

**Representative James A. Dunnigan** proposes the following substitute bill:

**INSURANCE LAW RELATED AMENDMENTS**

2011 GENERAL SESSION

STATE OF UTAH

**Chief Sponsor: James A. Dunnigan**

Senate Sponsor: J. Stuart Adams

---

**LONG TITLE**

**General Description:**

This bill modifies the Insurance Code and other provisions related to the regulation of insurance and insurance products.

**Highlighted Provisions:**

This bill:

- ▶ amends definitions;
- ▶ addresses fees for captive insurance companies and the cap on the Captive Insurance Restricted Account;
- ▶ modifies restrictions on foreign title insurers;
- ▶ removes outdated language;
- ▶ addresses grace periods for accident and health insurance policies;
- ▶ modifies provisions related to individuals, group, or blanket accident and health insurance coverage;
- ▶ addresses health benefit plan offerings;
- ▶ addresses producer lines of authority;
- ▶ addresses a written agreement related to a voluntary surrender of a license;
- ▶ amends provisions related to continuing education;
- ▶ provides for training related to long-term care insurance;



- 26           ▶ modifies title insurance agency and producer licensing requirements;
- 27           ▶ addresses when a title insurance producer may do an escrow involving a real
- 28 property transaction;
- 29           ▶ modifies provisions related to disbursements from escrow accounts;
- 30           ▶ modifies title insurance related assessments;
- 31           ▶ addresses when a person may represent that the person acts in behalf of an insurer;
- 32           ▶ modifies provisions related to providing the commissioner address, telephone, and
- 33 email address information;
- 34           ▶ addresses verification under a nonresident jurisdictional agreement;
- 35           ▶ addresses per diem and travel expenses of public representatives on the board of
- 36 directors of the Utah Life and Health Insurance Guaranty Association;
- 37           ▶ addresses the establishment of classes of business;
- 38           ▶ modifies rating restrictions;
- 39           ▶ addresses the renewal of a bail bond surety company license;
- 40           ▶ permits the commissioner to assign a department employee to engage in certain
- 41 activities related to the regulation of captive insurance companies;
- 42           ▶ requires a professional employer organization to notify the commissioner of
- 43 material changes;
- 44           ▶ removes the title insurance assessment from the sunset act;
- 45           ▶ converts certain dedicated credits into several restricted accounts and provides that
- 46 related appropriations are nonlapsing; and
- 47           ▶ makes technical and conforming amendments.

48 **Money Appropriated in this Bill:**

49           None

50 **Other Special Clauses:**

51           This bill has an effective date.

52           This bill provides for retrospective operation of certain provisions.

53 **Utah Code Sections Affected:**

54 AMENDS:

55           **31A-1-301**, as last amended by Laws of Utah 2010, Chapter 10

56           **31A-2-208**, as last amended by Laws of Utah 2010, Chapter 391

- 57           **31A-2-212**, as last amended by Laws of Utah 2007, Chapter 309
- 58           **31A-3-304**, as last amended by Laws of Utah 2010, Chapters 10, 68 and last amended
- 59 by Coordination Clause, Laws of Utah 2010, Chapter 265
- 60           **31A-14-211**, as last amended by Laws of Utah 2003, Chapter 298
- 61           **31A-22-305**, as last amended by Laws of Utah 2010, Chapter 354
- 62           **31A-22-607**, as last amended by Laws of Utah 2004, Chapter 329
- 63           **31A-22-610.6**, as enacted by Laws of Utah 2008, Chapters 345, 383, and 390
- 64           **31A-22-614.5**, as last amended by Laws of Utah 2010, Chapter 357
- 65           **31A-22-618.5**, as last amended by Laws of Utah 2010, Chapter 68
- 66           **31A-22-625**, as last amended by Laws of Utah 2010, Chapters 10 and 68
- 67           **31A-22-701**, as last amended by Laws of Utah 2010, Chapter 10
- 68           **31A-22-716**, as last amended by Laws of Utah 2005, Chapter 71
- 69           **31A-22-721**, as last amended by Laws of Utah 2004, Chapter 329
- 70           **31A-22-723**, as last amended by Laws of Utah 2010, Chapter 68
- 71           **31A-23a-102**, as last amended by Laws of Utah 2009, Chapter 349
- 72           **31A-23a-106**, as last amended by Laws of Utah 2009, Chapter 349
- 73           **31A-23a-111**, as last amended by Laws of Utah 2009, Chapters 349 and 355
- 74           **31A-23a-202**, as last amended by Laws of Utah 2009, Chapter 127
- 75           **31A-23a-203**, as last amended by Laws of Utah 2009, Chapter 349
- 76           **31A-23a-204**, as last amended by Laws of Utah 2009, Chapter 349
- 77           **31A-23a-406**, as last amended by Laws of Utah 2007, Chapter 325
- 78           **31A-23a-408**, as renumbered and amended by Laws of Utah 2003, Chapter 298
- 79           **31A-23a-412**, as renumbered and amended by Laws of Utah 2003, Chapter 298
- 80           **31A-23a-415**, as last amended by Laws of Utah 2010, Chapter 10 and last amended by
- 81 Coordination Clause, Laws of Utah 2010, Chapter 265
- 82           **31A-25-208**, as last amended by Laws of Utah 2009, Chapter 349
- 83           **31A-26-206**, as last amended by Laws of Utah 2008, Chapter 382
- 84           **31A-26-208**, as last amended by Laws of Utah 2008, Chapter 3
- 85           **31A-26-213**, as last amended by Laws of Utah 2009, Chapter 349
- 86           **31A-26-306**, as last amended by Laws of Utah 2004, Chapter 173
- 87           **31A-28-107**, as last amended by Laws of Utah 2010, Chapter 292

- 88            **31A-29-103**, as last amended by Laws of Utah 2008, Chapters 3 and 385
- 89            **31A-29-106**, as last amended by Laws of Utah 2008, Chapter 382
- 90            **31A-30-103**, as last amended by Laws of Utah 2010, Chapter 68
- 91            **31A-30-105**, as last amended by Laws of Utah 2010, Chapter 68
- 92            **31A-30-106**, as last amended by Laws of Utah 2010, Chapter 68
- 93            **31A-30-106.1**, as enacted by Laws of Utah 2010, Chapter 68
- 94            **31A-30-106.5**, as last amended by Laws of Utah 2010, Chapter 68
- 95            **31A-30-108**, as last amended by Laws of Utah 2008, Chapter 383
- 96            **31A-30-110**, as last amended by Laws of Utah 2002, Chapter 308
- 97            **31A-30-112**, as last amended by Laws of Utah 2009, Chapter 12
- 98            **31A-31-108**, as last amended by Laws of Utah 2010, Chapter 391
- 99            **31A-31-109**, as last amended by Laws of Utah 2010, Chapter 391
- 100           **31A-35-202**, as last amended by Laws of Utah 2000, Chapter 259
- 101           **31A-35-406**, as last amended by Laws of Utah 2010, Chapter 10
- 102           **31A-35-602**, as last amended by Laws of Utah 2000, Chapter 259
- 103           **31A-37-103**, as last amended by Laws of Utah 2008, Chapter 302
- 104           **31A-37-202**, as last amended by Laws of Utah 2009, Chapter 183
- 105           **31A-37-504**, as last amended by Laws of Utah 2007, Chapter 309
- 106           **59-9-105**, as last amended by Laws of Utah 2002, Chapter 308
- 107           **63I-2-231**, as last amended by Laws of Utah 2010, Chapters 68 and 285
- 108           **63J-1-602.2**, as enacted by Laws of Utah 2010, Chapter 265 and last amended by
- 109           Coordination Clause, Laws of Utah 2010, Chapter 265
- 110           **63J-1-602.3**, as enacted by Laws of Utah 2010, Chapter 265

111 ENACTS:

112            **31A-40-308**, Utah Code Annotated 1953

113 **Uncodified Material Affected:**

114 ENACTS UNCODIFIED MATERIAL



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

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

118            **31A-1-301. Definitions.**

119 As used in this title, unless otherwise specified:

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

122 (i) a medical condition including:

123 (A) a medical care expense; or

124 (B) the risk of disability;

125 (ii) accident; or

126 (iii) sickness.

127 (b) "Accident and health insurance":

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

129 (A) an income replacement contract;

130 (B) a health care contract;

131 (C) an expense reimbursement contract;

132 (D) a credit accident and health contract;

133 (E) a continuing care contract; and

134 (F) a long-term care contract; and

135 (ii) may provide:

136 (A) hospital coverage;

137 (B) surgical coverage;

138 (C) medical coverage;

139 (D) loss of income coverage;

140 (E) prescription drug coverage;

141 (F) dental coverage; or

142 (G) vision coverage.

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

144 (2) "Actuary" is as defined by the commissioner by rule, made in accordance with Title  
145 63G, Chapter 3, Utah Administrative Rulemaking Act.

146 (3) "Administrator" is defined in Subsection [~~(159)~~] (161).

147 (4) "Adult" means an individual who has attained the age of at least 18 years.

148 (5) "Affiliate" means a person who controls, is controlled by, or is under common

149 control with, another person. A corporation is an affiliate of another corporation, regardless of

150 ownership, if substantially the same group of individuals manage the corporations.

151 (6) "Agency" means:

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

154 (b) an insurance organization licensed or required to be licensed under Section  
155 31A-23a-301, 31A-25-207, or 31A-26-209.

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

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

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

162 (10) "Application" means a document:

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

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

167 (A) insure the risk under:

168 (I) the coverage as originally offered; or

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

170 (B) decline to insure the risk; or

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

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

174 (a) the original articles;

175 (b) a special law;

176 (c) a charter;

177 (d) an amendment;

178 (e) restated articles;

179 (f) articles of merger or consolidation;

180 (g) a trust instrument;

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

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

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

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

188 (14) "Blanket insurance policy" means a group policy covering a defined class of  
189 persons:

190 (a) without individual underwriting or application; and

191 (b) that is determined by definition [~~with or~~] without designating each person covered.

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

194 (16) "Bona fide office" means a physical office in this state:

195 (a) that is open to the public;

196 (b) that is staffed during regular business hours on regular business days; and

197 (c) at which the public may appear in person to obtain services.

198 [~~(16)~~] (17) "Business entity" means:

199 (a) a corporation;

200 (b) an association;

201 (c) a partnership;

202 (d) a limited liability company;

203 (e) a limited liability partnership; or

204 (f) another legal entity.

205 [~~(17)~~] (18) "Business of insurance" is defined in Subsection [~~(85)~~] (87).

