to this chapter shall be continued, subject to this section, unless:

(a) the contract is terminated pursuant to the contract's terms before the coverage date; or

(b) the contract is terminated pursuant to the order of liquidation, in which case Subsection (10) applies.

(4) (a) (i) At any time within 180 days of the coverage date, an affected guaranty association covering a life insurance policy, disability income insurance policy, long-term care insurance policy, or an annuity, in whole or in part, may elect to assume the rights and obligations of the ceding insurer that relate to the policy or annuity covered, in whole or in part, by the affected guaranty association, under one or more reinsurance contracts between the insolvent insurer and the insolvent insurer's reinsurers selected by the affected guaranty association.

(ii) An assumption under this Subsection (4)(a) is effective as of the coverage date.

(iii) The election described in this Subsection (4)(a) is made by the affected guaranty association or a nationally recognized association of guaranty associations that is designated by the affected guaranty association to act on the affected guaranty association's behalf for purposes of this Subsection (4)(a) by sending written notice, return receipt requested, to the affected reinsurers.

(b) (i) To facilitate the earliest practicable decision about whether to assume a contract

of reinsurance and to protect the financial position of the estate, the receiver and each reinsurer of the ceding insurer shall make available the information described in Subsection (4)(b)(ii):

(A) upon request to an affected guaranty association; or

(B) to a nationally recognized association of guaranty associations that is designated by the affected guaranty association to act on behalf of the affected guaranty associations for purposes of this Subsection (4) as soon as possible after commencement of formal delinquency proceedings.

(ii) The information described in Subsection (4)(b)(i) is:

(A) copies of all in-force contracts of reinsurance;

(B) all records related to in-force contracts of reinsurance relevant to the determination of whether the in-force contracts of reinsurance should be assumed; and

(C) notice of:

(I) [~~any~~] a default under the in-force contracts of reinsurance; or

(II) [~~any~~] a known event or condition that with the passage of time could become a default under the in-force contracts of reinsurance.

(c) Subsections (4)(c)(i) through (vi) apply to a reinsurance contract assumed by an affected guaranty association under this Subsection (4).

(i) The guaranty association is responsible for the following that relates to a life insurance policy, disability income insurance policy, long-term care insurance policy, or an annuity covered, in whole or in part, by the guaranty association:

(A) all unpaid premiums due under a reinsurance contract, for the periods both before and after the coverage date; and

(B) the performance of all other obligations to be performed after the coverage date.

(ii) The affected guaranty association:

(A) may charge a policy of insurance or annuity covered in part by the affected guaranty association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the affected guaranty association; and

(B) if it imposes a charge under this Subsection (4)(c)(ii), shall provide notice and an accounting of the charge to the liquidator.

(iii) The affected guaranty association is entitled to any amount payable by the reinsurer under the reinsurance contract with respect to a loss or event:

(A) that:

(I) occurs in a period on or after the coverage date; and

(II) relates to a life insurance policy, disability income insurance policy, long-term care insurance policy, or an annuity covered, in whole or in part, by the affected guaranty association; and

(B) except that upon receipt of the amount, the affected guaranty association is obliged to pay to the beneficiary under the insurance policy or annuity on account of which the amount is paid a portion of the amount equal to the lesser of:

(I) the amount received by the affected guaranty association; and

(II) an amount calculated by:

(Aa) determining the excess of the amount received by the affected guaranty association over the amount equal to the benefits paid by the affected guaranty association on account of the policy or annuity; and

(Bb) subtracting the retention of the insurer applicable to the loss or event.

(iv) (A) Within 30 days following the election date, the affected guaranty association and each reinsurer under a contract assumed by the affected guaranty association shall calculate the net balance due to or from the affected guaranty association under each reinsurance contract as of the election date with respect to a policy or annuity covered, in whole or in part, by the affected guaranty association.

(B) The calculation required by Subsection (4)(c)(iv)(A) shall give full credit to all items paid by the insurer, the insurer's receiver, or the reinsurer before the election date.

(C) The reinsurer shall pay the receiver an amount due for a loss or event before the coverage date, subject to any setoff for premiums unpaid for periods before the coverage date.

(D) Within five days of the completion of the calculation required by Subsection (4)(c)(iv)(A), the affected guaranty association or reinsurer shall pay any balance due the other after completion of the calculation.

(E) A dispute over an amount due to either the affected guaranty association or the reinsurer shall be resolved by arbitration:

(I) pursuant to the terms of the affected reinsurance contract; or

(II) if the affected reinsurance contract contains no arbitration clause, as provided in Subsection (10)(d).

(v) If the receiver receives an amount due the affected guaranty association pursuant to Subsection (4)(c)(iii), the receiver shall remit that amount to the affected guaranty association as promptly as practicable.