206 [~~(18)~~] (19) "Business plan" means the information required to be supplied to the  
207 commissioner under Subsections 31A-5-204(2)(i) and (j), including the information required  
208 when these subsections apply by reference under:

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

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

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

212            [~~(19)~~] (20) (a) "Bylaws" means the rules adopted for the regulation or management of a  
213 corporation's affairs, however designated.

214            (b) "Bylaws" includes comparable rules for a trust or other entity that is not a  
215 corporation.

216            [~~(20)~~] (21) "Captive insurance company" means:

217            (a) an insurer:

218            (i) owned by another organization; and

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

221            (b) in the case of a group or association, an insurer:

222            (i) owned by the insureds; and

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

224            (A) a member organization;

225            (B) a group member; or

226            (C) an affiliate of:

227            (I) a member organization; or

228            (II) a group member.

229            [~~(21)~~] (22) "Casualty insurance" means liability insurance.

230            [~~(22)~~] (23) "Certificate" means evidence of insurance given to:

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

232            (b) a third party.

233            [~~(23)~~] (24) "Certificate of authority" is included within the term "license."

234            [~~(24)~~] (25) "Claim," unless the context otherwise requires, means a request or demand  
235 on an insurer for payment of a benefit according to the terms of an insurance policy.

236            [~~(25)~~] (26) "Claims-made coverage" means an insurance contract or provision limiting  
237 coverage under a policy insuring against legal liability to claims that are first made against the  
238 insured while the policy is in force.

239            [~~(26)~~] (27) (a) "Commissioner" or "commissioner of insurance" means Utah's  
240 insurance commissioner.

241            (b) When appropriate, the terms listed in Subsection [~~(26)~~] (27)(a) apply to the  
242 equivalent supervisory official of another jurisdiction.

243            [~~(27)~~] (28) (a) "Continuing care insurance" means insurance that:  
244            (i) provides board and lodging;  
245            (ii) provides one or more of the following:  
246            (A) a personal service;  
247            (B) a nursing service;  
248            (C) a medical service; or  
249            (D) any other health-related service; and  
250            (iii) provides the coverage described in this Subsection [~~(27)~~] (28)(a) under an  
251 agreement effective:  
252            (A) for the life of the insured; or  
253            (B) for a period in excess of one year.  
254            (b) Insurance is continuing care insurance regardless of whether or not the board and  
255 lodging are provided at the same location as a service described in Subsection [~~(27)~~] (28)(a)(ii).  
256            [~~(28)~~] (29) (a) "Control," "controlling," "controlled," or "under common control"  
257 means the direct or indirect possession of the power to direct or cause the direction of the  
258 management and policies of a person. This control may be:  
259            (i) by contract;  
260            (ii) by common management;  
261            (iii) through the ownership of voting securities; or  
262            (iv) by a means other than those described in Subsections [~~(28)~~] (29)(a)(i) through (iii).  
263            (b) There is no presumption that an individual holding an official position with another  
264 person controls that person solely by reason of the position.  
265            (c) A person having a contract or arrangement giving control is considered to have  
266 control despite the illegality or invalidity of the contract or arrangement.  
267            (d) There is a rebuttable presumption of control in a person who directly or indirectly  
268 owns, controls, holds with the power to vote, or holds proxies to vote 10% or more of the  
269 voting securities of another person.  
270            [~~(29)~~] (30) "Controlled insurer" means a licensed insurer that is either directly or  
271 indirectly controlled by a producer.  
272            [~~(30)~~] (31) "Controlling person" means a person that directly or indirectly has the  
273 power to direct or cause to be directed, the management, control, or activities of a reinsurance

274 intermediary.

275 ~~[(31)]~~ (32) "Controlling producer" means a producer who directly or indirectly controls  
276 an insurer.

277 ~~[(32)]~~ (33) (a) "Corporation" means an insurance corporation, except when referring to:

278 (i) a corporation doing business:

279 (A) as:

280 (I) an insurance producer;

281 (II) a limited line producer;

282 (III) a consultant;

283 (IV) a managing general agent;

284 (V) a reinsurance intermediary;

285 (VI) a third party administrator; or

286 (VII) an adjuster; and

287 (B) under:

288 (I) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and

289 Reinsurance Intermediaries;

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

291 (III) Chapter 26, Insurance Adjusters; or

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

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

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

296 ~~[(33)]~~ (34) (a) "Creditable coverage" has the same meaning as provided in federal  
297 regulations adopted pursuant to the Health Insurance Portability and Accountability Act ~~[of~~  
298 ~~1996, Pub. L. 104-191, 110 Stat. 1936].~~

299 (b) "Creditable coverage" includes coverage that is offered through a public health plan  
300 such as:

301 (i) the Primary Care Network Program under a Medicaid primary care network

302 demonstration waiver obtained subject to Section 26-18-3;

303 (ii) the Children's Health Insurance Program under Section 26-40-106; or

304 (iii) the Ryan White Program Comprehensive AIDS Resources Emergency Act, Pub. L.

305 101-381, and Ryan White HIV/AIDS Treatment Modernization Act of 2006, Pub. L. 109-415.

306 [~~34~~] (35) "Credit accident and health insurance" means insurance on a debtor to  
307 provide indemnity for payments coming due on a specific loan or other credit transaction while  
308 the debtor is disabled.

309 [~~35~~] (36) (a) "Credit insurance" means insurance offered in connection with an  
310 extension of credit that is limited to partially or wholly extinguishing that credit obligation.

311 (b) "Credit insurance" includes:

- 312 (i) credit accident and health insurance;
- 313 (ii) credit life insurance;
- 314 (iii) credit property insurance;
- 315 (iv) credit unemployment insurance;
- 316 (v) guaranteed automobile protection insurance;
- 317 (vi) involuntary unemployment insurance;
- 318 (vii) mortgage accident and health insurance;
- 319 (viii) mortgage guaranty insurance; and
- 320 (ix) mortgage life insurance.

321 [~~36~~] (37) "Credit life insurance" means insurance on the life of a debtor in connection  
322 with an extension of credit that pays a person if the debtor dies.

323 [~~37~~] (38) "Credit property insurance" means insurance:

- 324 (a) offered in connection with an extension of credit; and
- 325 (b) that protects the property until the debt is paid.

326 [~~38~~] (39) "Credit unemployment insurance" means insurance:

- 327 (a) offered in connection with an extension of credit; and
- 328 (b) that provides indemnity if the debtor is unemployed for payments coming due on a:
  - 329 (i) specific loan; or
  - 330 (ii) credit transaction.

331 [~~39~~] (40) "Creditor" means a person, including an insured, having a claim, whether:

- 332 (a) matured;
- 333 (b) unmatured;
- 334 (c) liquidated;
- 335 (d) unliquidated;

336 (e) secured;

337 (f) unsecured;

338 (g) absolute;

339 (h) fixed; or

340 (i) contingent.

341 [~~(40)~~] (41) (a) "Customer service representative" means a person that provides an  
342 insurance service and insurance product information:

343 (i) for the customer service representative's:

344 (A) producer; or

345 (B) consultant employer; and

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

347 (A) customer;

348 (B) client; or

349 (C) organization.

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

352 [~~(41)~~] (42) "Deadline" means a final date or time:

353 (a) imposed by:

354 (i) statute;

355 (ii) rule; or

356 (iii) order; and

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

358 [~~(42)~~] (43) "Deemer clause" means a provision under this title under which upon the  
359 occurrence of a condition precedent, the commissioner is considered to have taken a specific  
360 action. If the statute so provides, a condition precedent may be the commissioner's failure to  
361 take a specific action.

362 [~~(43)~~] (44) "Degree of relationship" means the number of steps between two persons  
363 determined by counting the generations separating one person from a common ancestor and  
364 then counting the generations to the other person.

365 [~~(44)~~] (45) "Department" means the Insurance Department.

366 [~~(45)~~] (46) "Director" means a member of the board of directors of a corporation.

367            [~~(46)~~] (47) "Disability" means a physiological or psychological condition that partially  
368 or totally limits an individual's ability to:

369            (a) perform the duties of:

370            (i) that individual's occupation; or

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

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

374            (i) eating;

375            (ii) toileting;

376            (iii) transferring;

377            (iv) bathing; or

378            (v) dressing.

379            [~~(47)~~] (48) "Disability income insurance" is defined in Subsection [~~(76)~~] (78).

380            [~~(48)~~] (49) "Domestic insurer" means an insurer organized under the laws of this state.

381            [~~(49)~~] (50) "Domiciliary state" means the state in which an insurer:

382            (a) is incorporated;

383            (b) is organized; or

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

385            [~~(50)~~] (51) (a) "Eligible employee" means:

386            (i) an employee who:

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

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

389            (ii) a person described in Subsection [~~(50)~~] (51)(b).

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

392            (i) a sole proprietor;

393            (ii) a partner in a partnership; or

394            (iii) an independent contractor.

395            (c) "Eligible employee" does not include, unless eligible under Subsection [~~(50)~~]

396 (51)(b):

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

- 398 (ii) an employer's spouse; or
- 399 (iii) a dependent of an employer.
- 400 [~~(51)~~] (52) "Employee" means an individual employed by an employer.
- 401 [~~(52)~~] (53) "Employee benefits" means one or more benefits or services provided to:
- 402 (a) an employee; or
- 403 (b) a dependent of an employee.
- 404 [~~(53)~~] (54) (a) "Employee welfare fund" means a fund:
- 405 (i) established or maintained, whether directly or through a trustee, by:
- 406 (A) one or more employers;
- 407 (B) one or more labor organizations; or
- 408 (C) a combination of employers and labor organizations; and
- 409 (ii) that provides employee benefits paid or contracted to be paid, other than income
- 410 from investments of the fund:
- 411 (A) by or on behalf of an employer doing business in this state; or
- 412 (B) for the benefit of a person employed in this state.
- 413 (b) "Employee welfare fund" includes a plan funded or subsidized by a user fee or tax
- 414 revenues.
- 415 [~~(54)~~] (55) "Endorsement" means a written agreement attached to a policy or certificate
- 416 to modify the policy or certificate coverage.
- 417 [~~(55)~~] (56) "Enrollment date," with respect to a health benefit plan, means:
- 418 (a) the first day of coverage; or
- 419 (b) if there is a waiting period, the first day of the waiting period.
- 420 [~~(56)~~] (57) (a) "Escrow" means:
- 421 (i) a real estate settlement or real estate closing conducted by a third party pursuant to
- 422 the requirements of a written agreement between the parties in a real estate transaction; or
- 423 (ii) a settlement or closing involving:
- 424 (A) a mobile home;
- 425 (B) a grazing right;
- 426 (C) a water right; or
- 427 (D) other personal property authorized by the commissioner.
- 428 (b) "Escrow" includes the act of conducting a:

429 (i) real estate settlement; or

430 (ii) real estate closing.