(vi) If the affected guaranty association or the receiver on the affected guaranty association's behalf, within 60 days of the election date, pays the unpaid premiums due for periods both before and after the election date that relate to a life insurance policy, disability income insurance policy, long-term care insurance policy, or an annuity covered, in whole or in part, by the affected guaranty association, the reinsurer may not:

(A) terminate the reinsurance contract for failure to pay premiums, insofar as the reinsurance contract relates to a life insurance policy, disability income insurance policy, long-term care insurance policy, or an annuity covered, in whole or in part, by the affected guaranty association; and

(B) set off any unpaid amounts due under other contracts, or unpaid amounts due from parties other than the affected guaranty association, against amounts due the affected guaranty association.

(5) (a) If pursuant to court approval under Section 31A-27a-402 a receiver continues a life insurance policy, disability income insurance policy, long-term care insurance policy, or an annuity in force following an order of liquidation, and the policy of insurance or annuity is not covered in whole or in part by one or more affected guaranty associations, the receiver may elect to assume the rights and obligations of the ceding insurer under one or more of the reinsurance contracts that relate to the policy or annuity:

(i) within 180 days of the coverage date; and

(ii) if the contract is not terminated as set forth in Subsection (2).

(b) The election described in this Subsection (5) shall be made by sending written notice, return receipt requested, to the affected reinsurers.

(c) If the election described in this Subsection (5) is made:

(i) payment of premiums on the reinsurance contract for the policy or annuity, for periods both before and after the coverage date, shall be chargeable against the estate as a Class 1 administrative expense; and

(ii) amounts paid by the reinsurer on account of losses on the policy or annuity shall be to the estate of the insolvent insurer.

(6) During the period beginning on the coverage date and ending on the election date:

(a) (i) neither the affected guaranty association nor the reinsurer has any rights or obligations under a reinsurance contract that the affected guaranty association has the right to assume under Subsection (4), whether for a period before or after the coverage date;

(ii) (A) with respect to the period after the coverage date, neither the receiver nor the reinsurer has any rights or obligations under a reinsurance contract that the receiver has the right to assume under Subsection (5); and

(B) with respect to the period before the coverage date, the rights and obligations of the affected guaranty association and the reinsurer remain unchanged; and

(iii) the reinsurer, the receiver, and an affected guaranty association shall, to the extent practicable, provide each other data and records reasonably requested; and

(b) once the affected guaranty association or the receiver, as the case may be, elects or declines to elect to assume a reinsurance contract, the parties' rights and obligations are governed by Subsection (4), (5), or (10), as applicable.

(7) (a) If an affected guaranty association does not elect to assume a reinsurance contract by the election date pursuant to Subsection (4), the affected guaranty association has no rights or obligations, in each case for periods both before and after the coverage date, with respect to the reinsurance contract.

(b) If a receiver does not elect to assume a reinsurance contract by the election date pursuant to Subsection (5), the receiver and the reinsurer:

(i) retain their respective rights and obligations with respect to the reinsurance contract for the period before the coverage date; and

(ii) have no rights or obligations to each other for the period after the coverage date, except as provided in Subsection (10).

(c) (i) If an affected guaranty association or the receiver, as the case may be, does not elect to assume a reinsurance contract by the election date, the reinsurance contract terminates retroactively effective on the coverage date.

(ii) A reinsurance contract covering a life insurance policy, disability income insurance policy, long-term care insurance policy, or an annuity that is terminated pursuant to Section 31A-27a-402 terminates effective on the coverage date.

(iii) Subsection (10) applies to a reinsurance contract described in Subsection (7)(c)(i)

or (ii).

(8) (a) Subject to Subsection (8)(b), when a life insurance policy, disability income insurance policy, long-term care insurance policy, an annuity, or guaranty association obligation with respect to that policy or annuity is transferred to an assuming insurer, reinsurance on the policy or annuity may also be transferred:

(i) by the affected guaranty association, in the case of a contract assumed under Subsection (4); or

(ii) by the receiver, in the case of a contract assumed under Subsection (5).

(b) A transfer under Subsection (8)(a), is subject to the following:

(i) unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract transferred may not cover a new policy of insurance or new annuity in addition to those transferred;

(ii) the obligations described in Subsections (4) and (5) do not apply with respect to matters arising after the effective date of the transfer; and

(iii) notice shall be given in writing, return receipt requested, by the transferring party to the affected reinsurer not less than 30 days before the effective date of the transfer.

(9) (a) This section shall, to the extent provided in this chapter, supersede a law or an affected reinsurance contract that provides for or requires a payment of reinsurance proceeds on account of a loss or event:

(i) that occurs in a period after the coverage date; and

(ii) to the receiver of the insolvent insurer or to any other person.

(b) The receiver shall remain entitled to any amounts payable by the reinsurer under the reinsurance contract with respect to a loss or event that occurs in a period before the coverage date, subject to this chapter including applicable setoff provisions.