431 [~~57~~] 58 "Escrow agent" means:

432 (a) an insurance producer with:

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

434 (ii) an escrow subline of authority; or

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

436 [~~58~~] 59 (a) "Excludes" is not exhaustive and does not mean that another thing is not  
437 also excluded.

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

440 [~~59~~] 60 "Exclusion" means for the purposes of accident and health insurance that an  
441 insurer does not provide insurance coverage, for whatever reason, for one of the following:

442 (a) a specific physical condition;

443 (b) a specific medical procedure;

444 (c) a specific disease or disorder; or

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

446 [~~60~~] 61 "Expense reimbursement insurance" means insurance:

447 (a) written to provide a payment for an expense relating to hospital confinement  
448 resulting from illness or injury; and

449 (b) written:

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

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

452 [~~61~~] 62 "Fidelity insurance" means insurance guaranteeing the fidelity of a person  
453 holding a position of public or private trust.

454 [~~62~~] 63 (a) "Filed" means that a filing is:

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

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

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

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

461 (B) rule.

462 (b) "Filed" does not include a filing that is rejected by the department because it is not  
463 submitted in accordance with Subsection [~~(62)~~] (63)(a).

464 [~~(63)~~] (64) "Filing," when used as a noun, means an item required to be filed with the  
465 department including:

466 (a) a policy;

467 (b) a rate;

468 (c) a form;

469 (d) a document;

470 (e) a plan;

471 (f) a manual;

472 (g) an application;

473 (h) a report;

474 (i) a certificate;

475 (j) an endorsement;

476 (k) an actuarial certification;

477 (l) a licensee annual statement;

478 (m) a licensee renewal application;

479 (n) an advertisement; or

480 (o) an outline of coverage.

481 [~~(64)~~] (65) "First party insurance" means an insurance policy or contract in which the  
482 insurer agrees to pay a claim submitted to it by the insured for the insured's losses.

483 [~~(65)~~] (66) "Foreign insurer" means an insurer domiciled outside of this state, including  
484 an alien insurer.

485 [~~(66)~~] (67) (a) "Form" means one of the following prepared for general use:

486 (i) a policy;

487 (ii) a certificate;

488 (iii) an application;

489 (iv) an outline of coverage; or

490 (v) an endorsement.

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

493 [~~(67)~~] (68) "Franchise insurance" means an individual insurance policy provided  
494 through a mass marketing arrangement involving a defined class of persons related in some  
495 way other than through the purchase of insurance.

496 [~~(68)~~] (69) "General lines of authority" include:

497 (a) the general lines of insurance in Subsection [~~(69)~~] (70);

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

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

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

501 (iii) title marketing representative only;

502 (c) surplus lines;

503 (d) workers' compensation; and

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

506 [~~(69)~~] (70) "General lines of insurance" include:

507 (a) accident and health;

508 (b) casualty;

509 (c) life;

510 (d) personal lines;

511 (e) property; and

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

513 [~~(70)~~] (71) "Group health plan" means an employee welfare benefit plan to the extent  
514 that the plan provides medical care:

515 (a) (i) to an employee; or

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

517 (b) (i) directly;

518 (ii) through insurance reimbursement; or

519 (iii) through another method.

520 [~~(71)~~] (72) (a) "Group insurance policy" means a policy covering a group of persons  
521 that is issued:

522 (i) to a policyholder on behalf of the group; and  
523 (ii) for the benefit of a member of the group who is selected under a procedure defined  
524 in:

- 525 (A) the policy; or
- 526 (B) an agreement that is collateral to the policy.

527 (b) A group insurance policy may include a member of the policyholder's family or a  
528 dependent.

529 [~~(72)~~] (73) "Guaranteed automobile protection insurance" means insurance offered in  
530 connection with an extension of credit that pays the difference in amount between the  
531 insurance settlement and the balance of the loan if the insured automobile is a total loss.

532 [~~(73)~~] (74) (a) Except as provided in Subsection [~~(73)~~] (74)(b), "health benefit plan"  
533 means a policy or certificate that:

- 534 (i) provides health care insurance;
- 535 (ii) provides major medical expense insurance; or
- 536 (iii) is offered as a substitute for hospital or medical expense insurance, such as:
  - 537 (A) a hospital confinement indemnity; or
  - 538 (B) a limited benefit plan.

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

- 540 (i) provides benefits solely for:
  - 541 (A) accident;
  - 542 (B) dental;
  - 543 (C) income replacement;
  - 544 (D) long-term care;
  - 545 (E) a Medicare supplement;
  - 546 (F) a specified disease;
  - 547 (G) vision; or
  - 548 (H) a short-term limited duration; or
- 549 (ii) is offered and marketed as supplemental health insurance.

550 [~~(74)~~] (75) "Health care" means any of the following intended for use in the diagnosis,  
551 treatment, mitigation, or prevention of a human ailment or impairment:

- 552 (a) a professional service;

- 553 (b) a personal service;
- 554 (c) a facility;
- 555 (d) equipment;
- 556 (e) a device;
- 557 (f) supplies; or
- 558 (g) medicine.

559 ~~[(75)]~~ (76) (a) "Health care insurance" or "health insurance" means insurance  
560 providing:

- 561 (i) a health care benefit; or
- 562 (ii) payment of an incurred health care expense.

563 (b) "Health care insurance" or "health insurance" does not include accident and health  
564 insurance providing a benefit for:

- 565 (i) replacement of income;
- 566 (ii) short-term accident;
- 567 (iii) fixed indemnity;
- 568 (iv) credit accident and health;
- 569 (v) supplements to liability;
- 570 (vi) workers' compensation;
- 571 (vii) automobile medical payment;
- 572 (viii) no-fault automobile;
- 573 (ix) equivalent self-insurance; or
- 574 (x) a type of accident and health insurance coverage that is a part of or attached to

575 another type of policy.

576 (77) "Health Insurance Portability and Accountability Act" means the Health Insurance  
577 Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936, as amended.

578 ~~[(76)]~~ (78) "Income replacement insurance" or "disability income insurance" means  
579 insurance written to provide payments to replace income lost from accident or sickness.

580 ~~[(77)]~~ (79) "Indemnity" means the payment of an amount to offset all or part of an  
581 insured loss.

582 ~~[(78)]~~ (80) "Independent adjuster" means an insurance adjuster required to be licensed  
583 under Section 31A-26-201 who engages in insurance adjusting as a representative of an insurer.

584            [~~(79)~~] (81) "Independently procured insurance" means insurance procured under  
585 Section 31A-15-104.

586            [~~(80)~~] (82) "Individual" means a natural person.

587            [~~(81)~~] (83) "Inland marine insurance" includes insurance covering:

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

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

590            (c) bailee liability;

591            (d) fixed transportation property such as bridges, electric transmission systems, radio

592 and television transmission towers and tunnels; and

593            (e) personal and commercial property floaters.

594            [~~(82)~~] (84) "Insolvency" means that:

595            (a) an insurer is unable to pay its debts or meet its obligations as the debts and

596 obligations mature;

597            (b) an insurer's total adjusted capital is less than the insurer's mandatory control level

598 RBC under Subsection 31A-17-601(8)(c); or

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

600            [~~(83)~~] (85) (a) "Insurance" means:

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

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

605            (b) "Insurance" includes:

606            (i) a risk distributing arrangement providing for compensation or replacement for  
607 damages or loss through the provision of a service or a benefit in kind;

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

610            (iii) a plan in which the risk does not rest upon the person who makes an arrangement,  
611 but with a class of persons who have agreed to share the risk.

612            [~~(84)~~] (86) "Insurance adjuster" means a person who directs the investigation,  
613 negotiation, or settlement of a claim under an insurance policy other than life insurance or an  
614 annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.

615            [~~(85)~~] (87) "Insurance business" or "business of insurance" includes:

616            (a) providing health care insurance by an organization that is or is required to be

617 licensed under this title;

618            (b) providing a benefit to an employee in the event of a contingency not within the

619 control of the employee, in which the employee is entitled to the benefit as a right, which

620 benefit may be provided either:

621            (i) by a single employer or by multiple employer groups; or

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

623            (c) providing an annuity:

624            (i) including an annuity issued in return for a gift; and

625            (ii) except an annuity provided by a person specified in Subsections 31A-22-1305(2)

626 and (3);

627            (d) providing the characteristic services of a motor club as outlined in Subsection

628 [~~(113)~~] (115);

629            (e) providing another person with insurance;

630            (f) making as insurer, guarantor, or surety, or proposing to make as insurer, guarantor,

631 or surety, a contract or policy of title insurance;

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

633            (i) solicitation;

634            (ii) negotiation preliminary to execution;

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

636            (iv) insuring; and

637            (v) transacting matters subsequent to the execution of the contract and arising out of

638 the contract, including reinsurance; [~~and~~]

639            [~~(vi)~~] (h) transacting or proposing a life settlement; and

640            [~~(h)~~] (i) doing, or proposing to do, any business in substance equivalent to Subsections

641 [~~(85)~~] (87)(a) through [~~(g)~~] (h) in a manner designed to evade this title.

642            [~~(86)~~] (88) "Insurance consultant" or "consultant" means a person who:

643            (a) advises another person about insurance needs and coverages;

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

645 placed; and

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

648 ~~[(87)]~~ (89) "Insurance holding company system" means a group of two or more  
649 affiliated persons, at least one of whom is an insurer.

650 ~~[(88)]~~ (90) (a) "Insurance producer" or "producer" means a person licensed or required  
651 to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

652 ~~[(b) With regards to the selling, soliciting, or negotiating of an insurance product to an  
653 insurance customer or an insured:]~~

654 ~~[(i) "producer]~~ (b) (i) "Producer for the insurer" means a producer who is compensated  
655 directly or indirectly by an insurer for selling, soliciting, or negotiating ~~[a] an insurance~~ product  
656 of that insurer~~[; and]~~.

657 (ii) "Producer for the insurer" may be referred to as an "agent."

658 ~~[(ii) "producer]~~ (c) (i) "Producer for the insured" means a producer who:

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

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

663 (ii) "Producer for the insured" may be referred to as a "broker."

664 ~~[(89)]~~ (91) (a) "Insured" means a person to whom or for whose benefit an insurer  
665 makes a promise in an insurance policy and includes:

666 (i) a policyholder;

667 (ii) a subscriber;

668 (iii) a member; and

669 (iv) a beneficiary.

670 (b) The definition in Subsection ~~[(89)]~~ (91)(a):

671 (i) applies only to this title; and

672 (ii) does not define the meaning of this word as used in an insurance policy or  
673 certificate.

674 ~~[(90)]~~ (92) (a) "Insurer" means a person doing an insurance business as a principal  
675 including:

676 (i) a fraternal benefit society;

677 (ii) an issuer of a gift annuity other than an annuity specified in Subsections  
678 31A-22-1305(2) and (3);  
679 (iii) a motor club;  
680 (iv) an employee welfare plan; and  
681 (v) a person purporting or intending to do an insurance business as a principal on that  
682 person's own account.

683 (b) "Insurer" does not include a governmental entity to the extent the governmental  
684 entity is engaged in an activity described in Section 31A-12-107.

685 [~~91~~] (93) "Interinsurance exchange" is defined in Subsection [~~142~~] (144).

686 [~~92~~] (94) "Involuntary unemployment insurance" means insurance:

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

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

690 (i) specific loan; or

691 (ii) credit transaction.

692 [~~93~~] (95) "Large employer," in connection with a health benefit plan, means an  
693 employer who, with respect to a calendar year and to a plan year:

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

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

697 [~~94~~] (96) "Late enrollee," with respect to an employer health benefit plan, means an  
698 individual whose enrollment is a late enrollment.

699 [~~95~~] (97) "Late enrollment," with respect to an employer health benefit plan, means  
700 enrollment of an individual other than:

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

703 (b) through special enrollment.

704 [~~96~~] (98) (a) Except for a retainer contract or legal assistance described in Section  
705 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for a  
706 specified legal expense.

707 (b) "Legal expense insurance" includes an arrangement that creates a reasonable

708 expectation of an enforceable right.

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

711 [~~97~~] (99) (a) "Liability insurance" means insurance against liability:

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

714 (A) Subsection [~~107~~] (109) for medical malpractice insurance;

715 (B) Subsection [~~134~~] (136) for professional liability insurance; and

716 (C) Subsection [~~168~~] (170) for workers' compensation insurance;

717 (ii) for a medical, hospital, surgical, and funeral benefit to a person other than the  
718 insured who is injured, irrespective of legal liability of the insured, when issued with or  
719 supplemental to insurance against legal liability for the death, injury, or disability of a human  
720 being, exclusive of the coverages under:

721 (A) Subsection [~~107~~] (109) for medical malpractice insurance;

722 (B) Subsection [~~134~~] (136) for professional liability insurance; and

723 (C) Subsection [~~168~~] (170) for workers' compensation insurance;

724 (iii) for loss or damage to property resulting from an accident to or explosion of a  
725 boiler, pipe, pressure container, machinery, or apparatus;

726 (iv) for loss or damage to property caused by:

727 (A) the breakage or leakage of a sprinkler, water pipe, or water container; or

728 (B) water entering through a leak or opening in a building; or

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

731 (b) "Liability insurance" includes:

732 (i) vehicle liability insurance;

733 (ii) residential dwelling liability insurance; and

734 (iii) making inspection of, and issuing a certificate of inspection upon, an elevator,  
735 boiler, machinery, or apparatus of any kind when done in connection with insurance on the  
736 elevator, boiler, machinery, or apparatus.

737 [~~98~~] (100) (a) "License" means authorization issued by the commissioner to engage in  
738 an activity that is part of or related to the insurance business.

739 (b) "License" includes a certificate of authority issued to an insurer.

740 [~~99~~] (101) (a) "Life insurance" means:

741 (i) insurance on a human life; and

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

743 (b) The business of life insurance includes:

744 (i) granting a death benefit;

745 (ii) granting an annuity benefit;

746 (iii) granting an endowment benefit;

747 (iv) granting an additional benefit in the event of death by accident;

748 (v) granting an additional benefit to safeguard the policy against lapse; and

749 (vi) providing an optional method of settlement of proceeds.

750 [~~100~~] (102) "Limited license" means a license that:

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

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

753 [~~101~~] (103) "Limited line credit insurance" includes the following forms of

754 insurance:

755 (a) credit life;

756 (b) credit accident and health;

757 (c) credit property;

758 (d) credit unemployment;

759 (e) involuntary unemployment;

760 (f) mortgage life;

761 (g) mortgage guaranty;

762 (h) mortgage accident and health;

763 (i) guaranteed automobile protection; and

764 (j) another form of insurance offered in connection with an extension of credit that:

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

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

767 credit insurance.

768 [~~102~~] (104) "Limited line credit insurance producer" means a person who sells,

769 solicits, or negotiates one or more forms of limited line credit insurance coverage to an

770 individual through a master, corporate, group, or individual policy.

771 [~~(103)~~] (105) "Limited line insurance" includes:

772 (a) bail bond;

773 (b) limited line credit insurance;

774 (c) legal expense insurance;

775 (d) motor club insurance;

776 (e) [~~rental car-related~~] car rental related insurance;

777 (f) travel insurance;

778 (g) crop insurance;

779 (h) self-service storage insurance; [~~and~~]

780 (i) guaranteed asset protection waiver; and

781 [~~(j)~~] (j) another form of limited insurance that the commissioner determines by rule

782 should be designated a form of limited line insurance.

783 [~~(104)~~] (106) "Limited lines authority" includes:

784 (a) the lines of insurance listed in Subsection [~~(103)~~] (105); and

785 (b) a customer service representative.

786 [~~(105)~~] (107) "Limited lines producer" means a person who sells, solicits, or negotiates  
787 limited lines insurance.

788 [~~(106)~~] (108) (a) "Long-term care insurance" means an insurance policy or rider  
789 advertised, marketed, offered, or designated to provide coverage:

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

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

792 (A) expenses incurred;

793 (B) indemnity;

794 (C) prepayment; or

795 (D) another method;

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

797 (A) diagnostic;

798 (B) preventative;

799 (C) therapeutic;

800 (D) rehabilitative;

- 801 (E) maintenance; or
- 802 (F) personal care; and
- 803 (iv) that may be issued by:
- 804 (A) an insurer;
- 805 (B) a fraternal benefit society;
- 806 (C) (I) a nonprofit health hospital; and
- 807 (II) a medical service corporation;
- 808 (D) a prepaid health plan;
- 809 (E) a health maintenance organization; or
- 810 (F) an entity similar to the entities described in Subsections [~~(106)~~] (108)(a)(iv)(A)
- 811 through (E) to the extent that the entity is otherwise authorized to issue life or health care
- 812 insurance.
- 813 (b) "Long-term care insurance" includes:
- 814 (i) any of the following that provide directly or supplement long-term care insurance:
- 815 (A) a group or individual annuity or rider; or
- 816 (B) a life insurance policy or rider;
- 817 (ii) a policy or rider that provides for payment of benefits on the basis of:
- 818 (A) cognitive impairment; or
- 819 (B) functional capacity; or
- 820 (iii) a qualified long-term care insurance contract.
- 821 (c) "Long-term care insurance" does not include:
- 822 (i) a policy that is offered primarily to provide basic Medicare supplement coverage;
- 823 (ii) basic hospital expense coverage;
- 824 (iii) basic medical/surgical expense coverage;
- 825 (iv) hospital confinement indemnity coverage;
- 826 (v) major medical expense coverage;
- 827 (vi) income replacement or related asset-protection coverage;
- 828 (vii) accident only coverage;
- 829 (viii) coverage for a specified:
- 830 (A) disease; or
- 831 (B) accident;

832 (ix) limited benefit health coverage; or  
833 (x) a life insurance policy that accelerates the death benefit to provide the option of a  
834 lump sum payment:

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

836 (I) benefits; or

837 (II) eligibility; and

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

839 (I) terminal illness;

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

841 (III) permanent institutional confinement.

842 [~~(107)~~] (109) "Medical malpractice insurance" means insurance against legal liability  
843 incident to the practice and provision of a medical service other than the practice and provision  
844 of a dental service.

845 [~~(108)~~] (110) "Member" means a person having membership rights in an insurance  
846 corporation.

847 [~~(109)~~] (111) "Minimum capital" or "minimum required capital" means the capital that  
848 must be constantly maintained by a stock insurance corporation as required by statute.

849 [~~(110)~~] (112) "Mortgage accident and health insurance" means insurance offered in  
850 connection with an extension of credit that provides indemnity for payments coming due on a  
851 mortgage while the debtor is disabled.

852 [~~(111)~~] (113) "Mortgage guaranty insurance" means surety insurance under which a  
853 mortgagee or other creditor is indemnified against losses caused by the default of a debtor.

854 [~~(112)~~] (114) "Mortgage life insurance" means insurance on the life of a debtor in  
855 connection with an extension of credit that pays if the debtor dies.

856 [~~(113)~~] (115) "Motor club" means a person:

857 (a) licensed under:

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

859 (ii) Chapter 11, Motor Clubs; or

860 (iii) Chapter 14, Foreign Insurers; and

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

- 863 (i) legal services under Subsection 31A-11-102(1)(b);
- 864 (ii) bail services under Subsection 31A-11-102(1)(c); or
- 865 (iii) (A) trip reimbursement;
- 866 (B) towing services;
- 867 (C) emergency road services;
- 868 (D) stolen automobile services;
- 869 (E) a combination of the services listed in Subsections [~~(113)~~] (115)(b)(iii)(A) through
- 870 (D); or
- 871 (F) other services given in Subsections 31A-11-102(1)(b) through (f).
- 872 [~~(114)~~] (116) "Mutual" means a mutual insurance corporation.
- 873 [~~(115)~~] (117) "Network plan" means health care insurance:
- 874 (a) that is issued by an insurer; and
- 875 (b) under which the financing and delivery of medical care is provided, in whole or in
- 876 part, through a defined set of providers under contract with the insurer, including the financing
- 877 and delivery of an item paid for as medical care.
- 878 [~~(116)~~] (118) "Nonparticipating" means a plan of insurance under which the insured is
- 879 not entitled to receive a dividend representing a share of the surplus of the insurer.
- 880 [~~(117)~~] (119) "Ocean marine insurance" means insurance against loss of or damage to:
- 881 (a) ships or hulls of ships;
- 882 (b) goods, freight, cargoes, merchandise, effects, disbursements, profits, money,
- 883 securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia
- 884 interests, or other cargoes in or awaiting transit over the oceans or inland waterways;
- 885 (c) earnings such as freight, passage money, commissions, or profits derived from
- 886 transporting goods or people upon or across the oceans or inland waterways; or
- 887 (d) a vessel owner or operator as a result of liability to employees, passengers, bailors,
- 888 owners of other vessels, owners of fixed objects, customs or other authorities, or other persons
- 889 in connection with maritime activity.
- 890 [~~(118)~~] (120) "Order" means an order of the commissioner.
- 891 [~~(119)~~] (121) "Outline of coverage" means a summary that explains an accident and
- 892 health insurance policy.
- 893 [~~(120)~~] (122) "Participating" means a plan of insurance under which the insured is

894 entitled to receive a dividend representing a share of the surplus of the insurer.