(10) If a contract reinsuring a life insurance policy, disability income insurance policy, long-term care insurance policy, or an annuity is terminated pursuant to this chapter, the procedures of this Subsection (10) apply.

(a) The reinsurer and the receiver shall, upon written notice to the other party to the reinsurance contract no later than 30 days after the receipt by the reinsurer of notice of termination, commence a mandatory negotiation and arbitration procedure in accordance with this Subsection (10).

(b) (i) Each party shall appoint an actuary to determine an estimated sum due as a result of the termination of the reinsurance contract calculated in a way expected to make the parties economically indifferent as to whether the reinsurance contract continues or terminates, giving due regard to the economic effects of the insolvency.

(ii) The estimated sum described in this Subsection (10)(b) shall:

(A) take into account the present value of future cash flows expected under the reinsurance contract; and

(B) be based on a gross premium valuation of net liability using current assumptions:

(I) that reflect postinsolvency experience expectations, with no additional margins;

(II) that are net of any amounts payable and receivable; and

(III) with a market value adjustment to reflect premature sale of assets to fund the settlement.

(c) (i) Within 90 days of the day on which the written request pursuant to Subsection (10)(a) is made, each party shall provide the other party with:

(A) its estimate of the sum due as a result of the termination of the reinsurance contract; and

(B) all relevant documents and other information supporting the estimate.

(ii) The parties shall make a good faith effort to reach agreement on the sum due.

(d) (i) If the parties are unable to reach agreement within 90 days following the day on which the materials required in Subsection (10)(c) are submitted, either party may initiate arbitration proceedings:

(A) as provided in the reinsurance contract; or

(B) if the reinsurance contract does not contain an arbitration clause, pursuant to this Subsection (10)(d) by providing the other party with a written demand for arbitration.

(ii) Arbitration under Subsection (10)(d)(i)(B) shall be conducted pursuant to the following procedures:

(A) Venue for the arbitration shall be within the county of the court's jurisdiction or another location agreed to by the parties.

(B) Within 30 days of the responding party's receipt of the arbitration demand, each party shall appoint an arbitrator who is:

(I) a disinterested active or retired officer or executive of a life insurance or reinsurance

company; or

(II) other professional with no less than ten years experience in or relating to the field of life insurance or life reinsurance.

(C) The two arbitrators appointed under Subsection (10)(d)(ii)(B) shall appoint an independent, impartial, disinterested umpire who is an:

(I) active or retired officer or executive of a life insurance or reinsurance company; or

(II) other professional with no less than ten years experience in the field of life insurance or life reinsurance.

(D) If the arbitrators appointed under Subsection (10)(d)(ii)(B) are unable to agree on an umpire:

(I) each arbitrator shall provide the other with the names of three qualified individuals;

(II) each arbitrator shall strike two names from the other's list; and

(III) the umpire shall be chosen by drawing lots from the remaining individuals.

(E) Within 60 days following the day on which the umpire is appointed, each party shall, unless otherwise ordered by the arbitration panel, submit to the arbitration panel:

(I) the party's estimates of the sum due as a result of the termination of the reinsurance contract; and

(II) all relevant documents and other information supporting the estimate.

(F) The time periods set forth in this Subsection (10)(d)(ii) may be extended upon mutual agreement of the parties.

(G) The arbitration panel has all powers necessary to conduct the arbitration proceedings in a fair and appropriate manner, including the power to:

(I) request additional information from the parties;

(II) authorize discovery;

(III) hold hearings; and

(IV) hear testimony.

(H) The arbitration panel may, if the arbitration panel considers it necessary, appoint one or more independent actuarial experts, the expense of which shall be shared equally between the parties.

(I) An arbitration panel considering the matters set forth in this Subsection (10)(d) shall:

(I) apply the standards set forth in Subsection (10)(b); and

(II) issue a written award specifying a net settlement amount due from one party or the other as a result of the termination of the reinsurance contract.

(e) The supervising court shall confirm an award issued under Subsection (10)(d)(ii)(I) absent proof of statutory grounds for vacating or modifying arbitration awards under the Federal Arbitration Act, 9 U.S.C. Sec. 1 et seq.

(f) (i) If the net settlement amount agreed or awarded pursuant to this Subsection (10) is payable by the reinsurer, the reinsurer shall pay the amount due to the estate subject to any applicable setoff under Section 31A-27a-510.

(ii) If the net settlement amount agreed or awarded pursuant to this Subsection (10) is payable by the insurer, the reinsurer is considered to have a timely filed claim against the estate for that amount, which claim shall be paid pursuant to the priority established in Subsection 31A-27a-701(2)(f).

(iii) A guaranty association:

(A) is not entitled to receive the net settlement amount, except to the extent it is entitled to share in the estate assets as creditors of the estate; and

(B) has no responsibility for the net settlement amount.