895 ~~[(121)]~~ (123) "Participation," as used in a health benefit plan, means a requirement  
896 relating to the minimum percentage of eligible employees that must be enrolled in relation to  
897 the total number of eligible employees of an employer reduced by each eligible employee who  
898 voluntarily declines coverage under the plan because the employee:

899 (a) has other group health care insurance coverage; or

900 (b) receives:

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

903 (ii) another government health benefit.

904 ~~[(122)]~~ (124) "Person" includes:

905 (a) an individual;

906 (b) a partnership;

907 (c) a corporation;

908 (d) an incorporated or unincorporated association;

909 (e) a joint stock company;

910 (f) a trust;

911 (g) a limited liability company;

912 (h) a reciprocal;

913 (i) a syndicate; or

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

915 ~~[(123)]~~ (125) "Personal lines insurance" means property and casualty insurance  
916 coverage sold for primarily noncommercial purposes to:

917 (a) an individual; or

918 (b) a family.

919 ~~[(124)]~~ (126) "Plan sponsor" is as defined in 29 U.S.C. Sec. 1002(16)(B).

920 ~~[(125)]~~ (127) "Plan year" means:

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

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

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

924 (b) if the plan document or summary plan description does not designate a plan year or

925 there is no plan document or summary plan description:

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

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

928 or

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

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

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

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

933 (c) in a case not described in Subsection [~~(125)~~] (127)(a) or (b), the calendar year.

934 [~~(126)~~] (128) (a) "Policy" means a document, including an attached endorsement or

935 application that:

936 (i) purports to be an enforceable contract; and

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

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

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

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

941 (iii) a corporation licensed under:

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

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

944 (c) "Policy" does not include:

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

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

947 [~~(127)~~] (129) "Policyholder" means a person who controls a policy, binder, or oral

948 contract by ownership, premium payment, or otherwise.

949 [~~(128)~~] (130) "Policy illustration" means a presentation or depiction that includes

950 nonguaranteed elements of a policy of life insurance over a period of years.

951 [~~(129)~~] (131) "Policy summary" means a synopsis describing the elements of a life

952 insurance policy.

953 [~~(130)~~] (132) "Preexisting condition," with respect to a health benefit plan:

954 (a) means a condition that was present before the effective date of coverage, whether or

955 not medical advice, diagnosis, care, or treatment was recommended or received before that day;

956 and

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

959 [~~(131)~~] (133) (a) "Premium" means the monetary consideration for an insurance policy.

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

961 (i) an assessment;

962 (ii) a membership fee;

963 (iii) a required contribution; or

964 (iv) monetary consideration.

965 (c) (i) "Premium" does not include consideration paid to a third party administrator for  
966 the third party administrator's services.

967 (ii) "Premium" includes an amount paid by a third party administrator to an insurer for  
968 insurance on the risks administered by the third party administrator.

969 [~~(132)~~] (134) "Principal officers" for a corporation means the officers designated under  
970 Subsection 31A-5-203(3).

971 [~~(133)~~] (135) "Proceeding" includes an action or special statutory proceeding.

972 [~~(134)~~] (136) "Professional liability insurance" means insurance against legal liability  
973 incident to the practice of a profession and provision of a professional service.

974 [~~(135)~~] (137) (a) Except as provided in Subsection [~~(135)~~] (137)(b), "property  
975 insurance" means insurance against loss or damage to real or personal property of every kind  
976 and any interest in that property:

977 (i) from all hazards or causes; and

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

980 (b) "Property insurance" does not include:

981 (i) inland marine insurance; and

982 (ii) ocean marine insurance.

983 [~~(136)~~] (138) "Qualified long-term care insurance contract" or "federally tax qualified  
984 long-term care insurance contract" means:

985 (a) an individual or group insurance contract that meets the requirements of Section  
986 7702B(b), Internal Revenue Code; or

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

988 (i) (A) by rider; or

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

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

991 Code.

992 [~~(137)~~] (139) "Qualified United States financial institution" means an institution that:

993 (a) is:

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

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

997 (b) is regulated, supervised, and examined by a United States federal or state authority  
998 having regulatory authority over a bank or trust company; and

999 (c) meets the standards of financial condition and standing that are considered  
1000 necessary and appropriate to regulate the quality of a financial institution whose letters of credit  
1001 will be acceptable to the commissioner as determined by:

1002 (i) the commissioner by rule; or

1003 (ii) the Securities Valuation Office of the National Association of Insurance  
1004 Commissioners.

1005 [~~(138)~~] (140) (a) "Rate" means:

1006 (i) the cost of a given unit of insurance; or

1007 (ii) for property or casualty insurance, that cost of insurance per exposure unit either  
1008 expressed as:

1009 (A) a single number; or

1010 (B) a pure premium rate, adjusted before the application of individual risk variations  
1011 based on loss or expense considerations to account for the treatment of:

1012 (I) expenses;

1013 (II) profit; and

1014 (III) individual insurer variation in loss experience.

1015 (b) "Rate" does not include a minimum premium.

1016 [~~(139)~~] (141) (a) Except as provided in Subsection [~~(139)~~] (141)(b), "rate service  
1017 organization" means a person who assists an insurer in rate making or filing by:

- 1018 (i) collecting, compiling, and furnishing loss or expense statistics;
- 1019 (ii) recommending, making, or filing rates or supplementary rate information; or
- 1020 (iii) advising about rate questions, except as an attorney giving legal advice.
- 1021 (b) "Rate service organization" does not mean:
- 1022 (i) an employee of an insurer;
- 1023 (ii) a single insurer or group of insurers under common control;
- 1024 (iii) a joint underwriting group; or
- 1025 (iv) an individual serving as an actuarial or legal consultant.
- 1026 [~~140~~] (142) "Rating manual" means any of the following used to determine initial and
- 1027 renewal policy premiums:
- 1028 (a) a manual of rates;
- 1029 (b) a classification;
- 1030 (c) a rate-related underwriting rule; and
- 1031 (d) a rating formula that describes steps, policies, and procedures for determining
- 1032 initial and renewal policy premiums.
- 1033 [~~141~~] (143) "Received by the department" means:
- 1034 (a) the date delivered to and stamped received by the department, if delivered in
- 1035 person;
- 1036 (b) the post mark date, if delivered by mail;
- 1037 (c) the delivery service's post mark or pickup date, if delivered by a delivery service;
- 1038 (d) the received date recorded on an item delivered, if delivered by:
- 1039 (i) facsimile;
- 1040 (ii) email; or
- 1041 (iii) another electronic method; or
- 1042 (e) a date specified in:
- 1043 (i) a statute;
- 1044 (ii) a rule; or
- 1045 (iii) an order.
- 1046 [~~142~~] (144) "Reciprocal" or "interinsurance exchange" means an unincorporated
- 1047 association of persons:
- 1048 (a) operating through an attorney-in-fact common to all of the persons; and

1049 (b) exchanging insurance contracts with one another that provide insurance coverage  
1050 on each other.

1051 [~~(143)~~] (145) "Reinsurance" means an insurance transaction where an insurer, for  
1052 consideration, transfers any portion of the risk it has assumed to another insurer. In referring to  
1053 reinsurance transactions, this title sometimes refers to:

1054 (a) the insurer transferring the risk as the "ceding insurer"; and

1055 (b) the insurer assuming the risk as the:

1056 (i) "assuming insurer"; or

1057 (ii) "assuming reinsurer."

1058 [~~(144)~~] (146) "Reinsurer" means a person licensed in this state as an insurer with the  
1059 authority to assume reinsurance.

1060 [~~(145)~~] (147) "Residential dwelling liability insurance" means insurance against  
1061 liability resulting from or incident to the ownership, maintenance, or use of a residential  
1062 dwelling that is a detached single family residence or multifamily residence up to four units.

1063 [~~(146)~~] (148) (a) "Retrocession" means reinsurance with another insurer of a liability  
1064 assumed under a reinsurance contract.

1065 (b) A reinsurer "retrocedes" when the reinsurer reinsures with another insurer part of a  
1066 liability assumed under a reinsurance contract.

1067 [~~(147)~~] (149) "Rider" means an endorsement to:

1068 (a) an insurance policy; or

1069 (b) an insurance certificate.

1070 [~~(148)~~] (150) (a) "Security" means a:

1071 (i) note;

1072 (ii) stock;

1073 (iii) bond;

1074 (iv) debenture;

1075 (v) evidence of indebtedness;

1076 (vi) certificate of interest or participation in a profit-sharing agreement;

1077 (vii) collateral-trust certificate;

1078 (viii) preorganization certificate or subscription;

1079 (ix) transferable share;

1080 (x) investment contract;

1081 (xi) voting trust certificate;

1082 (xii) certificate of deposit for a security;

1083 (xiii) certificate of interest of participation in an oil, gas, or mining title or lease or in

1084 payments out of production under such a title or lease;

1085 (xiv) commodity contract or commodity option;

1086 (xv) certificate of interest or participation in, temporary or interim certificate for,

1087 receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed

1088 in Subsections [~~(148)~~] (150)(a)(i) through (xiv); or

1089 (xvi) another interest or instrument commonly known as a security.

1090 (b) "Security" does not include:

1091 (i) any of the following under which an insurance company promises to pay money in a

1092 specific lump sum or periodically for life or some other specified period:

1093 (A) insurance;

1094 (B) an endowment policy; or

1095 (C) an annuity contract; or

1096 (ii) a burial certificate or burial contract.

1097 [~~(149)~~] (151) "Secondary medical condition" means a complication related to an

1098 exclusion from coverage in accident and health insurance.

1099 [~~(150)~~] (152) (a) "Self-insurance" means an arrangement under which a person

1100 provides for spreading its own risks by a systematic plan.

1101 [~~(a)~~] (b) Except as provided in this Subsection [~~(150)~~] (152), "self-insurance" does not

1102 include an arrangement under which a number of persons spread their risks among themselves.

1103 [~~(b)~~] (c) "Self-insurance" includes:

1104 (i) an arrangement by which a governmental entity undertakes to indemnify an

1105 employee for liability arising out of the employee's employment; and

1106 (ii) an arrangement by which a person with a managed program of self-insurance and

1107 risk management undertakes to indemnify its affiliates, subsidiaries, directors, officers, or

1108 employees for liability or risk that is related to the relationship or employment.

1109 [~~(c)~~] (d) "Self-insurance" does not include an arrangement with an independent

1110 contractor.

1111 [~~(151)~~] (153) "Sell" means to exchange a contract of insurance:

1112 (a) by any means;

1113 (b) for money or its equivalent; and

1114 (c) on behalf of an insurance company.

1115 [~~(152)~~] (154) "Short-term care insurance" means an insurance policy or rider

1116 advertised, marketed, offered, or designed to provide coverage that is similar to long-term care

1117 insurance, but that provides coverage for less than 12 consecutive months for each covered

1118 person.

1119 [~~(153)~~] (155) "Significant break in coverage" means a period of 63 consecutive days

1120 during each of which an individual does not have creditable coverage.

1121 [~~(154)~~] (156) "Small employer," in connection with a health benefit plan, means an

1122 employer who, with respect to a calendar year and to a plan year:

1123 (a) employed an average of at least two employees but not more than 50 eligible

1124 employees on each business day during the preceding calendar year; and

1125 (b) employs at least two employees on the first day of the plan year.

1126 [~~(155)~~] (157) "Special enrollment period," in connection with a health benefit plan, has

1127 the same meaning as provided in federal regulations adopted pursuant to the Health Insurance

1128 Portability and Accountability Act [~~of 1996, Pub. L. 104-191, 110 Stat. 1936~~].

1129 [~~(156)~~] (158) (a) "Subsidiary" of a person means an affiliate controlled by that person

1130 either directly or indirectly through one or more affiliates or intermediaries.

1131 (b) "Wholly owned subsidiary" of a person is a subsidiary of which all of the voting

1132 shares are owned by that person either alone or with its affiliates, except for the minimum

1133 number of shares the law of the subsidiary's domicile requires to be owned by directors or

1134 others.

1135 [~~(157)~~] (159) Subject to Subsection [~~(83)~~] (85)(b), "surety insurance" includes:

1136 (a) a guarantee against loss or damage resulting from the failure of a principal to pay or

1137 perform the principal's obligations to a creditor or other obligee;

1138 (b) bail bond insurance; and

1139 (c) fidelity insurance.

1140 [~~(158)~~] (160) (a) "Surplus" means the excess of assets over the sum of paid-in capital

1141 and liabilities.

1142 (b) (i) "Permanent surplus" means the surplus of a mutual insurer that is designated by  
1143 the insurer as permanent.

1144 (ii) Sections 31A-5-211, 31A-7-201, 31A-8-209, 31A-9-209, and 31A-14-209 require  
1145 that mutuals doing business in this state maintain specified minimum levels of permanent  
1146 surplus.

1147 (iii) Except for assessable mutuals, the minimum permanent surplus requirement is the  
1148 same as the minimum required capital requirement that applies to stock insurers.

1149 (c) "Excess surplus" means:

1150 (i) for a life insurer, accident and health insurer, health organization, or property and  
1151 casualty insurer as defined in Section 31A-17-601, the lesser of:

1152 (A) that amount of an insurer's or health organization's total adjusted capital that  
1153 exceeds the product of:

1154 (I) 2.5; and

1155 (II) the sum of the insurer's or health organization's minimum capital or permanent  
1156 surplus required under Section 31A-5-211, 31A-9-209, or 31A-14-205; or

1157 (B) that amount of an insurer's or health organization's total adjusted capital that  
1158 exceeds the product of:

1159 (I) 3.0; and

1160 (II) the authorized control level RBC as defined in Subsection 31A-17-601(8)(a); and

1161 (ii) for a monoline mortgage guaranty insurer, financial guaranty insurer, or title insurer  
1162 that amount of an insurer's paid-in-capital and surplus that exceeds the product of:

1163 (A) 1.5; and

1164 (B) the insurer's total adjusted capital required by Subsection 31A-17-609(1).

1165 ~~[(159)]~~ (161) "Third party administrator" or "administrator" means a person who  
1166 collects charges or premiums from, or who, for consideration, adjusts or settles claims of  
1167 residents of the state in connection with insurance coverage, annuities, or service insurance  
1168 coverage, except:

1169 (a) a union on behalf of its members;

1170 (b) a person administering a:

1171 (i) pension plan subject to the federal Employee Retirement Income Security Act of  
1172 1974;

1173 (ii) governmental plan as defined in Section 414(d), Internal Revenue Code; or  
 1174 (iii) nonelecting church plan as described in Section 410(d), Internal Revenue Code;  
 1175 (c) an employer on behalf of the employer's employees or the employees of one or  
 1176 more of the subsidiary or affiliated corporations of the employer;

1177 (d) an insurer licensed under [~~Chapter 5, 7, 8, 9, or 14~~] the following, but only for a  
 1178 line of insurance for which the insurer holds a license in this state[~~;~~or]:

1179 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;

1180 (ii) Chapter 7, Nonprofit Health Service Insurance Corporations;

1181 (iii) Chapter 8, Health Maintenance Organizations and Limited Health Plans;

1182 (iv) Chapter 9, Insurance Fraternal; or

1183 (v) Chapter 14, Foreign Insurers; or

1184 (e) a person:

1185 (i) licensed or exempt from licensing under:

1186 (A) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and  
 1187 Reinsurance Intermediaries; or

1188 (B) Chapter 26, Insurance Adjusters; and

1189 (ii) whose activities are limited to those authorized under the license the person holds  
 1190 or for which the person is exempt.

1191 [~~(160)~~] (162) "Title insurance" means the insuring, guaranteeing, or indemnifying of an  
 1192 owner of real or personal property or the holder of liens or encumbrances on that property, or  
 1193 others interested in the property against loss or damage suffered by reason of liens or  
 1194 encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity  
 1195 or unenforceability of any liens or encumbrances on the property.

1196 [~~(161)~~] (163) "Total adjusted capital" means the sum of an insurer's or health  
 1197 organization's statutory capital and surplus as determined in accordance with:

1198 (a) the statutory accounting applicable to the annual financial statements required to be  
 1199 filed under Section 31A-4-113; and

1200 (b) another item provided by the RBC instructions, as RBC instructions is defined in  
 1201 Section 31A-17-601.

1202 [~~(162)~~] (164) (a) "Trustee" means "director" when referring to the board of directors of  
 1203 a corporation.

1204 (b) "Trustee," when used in reference to an employee welfare fund, means an  
1205 individual, firm, association, organization, joint stock company, or corporation, whether acting  
1206 individually or jointly and whether designated by that name or any other, that is charged with  
1207 or has the overall management of an employee welfare fund.

1208 ~~[(163)]~~ (165) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted  
1209 insurer" means an insurer:

1210 (i) not holding a valid certificate of authority to do an insurance business in this state;

1211 or

1212 (ii) transacting business not authorized by a valid certificate.

1213 (b) "Admitted insurer" or "authorized insurer" means an insurer:

1214 (i) holding a valid certificate of authority to do an insurance business in this state; and

1215 (ii) transacting business as authorized by a valid certificate.

1216 ~~[(164)]~~ (166) "Underwrite" means the authority to accept or reject risk on behalf of the  
1217 insurer.

1218 ~~[(165)]~~ (167) "Vehicle liability insurance" means insurance against liability resulting  
1219 from or incident to ownership, maintenance, or use of a land vehicle or aircraft, exclusive of a  
1220 vehicle comprehensive or vehicle physical damage coverage under Subsection ~~[(135)]~~ (137).

1221 ~~[(166)]~~ (168) "Voting security" means a security with voting rights, and includes a  
1222 security convertible into a security with a voting right associated with the security.

1223 ~~[(167)]~~ (169) "Waiting period" for a health benefit plan means the period that must  
1224 pass before coverage for an individual, who is otherwise eligible to enroll under the terms of  
1225 the health benefit plan, can become effective.

1226 ~~[(168)]~~ (170) "Workers' compensation insurance" means:

1227 (a) insurance for indemnification of an employer against liability for compensation  
1228 based on:

1229 (i) a compensable accidental injury; and

1230 (ii) occupational disease disability;

1231 (b) employer's liability insurance incidental to workers' compensation insurance and  
1232 written in connection with workers' compensation insurance; and

1233 (c) insurance assuring to a person entitled to workers' compensation benefits the  
1234 compensation provided by law.

1235 Section 2. Section 31A-2-208 is amended to read:

1236 **31A-2-208. Publications.**

1237 (1) The commissioner may prepare and distribute books, pamphlets, and other  
1238 publications relating to insurance. Except as otherwise provided under this title, the  
1239 ~~[insurance]~~ commissioner may charge the cost of producing ~~[the publications]~~ a publication to  
1240 those desiring to receive ~~[them]~~ the publication. Money collected from subscription fees  
1241 charged for ~~[these publications]~~ a publication shall be deposited ~~[as dedicated credits to be used~~  
1242 ~~solely for the production and mailing costs of the publications]~~ into the Relative Value Study  
1243 Restricted Account, created in Section 59-9-105, to be used as provided in Section 59-9-105.

1244 (2) The commissioner shall have the annual report required in Subsection  
1245 31A-2-207(5) printed;

1246 (a) in a form determined by ~~[him]~~ the commissioner; and

1247 (b) in sufficient numbers to meet ~~[all]~~ requests for copies.

1248 (3) The commissioner shall publish in ~~[his]~~ the annual report required in Subsection  
1249 31A-2-207(5) an up-to-date chart and explanation of the organization of ~~[his]~~ the  
1250 commissioner's office, making clear the allocation of responsibility and authority among the  
1251 staff. This ~~[document]~~ up-to-date chart and explanation shall be printed in sufficient numbers  
1252 ~~[sufficient]~~ to meet ~~[all]~~ requests for copies.