(11) (a) Except as otherwise provided in this section, this section does not alter or modify the terms and conditions of a reinsurance contract.

(b) This section does not abrogate or limit any rights of a reinsurer to claim that it is entitled to rescind a reinsurance contract.

(c) This section does not give a policyholder or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract.

(d) This section does not limit or affect any guaranty association's rights as a creditor of the estate against the assets of the estate.

(e) This section does not apply to a reinsurance agreement covering property or casualty risks.

Section 23. Section **31A-27a-515** is amended to read:

31A-27a-515. Commutation and release agreements.

(1) For purposes of this section, "casualty claims" means the insurer's aggregate claims arising out of insurance contracts in the following lines:

(a) farm owner multiperil;

(b) homeowner multiperil;

(c) commercial multiperil;

(d) medical malpractice;

(e) workers' compensation;

(f) other liability;

(g) products liability;

(h) auto liability;

(i) aircraft, all peril; and

(j) international, for lines listed in Subsections (1)(a) through (i).

(2) (a) Notwithstanding Section 31A-27a-512, the liquidator and a reinsurer may negotiate a voluntary commutation and release of all obligations arising from a reinsurance agreement in which the insurer is the ceding party.

(b) A commutation and release agreement voluntarily entered into by the parties shall be commercially reasonable, actuarially sound, and in the best interests of the creditors of the insurer.

(c) (i) An agreement subject to this Subsection (2) that has a gross consideration in excess of $250,000 shall be submitted pursuant to Section 31A-27a-107 to the receivership court for approval.

(ii) An agreement described in this Subsection (2)(c) shall be approved by the receivership court if it meets the standards described in this Subsection (2).

(3) Without derogating from Section 31A-27a-512, if the liquidator is unable to negotiate a voluntary commutation with a reinsurer with respect to a reinsurance agreement between the insurer and that reinsurer, the liquidator may, in addition to any other remedy available under applicable law, apply to the receivership court, with notice to the reinsurer, for an order requiring that the parties submit commutation proposals with respect to the reinsurance agreement to a panel of three arbitrators:

(a) at any time after 75% of the actuarially estimated ultimate incurred liability for all of the casualty claims against the liquidation estate is reached by allowance of claims in the liquidation estate pursuant to Sections 31A-27a-603 and 31A-27a-605, calculated:

(i) as of the day on which the order of liquidation is entered by or at the instance of the

liquidator; and

(ii) for purposes of this Subsection (3), not performed during the five-year period subsequent to the day on which the order of liquidation is entered; or

(b) at any time in regard to a reinsurer if that reinsurer has a total adjusted capital that is less than 250% of its authorized control level RBC as defined in Section 31A-17-601.

(4) Venue for the arbitration is within the district of the receivership court's jurisdiction or at another location agreed to by the parties.

(5) (a) If the liquidator determines that commutation would be in the best interests of the creditors of the liquidation estate, the liquidator may petition the receivership court to order arbitration.

(b) If the liquidator petitions the receivership court under Subsection (5)(a), the receivership court shall require that the liquidator and the reinsurer each appoint an arbitrator within 30 days after the day on which the order for arbitration is entered.

(c) If either party fails to appoint an arbitrator within the 30-day period, the other party may appoint both arbitrators and the appointments are binding on the parties.

(d) The two arbitrators shall be active or retired executive officers of insurance or reinsurance companies, not under the control of or affiliated with the insurer or the reinsurer.

(e) (i) Within 30 days after the day on which both arbitrators have been appointed, the two arbitrators shall agree to the appointment of a third independent, impartial, disinterested arbitrator.

(ii) If agreement to the disinterested arbitrator is not reached within the 30-day period, the third arbitrator shall be appointed by the receivership court.

(f) The disinterested arbitrator shall be a person who:

(i) is or, if retired, has been, an executive officer of a United States domiciled insurance or reinsurance company that is not under the control of or affiliated with either of the parties; and

(ii) has at least 15 years experience in the reinsurance industry.

(6) (a) The arbitration panel may choose to retain as an expert to assist the panel in its determinations, a retired, disinterested executive officer of a United States domiciled insurance or reinsurance company having at least 15 years loss reserving actuarial experience.

(b) If the arbitration panel is unable to unanimously agree on the identity of the expert

within 14 days of the day on which the disinterested arbitrator is appointed, the expert shall be:

(i) designated by the commissioner:

(A) by rule made in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act; and

(B) on the basis of recommendations made by a nationally recognized society of actuaries; and

(ii) a disinterested person that has knowledge, experience, and training applicable to the line of insurance that is the subject of the arbitration.

(c) The expert:

(i) may not vote in the proceeding; and

(ii) shall issue a written report and recommendations to the arbitration panel within 60 days after the day on which the arbitration panel receives the commutation proposals submitted by the parties pursuant to Subsection (7), which report shall:

(A) be included as part of the arbitration record; and

(B) accompany the award issued by the arbitration panel pursuant to Subsection (8).

(d) The cost of the expert is to be paid equally by the parties.

(7) Within 90 days after the day on which the disinterested arbitrator is appointed under Subsection (5), each party shall submit to the arbitration panel:

(a) the party's commutation proposals; and

(b) other documents and information relevant to the determination of the parties' rights and obligations under the reinsurance agreement to be commuted, including:

(i) a written review of any disputed paid claim balances;

(ii) any open claim files and related case reserves at net present value; and

(iii) any actuarial estimates with the basis of computation of any other reserves and any incurred-but-not-reported losses at net present value.

(8) (a) Within 90 days after the day on which the parties submit the information required by Subsection (7), the arbitration panel:

(i) shall issue an award, determined by a majority of the arbitration panel, specifying the terms of a commercially reasonable and actuarially sound commutation agreement between the parties; or

(ii) may issue an award declining commutation between the parties for a period not to

exceed two years if a majority of the arbitration panel determines that it is unable to derive a commercially reasonable and actuarially sound commutation on the basis of:

(A) the submissions of the parties; and

(B) if applicable, the report and recommendation of the expert retained in accordance with Subsection (6).

(b) Following the expiration of the two-year period described in Subsection (8)(a), the liquidator may again invoke arbitration in accordance with Subsection (2), in which event Subsections (2) through (9) apply to the renewed proceeding, except that the arbitration panel is obliged to issue an award under Subsection (8)(a).

(9) Once an award is issued, the liquidator shall promptly submit the award to the receivership court for confirmation.

(10) (a) Within 30 days of the day on which the receivership court confirms the award, the reinsurer shall give notice to the receiver that the reinsurer:

(i) will commute the reinsurer's liabilities to the insurer for the amount of the award in return for a full and complete release of all liabilities between the parties, whether past, present, or future; or

(ii) will not commute the reinsurer's liabilities to the insurer.

(b) If the reinsurer's liabilities are not commuted under Subsection (10)(a), the reinsurer shall:

(i) establish and maintain in accordance with Section 31A-27a-516 a reinsurance recoverable trust in the amount of 102% of the award; and

(ii) pay the costs and fees associated with establishing and maintaining the trust established under this Subsection (10)(b).

(11) (a) If the reinsurer notifies the liquidator that it will commute the reinsurer's liabilities pursuant to Subsection (10)(a)(i), the liquidator has 30 days from the day on which the reinsurer notifies the liquidator to:

(i) tender to the reinsurer a proposed commutation and release agreement:

(A) providing for a full and complete release of all liabilities between the parties, whether past, present, or future; and

(B) that requires that the reinsurer make payment of the commutation amount within 14 days from the day on which the agreement is consummated; or

(ii) reject the commutation in writing, subject to receivership court approval.

(b) If the liquidator rejects the commutation subject to approval of the receivership court in accordance with Subsection (11)(a)(ii), the reinsurer shall establish and maintain a reinsurance recoverable trust in accordance with Section 31A-27a-516.

(c) The liquidator and the reinsurer shall share equally in the costs and fees associated with establishing and maintaining the trust established under Subsection (11)(b).

(12) Except for the period provided in Subsection (8)(b), the time periods established in Subsections (6), (7), (8), (10), and (11) may be extended:

(a) upon the consent of the parties; or

(b) by order of the receivership court, for good cause shown.

(13) Subject to Subsection (14), this section may not be construed to supersede or impair any provision in a reinsurance agreement that establishes a commercially reasonable and actuarially sound method for valuing and commuting the obligations of the parties to the reinsurance agreement by providing in the contract the specific methodology to be used for valuing and commuting the obligations between the parties.

(14) (a) A commutation provision in a reinsurance agreement is not effective if it is demonstrated to the receivership court that the provision is entered into in contemplation of the insolvency of one or more of the parties.

(b) A contractual commutation provision entered into within one year of the day on which the liquidation order of the insurer is entered is rebuttably presumed to have been entered into in contemplation of insolvency.

Section 24. Section **31A-27a-516** is amended to read:

31A-27a-516. Reinsurance recoverable trust provisions.

(1) As used in this section:

(a) "Beneficiary" means the domiciliary insurance commissioner, as liquidator of the insurer for whose sole benefit a reinsurance recoverable trust is established.

(b) "Grantor" means the reinsurer who has established a reinsurance recoverable trust for the sole benefit of the beneficiary.

(c) "Qualified United States financial institution" means an institution that:

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

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

(ii) is granted authority to operate with fiduciary powers; and

(iii) is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.