1253 Section 3. Section 31A-2-212 is amended to read:

1254 **31A-2-212. Miscellaneous duties.**

1255 (1) Upon issuance of ~~[any]~~ an order limiting, suspending, or revoking ~~[an insurer's]~~ a  
1256 person's authority to do business in Utah, and ~~[on institution of any proceedings]~~ when the  
1257 commissioner begins a proceeding against ~~[the]~~ an insurer under Chapter 27a, Insurer  
1258 Receivership Act, the commissioner:

1259 (a) shall notify by mail ~~[all agents]~~ the producers of the person or insurer of whom the  
1260 commissioner has record; and

1261 (b) may publish notice of the order or proceeding in any manner the commissioner  
1262 considers necessary to protect the rights of the public.

1263 (2) When required for evidence in ~~[any]~~ a legal proceeding, the commissioner shall  
1264 furnish a certificate of ~~[the]~~ authority of ~~[any]~~ a licensee to transact ~~[insurance]~~ the business of  
1265 insurance in Utah on any particular date. The court or other officer shall receive the certificate

1266 of authority in lieu of the commissioner's testimony.

1267 (3) (a) On the request of [~~any~~] an insurer authorized to do a surety business, the  
1268 commissioner shall furnish a copy of the insurer's certificate of authority to [~~any~~] a designated  
1269 public officer in this state who requires that certificate of authority before accepting a bond.

1270 (b) The public officer described in Subsection (3)(a) shall file the certificate of  
1271 authority furnished under Subsection (3)(a).

1272 (c) After a certified copy of a certificate of authority [~~has been~~] is furnished to a public  
1273 officer, it is not necessary, while the certificate of authority remains effective, to attach a copy  
1274 of it to any instrument of suretyship filed with that public officer.

1275 (d) Whenever the commissioner revokes the certificate of authority or [~~starts~~  
1276 ~~proceedings~~] begins a proceeding under Chapter 27a, Insurer Receivership Act, against [~~any~~]  
1277 an insurer authorized to do a surety business, the commissioner shall immediately give notice  
1278 of that action to each public officer who [~~was~~] is sent a certified copy under this Subsection (3).

1279 (4) (a) The commissioner shall immediately notify every judge and clerk of [~~all~~] the  
1280 courts of record in the state when:

1281 (i) an authorized insurer doing a surety business:

1282 (A) files a petition for receivership; or

1283 (B) is in receivership; or

1284 (ii) the commissioner has reason to believe that the authorized insurer doing surety  
1285 business:

1286 (A) is in financial difficulty; or

1287 (B) has unreasonably failed to carry out any of its contracts.

1288 (b) Upon the receipt of the notice required by this Subsection (4), it is the duty of the  
1289 judges and clerks to notify and require [~~every~~] a person that [~~has filed~~] files with the court a  
1290 bond on which the authorized insurer doing surety business is surety[;] to immediately file a  
1291 new bond with a new surety.

1292 (5) The commissioner shall require an insurer that issues, sells, renews, or offers health  
1293 insurance coverage in this state to comply with the Health Insurance Portability and  
1294 Accountability Act[; ~~P.L. 104-191, pursuant to 110 Stat. 1968, Sec. 2722~~].

1295 Section 4. Section **31A-3-304** is amended to read:

1296 **31A-3-304. Annual fees -- Other taxes or fees prohibited -- Captive Insurance**

1297 **Restricted Account.**

1298 (1) (a) A captive insurance company shall pay an annual fee imposed under this section  
1299 to obtain or renew a certificate of authority.

1300 (b) The commissioner shall:

1301 (i) determine the annual fee pursuant to Section 31A-3-103; and

1302 (ii) consider whether the annual fee is competitive with fees imposed by other states on  
1303 captive insurance companies.

1304 (2) A captive insurance company that fails to pay the fee required by this section is  
1305 subject to the relevant sanctions of this title.

1306 (3) (a) Except as provided in Subsection (3)~~(b)~~(d) and notwithstanding Title 59,  
1307 Chapter 9, Taxation of Admitted Insurers, ~~[the fee provided for in this section constitutes the~~  
1308 ~~sole tax or fee]~~ the following constitute the sole taxes, fees, or charges under the laws of this  
1309 state that may be ~~[otherwise]~~ levied or assessed on a captive insurance company~~[-, and no other~~  
1310 ~~occupation tax or other tax or fee may be levied or collected from a captive insurance company~~  
1311 ~~by the state or a county, city, or municipality within this state.];~~

1312 ~~[(b) Notwithstanding Subsection (3)(a), a]~~

1313 (i) a fee under this section;

1314 (ii) a fee under Chapter 37, Captive Insurance Companies Act; and

1315 (iii) a fee under Chapter 37a, Special Purpose Financial Captive Insurance Company  
1316 Act.

1317 (b) The state or a county, city, or town within the state may not levy or collect an  
1318 occupation tax or other tax, fee, or charge not described in Subsections (3)(a)(i) through (iii)  
1319 against a captive insurance company.

1320 (c) The state may not levy, assess, or collect a withdrawal fee under Section 31A-4-115  
1321 against a captive insurance company.

1322 (d) A captive insurance company is subject to real and personal property taxes.

1323 (4) A captive insurance company shall pay the fee imposed by this section to the  
1324 commissioner by ~~[March 31]~~ June 20 of each year.

1325 (5) (a) Money received pursuant to ~~[Subsection (2)]~~ a fee described in Subsection  
1326 (3)(a) shall be deposited into the Captive Insurance Restricted Account.

1327 (b) There is created in the General Fund a restricted account known as the "Captive

1328 Insurance Restricted Account."

1329 (c) The Captive Insurance Restricted Account shall consist of the fees [~~imposed by the~~  
1330 ~~commissioner in accordance with this section~~] described in Subsection (3)(a).

1331 (d) The commissioner shall administer the Captive Insurance Restricted Account.

1332 Subject to appropriations by the Legislature, the commissioner shall use the money deposited  
1333 into the Captive Insurance Restricted Account to:

1334 (i) administer and enforce;

1335 (A) Chapter 37, Captive Insurance Companies Act; and

1336 (B) Chapter 37a, Special Purpose Financial Captive Insurance Company Act; and

1337 (ii) promote the captive insurance industry in Utah.

1338 (e) An appropriation from the Captive Insurance Restricted Account is nonlapsing,  
1339 except that at the end of each fiscal year, money received by the commissioner in excess of  
1340 [~~\$600,000~~] \$950,000 shall be treated as free revenue in the General Fund.

1341 Section 5. Section **31A-14-211** is amended to read:

1342 **31A-14-211. Restrictions on foreign title insurers.**

1343 (1) An authorized foreign title insurer may not insure property in this state except:

1344 (a) through a title insurance producer who is a resident in Utah; or

1345 (b) through a bona fide [~~branch~~] office in Utah;

1346 (i) that is under the direction and control of the authorized foreign title insurer [that  
1347 pays all];

1348 (ii) for which the authorized foreign title insurer pays the expenses [of the branch  
1349 office], including compensation of [all] the employees[; or] of the bona fide office;

1350 (iii) at which a person may request information about title services related to a real  
1351 estate transaction for which the person is a party;

1352 (iv) at which a person may deliver written communications to the authorized foreign  
1353 title insurer as required by the real estate transaction for which the person is a party; and

1354 (v) at which a person may deliver escrow money related to a real estate transaction for  
1355 which the person is a party.

1356 [~~(c) through a subsidiary title insurer authorized to do business in Utah.~~]

1357 (2) This section does not apply to reinsurance.

1358 Section 6. Section **31A-22-305** is amended to read:

1359 **31A-22-305. Uninsured motorist coverage.**

1360 (1) As used in this section, "covered persons" includes:

1361 (a) the named insured;

1362 (b) persons related to the named insured by blood, marriage, adoption, or guardianship,  
1363 who are residents of the named insured's household, including those who usually make their  
1364 home in the same household but temporarily live elsewhere;

1365 (c) any person occupying or using a motor vehicle:

1366 (i) referred to in the policy; or

1367 (ii) owned by a self-insured; and

1368 (d) any person who is entitled to recover damages against the owner or operator of the  
1369 uninsured or underinsured motor vehicle because of bodily injury to or death of persons under  
1370 Subsection (1)(a), (b), or (c).

1371 (2) As used in this section, "uninsured motor vehicle" includes:

1372 (a) (i) a motor vehicle, the operation, maintenance, or use of which is not covered  
1373 under a liability policy at the time of an injury-causing occurrence; or1374 (ii) (A) a motor vehicle covered with lower liability limits than required by Section  
1375 31A-22-304; and1376 (B) the motor vehicle described in Subsection (2)(a)(ii)(A) is uninsured to the extent of  
1377 the deficiency;1378 (b) an unidentified motor vehicle that left the scene of an accident proximately caused  
1379 by the motor vehicle operator;1380 (c) a motor vehicle covered by a liability policy, but coverage for an accident is  
1381 disputed by the liability insurer for more than 60 days or continues to be disputed for more than  
1382 60 days; or1383 (d) (i) an insured motor vehicle if, before or after the accident, the liability insurer of  
1384 the motor vehicle is declared insolvent by a court of competent jurisdiction; and1385 (ii) the motor vehicle described in Subsection (2)(d)(i) is uninsured only to the extent  
1386 that the claim against the insolvent insurer is not paid by a guaranty association or fund.1387 (3) (a) Uninsured motorist coverage under Subsection 31A-22-302(1)(b) provides  
1388 coverage for covered persons who are legally entitled to recover damages from owners or  
1389 operators of uninsured motor vehicles because of bodily injury, sickness, disease, or death.

1390 (b) For new policies written on or after January 1, 2001, the limits of uninsured  
1391 motorist coverage shall be equal to the lesser of the limits of the insured's motor vehicle  
1392 liability coverage or the maximum uninsured motorist coverage limits available by the insurer  
1393 under the insured's motor vehicle policy, unless the insured purchases coverage in a lesser  
1394 amount by signing an acknowledgment form that:

1395 (i) is filed with the department;

1396 (ii) is provided by the insurer;

1397 (iii) waives the higher coverage;

1398 (iv) reasonably explains the purpose of uninsured motorist coverage; and

1399 (v) discloses the additional premiums required to purchase uninsured motorist

1400 coverage with limits equal to the lesser of the limits of the insured's motor vehicle liability  
1401 coverage or the maximum uninsured motorist coverage limits available by the insurer under the  
1402 insured's motor vehicle policy.

1403 (c) A self-insured, including a governmental entity, may elect to provide uninsured  
1404 motorist coverage in an amount that is less than its maximum self-insured retention under  
1405 Subsections (3)(b) and (4)(a) by issuing a declaratory memorandum or policy statement from  
1406 the chief financial officer or chief risk officer that declares the:

1407 (i) self-insured entity's coverage level; and

1408 (ii) process for filing an uninsured motorist claim.