(d) "Reinsurance recoverable trust" means a trust established pursuant to Section 31A-27a-515.

(2) (a) The trustee of a reinsurance recoverable trust shall be a qualified United States financial institution.

(b) The trust agreement governing a reinsurance recoverable trust shall:

(i) be entered into by the beneficiary, the grantor, and a trustee;

(ii) create a trust account into which assets shall be deposited in accordance with Section 31A-27a-515;

(iii) provide that the beneficiary may withdraw assets from the trust only:

(A) (I) on the basis of a filed claim allowed pursuant to Section 31A-27a-603 or 31A-27a-605;

[~~(B)~~] (II) where the grantor is notified, in writing, of the allowance of the claim;

[~~(C)~~] (III) to the extent that the amount to be withdrawn exceeds any setoff permitted by Section 31A-27a-510 due to the grantor; and

[~~(D)~~] (IV) when 60 days expires during which the grantor fails to:

[~~(I)~~] (Aa) pay the claim; or

[~~(II)~~] (Bb) subject to and without derogation from Section 31A-27a-512, which at all times governs and remains binding on the reinsurer, file notice of a written dispute with respect to the claim under and in terms of the reinsurance agreement; or

[~~(E)~~] (B) if the beneficiary complies with any different or other terms and conditions mutually agreed to by the beneficiary and the grantor in the trust agreement;

(iv) require the trustee to:

(A) receive assets and hold all assets at the trustee's office in the United States in a safe place;

(B) determine that all assets are in such form that the beneficiary, or the trustee upon direction by the beneficiary, may whenever necessary negotiate the assets, without consent or

signature from the grantor or any other person;

(C) furnish to the grantor and the beneficiary a statement of all assets in the trust account upon its inception and at intervals no less frequent than the end of each calendar quarter; and

(D) notify the grantor and the beneficiary within ten days of a deposit to or withdrawal from the trust account;

(v) be made subject to and governed by the laws of this state;

(vi) prohibit the invasion of the trust corpus for the purpose of paying compensation to, or reimbursing the expenses of, the trustee;

(vii) provide that the trustee is liable for the trustee's negligence, willful misconduct, or lack of good faith;

(viii) subject to Subsection (2)(c), provide that the trustee may resign upon delivery of a written notice of resignation, effective not less than 90 days after the day on which the beneficiary and grantor receive the notice;

(ix) subject to Subsection (2)(c), provide that the trustee may be removed by the grantor by delivery to the trustee and the beneficiary of a written notice of removal, effective not less than 90 days after the day on which the trustee and the beneficiary receive the notice;

(x) provide that the grantor has the full and unqualified right to vote any shares of stock in the trust account except that, subject to other provisions of this section, an interest or dividend paid on shares of stock or other obligation in the trust account shall remain in the trust;

(xi) specify categories of investments reasonably acceptable to the beneficiary;

(xii) authorize the trustee to invest funds and to accept substitutions, by the grantor, that the trustee determines are at least equal in market value to the assets withdrawn provided that no investment or substitution shall be made without prior approval from the beneficiary, which may not be unreasonably or arbitrarily withheld;

(xiii) subject to Subsection (2)(d), provide that the beneficiary may at any time designate a party to which all or part of the trust assets are to be transferred;

(xiv) specify the types of assets that may be included in the trust account:

(A) which shall consist only of:

(I) cash in United States dollars;

(II) certificates of deposit issued by a United States bank and payable in United States dollars;

(III) investments permitted by this state's insurance law; or

(IV) any combination of the types specified by this Subsection (2)(b)(xiv)(A);

(B) except that if investments in or issued by an entity controlling, controlled by, or under common control with either the grantor or the beneficiary of the trust, may not exceed 5% of total investments; and

(C) subject to the assets deposited in the trust account being valued according to the asset's current fair market value;

(xv) give the grantor the right to seek approval from the beneficiary, which may not be unreasonably or arbitrarily withheld, to withdraw from the trust account all or any part of the trust assets and transfer those assets to the grantor, if:

(A) the grantor, at the time of withdrawal, replaces the withdrawn assets with other qualified assets so as to maintain at all times the deposit in the required amount; or

(B) after withdrawal and transfer, the market value of the trust account is no less than 102% of the award made pursuant to Subsection 31A-27a-515[~~(7)~~] (8)(a);

(xvi) provide for the return of any amount withdrawn in excess of the actual amounts required for:

(A) payment of reported allowed claims under Subsection (2)(b)(iii); and

(B) interest payments at a rate not in excess of the prime rate of interest on the excess amounts withdrawn; and

(xvii) provide for termination of the reinsurance recoverable trust in accordance with Subsection (6).

(c) Notwithstanding Subsection (2)(b)(viii) or (ix), a resignation or removal may not be effective until:

(i) a successor trustee is appointed and approved by the beneficiary and the grantor; and

(ii) all assets in the trust are transferred to the new trustee.

(d) Notwithstanding Subsection (2)(b)(xiii), a transfer may be conditioned upon the trustee receiving, before or simultaneously with, other specified assets.

(e) Subsection (2)(b) may not be construed to alter the rights or obligations of the

parties pursuant to contractual and statutory provisions providing for notice and the determination of a claim.

(3) The grantor shall, before depositing assets with the trustee, execute assignments or endorsements in blank, or transfer legal title to the trustee of all shares, obligations, or any other assets requiring assignments, in order that the beneficiary, or the trustee upon the direction of the beneficiary, may whenever necessary negotiate these assets without consent or signature from the grantor or any other person.

(4) (a) Without derogating Section 31A-27a-512, the grantor or the beneficiary may request that the receivership court review the amount held if:

(i) the grantor and beneficiary fail to reach agreement on the extent, if any, to which supplementation or reduction of a reinsurance recoverable trust should be occasioned;

(ii) (A) the reinsurance recoverable trust is exhausted; or

(B) the reinsurance recoverable trust is insufficient to respond to claims allowed pursuant to Section 31A-27a-603 or 31A-27a-605; and

(iii) the grantor or the beneficiary believe that the amount held in the reinsurance recoverable trust is either deficient or overstated.

(b) The review described in this Subsection (4) shall be conducted applying procedures and terms as the receivership court shall, in its sole discretion, direct.

(5) A reinsurance recoverable trust shall terminate upon the earlier of:

(a) receivership court approval of a voluntary commutation between the grantor and the beneficiary pursuant to Subsection 31A-27a-515[~~(1)~~] (2);

(b) the mutual agreement of the grantor and the beneficiary; or

(c) a finding by the receivership court that the grantor has discharged its liabilities to the beneficiary.

(6) Upon termination of a reinsurance recoverable trust, all assets not previously withdrawn by the beneficiary, pursuant to Subsection (2)(b)(iii), shall, with written approval of the beneficiary, be delivered to the grantor.

Section 25. Section **31A-30-102** is amended to read:

31A-30-102. Purpose statement.

The purpose of this chapter is to:

(1) prevent abusive rating practices;

(2) require disclosure of rating practices to purchasers;

(3) establish rules regarding:

(a) a universal individual and small group application; and

(b) renewability of coverage;

(4) improve the overall fairness and efficiency of the individual and small group insurance market; and

(5) provide increased access for individuals and small employers to health insurance.

Section 26. Section **31A-30-108** is amended to read:

31A-30-108. Eligibility for small employer and individual market.

(1) (a) Small employer carriers shall accept residents for small group coverage as set forth in the Health Insurance Portability and Accountability Act, P.L. 104-191, 110 Stat. 1962, Sec. 2701(f) and 2711(a).

(b) Individual carriers shall accept residents for individual coverage pursuant:

(i) to P.L. 104-191, 110 Stat. 1979, Sec. 2741(a)-(b); and

(ii) Subsection (3).

(2) (a) Small employer carriers shall offer to accept all eligible employees and their dependents at the same level of benefits under any health benefit plan provided to a small employer.

(b) Small employer carriers may:

(i) request a small employer to submit a copy of the small employer's quarterly income tax withholdings to determine whether the employees for whom coverage is provided or requested are bona fide employees of the small employer; and

(ii) deny or terminate coverage if the small employer refuses to provide documentation requested under Subsection (2)(b)(i).

(3) Except as provided in Subsections (5) and (6) and Section 31A-30-110, individual carriers shall accept for coverage individuals to whom all of the following conditions apply:

(a) the individual is not covered or eligible for coverage:

(i) (A) as an employee of an employer;

(B) as a member of an association; or

(C) as a member of any other group; and

(ii) under:

(A) a health benefit plan; or

(B) a self-insured arrangement that provides coverage similar to that provided by a health benefit plan as defined in Section 31A-1-301;

(b) the individual is not covered and is not eligible for coverage under any public health benefits arrangement including:

(i) the Medicare program established under Title XVIII of the Social Security Act;

[~~(ii) the Medicaid program established under Title XIX of the Social Security Act;~~]

[~~(iii)~~] (ii) any act of Congress or law of this or any other state that provides benefits comparable to the benefits provided under this chapter; or

[~~(iv)~~] (iii) coverage under the Comprehensive Health Insurance Pool Act created in Chapter 29, Comprehensive Health Insurance Pool Act;

(c) unless the maximum benefit has been reached the individual is not covered or eligible for coverage under any:

(i) Medicare supplement policy;

(ii) conversion option;

(iii) continuation or extension under COBRA; or

(iv) state extension;

(d) the individual has not terminated or declined coverage described in Subsection (3)(a), (b), or (c) within 93 days of application for coverage, unless the individual is eligible for individual coverage under P.L. 104-191, 110 Stat. 1979, Sec. 2741(b), in which case, the requirement of this Subsection (3)(d) does not apply; and

(e) the individual is certified as ineligible for the Health Insurance Pool if:

(i) the individual applies for coverage with the Comprehensive Health Insurance Pool within 30 days after being rejected or refused coverage by the covered carrier and reapplies for coverage with that covered carrier within 30 days after the date of issuance of a certificate under Subsection 31A-29-111 (5)(c); or

(ii) the individual applies for coverage with any individual carrier within 45 days after:

(A) notice of cancellation of coverage under Subsection 31A-29-115(1); or

(B) the date of issuance of a certificate under Subsection 31A-29-111 (5)(c) if the individual applied first for coverage with the Comprehensive Health Insurance Pool.

(4) (a) If coverage is obtained under Subsection (3)(e)(i) and the required premium is

paid, the effective date of coverage shall be the first day of the month following the individual's submission of a completed insurance application to that covered carrier.

(b) If coverage is obtained under Subsection (3)(e)(ii) and the required premium is paid, the effective date of coverage shall be the day following the:

(i) cancellation of coverage under Subsection 31A-29-115(1); or

(ii) submission of a completed insurance application to the Comprehensive Health Insurance Pool.

(5) (a) An individual carrier is not required to accept individuals for coverage under Subsection (3) if the carrier issues no new individual policies in the state after July 1, 1997.

(b) A carrier described in Subsection (5)(a) may not issue new individual policies in the state for five years from July 1, 1997.

(c) Notwithstanding Subsection (5)(b), a carrier may request permission to issue new policies after July 1, 1999, which may only be granted if:

(i) the carrier accepts uninsurables as is required of a carrier entering the market under Subsection 31A-30-110; and

(ii) the commissioner finds that the carrier's issuance of new individual policies:

(A) is in the best interests of the state; and

(B) does not provide an unfair advantage to the carrier.

(6) (a) If the Comprehensive Health Insurance Pool as set forth under Title 31A, Chapter 29, is dissolved or discontinued, or if enrollment is capped or suspended, an individual carrier may decline to accept individuals applying for individual enrollment, other than individuals applying for coverage as set forth in P.L. 104-191, 110 Stat. 1979, Sec. 2741 (a)-(b).

(b) Within two calendar days of taking action under Subsection (6)(a), an individual carrier will provide written notice to the Utah Insurance Department.

(7) (a) If a small employer carrier offers health benefit plans to small employers through a network plan, the small employer carrier may:

(i) limit the employers that may apply for the coverage to those employers with eligible employees who live, reside, or work in the service area for the network plan; and

(ii) within the service area of the network plan, deny coverage to an employer if the small employer carrier has demonstrated to the commissioner that the small employer carrier:

(A) will not have the capacity to deliver services adequately to enrollees of any additional groups because of the small employer carrier's obligations to existing group contract holders and enrollees; and

(B) applies this section uniformly to all employers without regard to:

(I) the claims experience of an employer, an employer's employee, or a dependent of an employee; or

(II) any health status-related factor relating to an employee or dependent of an employee.

(b) (i) A small employer carrier that denies a health benefit product to an employer in any service area in accordance with this section may not offer coverage in the small employer market within the service area to any employer for a period of 180 days after the date the coverage is denied.

(ii) This Subsection (7)(b) does not:

(A) limit the small employer carrier's ability to renew coverage that is in force; or

(B) relieve the small employer carrier of the responsibility to renew coverage that is in force.

(c) Coverage offered within a service area after the 180-day period specified in Subsection (7)(b) is subject to the requirements of this section.

Section 27. Section **31A-30-112** is amended to read:

31A-30-112. Employee participation levels.

(1) (a) Except as provided in Subsection (2), [~~requirements~~] a requirement used by a covered carrier in determining whether to provide coverage to a small employer, including [~~requirements~~] a requirement for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the covered carrier.

(b) In addition to applying Subsection 31A-1-301[~~(120)~~](121), a covered carrier may require that a small employer have a minimum of two eligible employees to meet participation requirements.

(2) A covered carrier may not increase [~~any~~] a requirement for minimum employee participation or [~~any~~] a requirement for minimum employer contribution applicable to a small

employer at any time after the small employer [~~has been~~] is accepted for coverage.

Legislative Review Note
as of 1-23-08 5:37 PM

Office of Legislative Research and General Counsel

Fiscal Note

H.B. 342 - Insurance Code Amendments

2008 General Session

State of Utah

State Impact

Enactment of this bill will not require additional appropriations.

Individual, Business and/or Local Impact

Enactment of this bill likely will not result in direct, measurable costs and/or benefits for individuals, businesses, or local governments.

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Office of the Legislative Fiscal Analyst