1409 (d) Uninsured motorist coverage may not be sold with limits that are less than the  
1410 minimum bodily injury limits for motor vehicle liability policies under Section 31A-22-304.

1411 (e) The acknowledgment under Subsection (3)(b) continues for that issuer of the  
1412 uninsured motorist coverage until the insured, in writing, requests different uninsured motorist  
1413 coverage from the insurer.

1414 ~~[(f)(i) In conjunction with the first two renewal notices sent after January 1, 2001, for~~  
1415 ~~policies existing on that date, the insurer shall disclose in the same medium as the premium~~  
1416 ~~renewal notice, an explanation of:]~~

1417 ~~[(A) the purpose of uninsured motorist coverage; and]~~

1418 ~~[(B) the costs associated with increasing the coverage in amounts up to and including~~  
1419 ~~the maximum amount available by the insurer under the insured's motor vehicle policy.]~~

1420 ~~[(ii) The disclosure required under this Subsection (3)(f) shall be sent to all insureds~~

1421 ~~that carry uninsured motorist coverage limits in an amount less than the insured's motor vehicle~~  
1422 ~~liability policy limits or the maximum uninsured motorist coverage limits available by the~~  
1423 ~~insurer under the insured's motor vehicle policy.]~~

1424 (4) (a) (i) Except as provided in Subsection (4)(b), the named insured may reject  
1425 uninsured motorist coverage by an express writing to the insurer that provides liability  
1426 coverage under Subsection 31A-22-302(1)(a).

1427 (ii) This rejection shall be on a form provided by the insurer that includes a reasonable  
1428 explanation of the purpose of uninsured motorist coverage.

1429 (iii) This rejection continues for that issuer of the liability coverage until the insured in  
1430 writing requests uninsured motorist coverage from that liability insurer.

1431 (b) (i) All persons, including governmental entities, that are engaged in the business of,  
1432 or that accept payment for, transporting natural persons by motor vehicle, and all school  
1433 districts that provide transportation services for their students, shall provide coverage for all  
1434 motor vehicles used for that purpose, by purchase of a policy of insurance or by self-insurance,  
1435 uninsured motorist coverage of at least \$25,000 per person and \$500,000 per accident.

1436 (ii) This coverage is secondary to any other insurance covering an injured covered  
1437 person.

1438 (c) Uninsured motorist coverage:

1439 (i) is secondary to the benefits provided by Title 34A, Chapter 2, Workers'  
1440 Compensation Act;

1441 (ii) may not be subrogated by the workers' compensation insurance carrier;

1442 (iii) may not be reduced by any benefits provided by workers' compensation insurance;

1443 (iv) may be reduced by health insurance subrogation only after the covered person has  
1444 been made whole;

1445 (v) may not be collected for bodily injury or death sustained by a person:

1446 (A) while committing a violation of Section 41-1a-1314;

1447 (B) who, as a passenger in a vehicle, has knowledge that the vehicle is being operated  
1448 in violation of Section 41-1a-1314; or

1449 (C) while committing a felony; and

1450 (vi) notwithstanding Subsection (4)(c)(v), may be recovered:

1451 (A) for a person under 18 years of age who is injured within the scope of Subsection

1452 (4)(c)(v) but limited to medical and funeral expenses; or

1453 (B) by a law enforcement officer as defined in Section 53-13-103, who is injured  
1454 within the course and scope of the law enforcement officer's duties.

1455 (d) As used in this Subsection (4), "motor vehicle" has the same meaning as under  
1456 Section 41-1a-102.

1457 (5) When a covered person alleges that an uninsured motor vehicle under Subsection  
1458 (2)(b) proximately caused an accident without touching the covered person or the motor  
1459 vehicle occupied by the covered person, the covered person must show the existence of the  
1460 uninsured motor vehicle by clear and convincing evidence consisting of more than the covered  
1461 person's testimony.

1462 (6) (a) The limit of liability for uninsured motorist coverage for two or more motor  
1463 vehicles may not be added together, combined, or stacked to determine the limit of insurance  
1464 coverage available to an injured person for any one accident.

1465 (b) (i) Subsection (6)(a) applies to all persons except a covered person as defined under  
1466 Subsection (7)(b)(ii).

1467 (ii) A covered person as defined under Subsection (7)(b)(ii) is entitled to the highest  
1468 limits of uninsured motorist coverage afforded for any one motor vehicle that the covered  
1469 person is the named insured or an insured family member.

1470 (iii) This coverage shall be in addition to the coverage on the motor vehicle the covered  
1471 person is occupying.

1472 (iv) Neither the primary nor the secondary coverage may be set off against the other.

1473 (c) Coverage on a motor vehicle occupied at the time of an accident shall be primary  
1474 coverage, and the coverage elected by a person described under Subsections (1)(a) and (b) shall  
1475 be secondary coverage.

1476 (7) (a) Uninsured motorist coverage under this section applies to bodily injury,  
1477 sickness, disease, or death of covered persons while occupying or using a motor vehicle only if  
1478 the motor vehicle is described in the policy under which a claim is made, or if the motor  
1479 vehicle is a newly acquired or replacement motor vehicle covered under the terms of the policy.  
1480 Except as provided in Subsection (6) or this Subsection (7), a covered person injured in a  
1481 motor vehicle described in a policy that includes uninsured motorist benefits may not elect to  
1482 collect uninsured motorist coverage benefits from any other motor vehicle insurance policy

1483 under which the person is a covered person.

1484 (b) Each of the following persons may also recover uninsured motorist benefits under  
1485 any one other policy in which they are described as a "covered person" as defined in Subsection  
1486 (1):

1487 (i) a covered person injured as a pedestrian by an uninsured motor vehicle; and

1488 (ii) except as provided in Subsection (7)(c), a covered person injured while occupying  
1489 or using a motor vehicle that is not owned, leased, or furnished:

1490 (A) to the covered person;

1491 (B) to the covered person's spouse; or

1492 (C) to the covered person's resident parent or resident sibling.

1493 (c) (i) A covered person may recover benefits from no more than two additional  
1494 policies, one additional policy from each parent's household if the covered person is:

1495 (A) a dependent minor of parents who reside in separate households; and

1496 (B) injured while occupying or using a motor vehicle that is not owned, leased, or  
1497 furnished:

1498 (I) to the covered person;

1499 (II) to the covered person's resident parent; or

1500 (III) to the covered person's resident sibling.

1501 (ii) Each parent's policy under this Subsection (7)(c) is liable only for the percentage of  
1502 the damages that the limit of liability of each parent's policy of uninsured motorist coverage  
1503 bears to the total of both parents' uninsured coverage applicable to the accident.

1504 (d) A covered person's recovery under any available policies may not exceed the full  
1505 amount of damages.

1506 (e) A covered person in Subsection (7)(b) is not barred against making subsequent  
1507 elections if recovery is unavailable under previous elections.

1508 (f) (i) As used in this section, "interpolicy stacking" means recovering benefits for a  
1509 single incident of loss under more than one insurance policy.

1510 (ii) Except to the extent permitted by Subsection (6) and this Subsection (7),  
1511 interpolicy stacking is prohibited for uninsured motorist coverage.

1512 (8) (a) When a claim is brought by a named insured or a person described in  
1513 Subsection (1) and is asserted against the covered person's uninsured motorist carrier, the

1514 claimant may elect to resolve the claim:

1515 (i) by submitting the claim to binding arbitration; or

1516 (ii) through litigation.

1517 (b) Unless otherwise provided in the policy under which uninsured benefits are

1518 claimed, the election provided in Subsection (8)(a) is available to the claimant only.

1519 (c) Once the claimant has elected to commence litigation under Subsection (8)(a)(ii),

1520 the claimant may not elect to resolve the claim through binding arbitration under this section

1521 without the written consent of the uninsured motorist carrier.

1522 (d) (i) Unless otherwise agreed to in writing by the parties, a claim that is submitted to

1523 binding arbitration under Subsection (8)(a)(i) shall be resolved by a single arbitrator.

1524 (ii) All parties shall agree on the single arbitrator selected under Subsection (8)(d)(i).

1525 (iii) If the parties are unable to agree on a single arbitrator as required under Subsection

1526 (8)(d)(ii), the parties shall select a panel of three arbitrators.

1527 (e) If the parties select a panel of three arbitrators under Subsection (8)(d)(iii):

1528 (i) each side shall select one arbitrator; and

1529 (ii) the arbitrators appointed under Subsection (8)(e)(i) shall select one additional

1530 arbitrator to be included in the panel.

1531 (f) Unless otherwise agreed to in writing:

1532 (i) each party shall pay an equal share of the fees and costs of the arbitrator selected

1533 under Subsection (8)(d)(i); or

1534 (ii) if an arbitration panel is selected under Subsection (8)(d)(iii):

1535 (A) each party shall pay the fees and costs of the arbitrator selected by that party; and

1536 (B) each party shall pay an equal share of the fees and costs of the arbitrator selected

1537 under Subsection (8)(e)(ii).

1538 (g) Except as otherwise provided in this section or unless otherwise agreed to in

1539 writing by the parties, an arbitration proceeding conducted under this section shall be governed

1540 by Title 78B, Chapter 11, Utah Uniform Arbitration Act.

1541 (h) The arbitration shall be conducted in accordance with Rules 26 through 37, 54, and

1542 68 of the Utah Rules of Civil Procedure.

1543 (i) All issues of discovery shall be resolved by the arbitrator or the arbitration panel.

1544 (j) A written decision by a single arbitrator or by a majority of the arbitration panel

1545 shall constitute a final decision.

1546 (k) (i) The amount of an arbitration award may not exceed the uninsured motorist  
1547 policy limits of all applicable uninsured motorist policies, including applicable uninsured  
1548 motorist umbrella policies.

1549 (ii) If the initial arbitration award exceeds the uninsured motorist policy limits of all  
1550 applicable uninsured motorist policies, the arbitration award shall be reduced to an amount  
1551 equal to the combined uninsured motorist policy limits of all applicable uninsured motorist  
1552 policies.

1553 (l) The arbitrator or arbitration panel may not decide the issues of coverage or  
1554 extra-contractual damages, including:

1555 (i) whether the claimant is a covered person;

1556 (ii) whether the policy extends coverage to the loss; or

1557 (iii) any allegations or claims asserting consequential damages or bad faith liability.

1558 (m) The arbitrator or arbitration panel may not conduct arbitration on a class-wide or  
1559 class-representative basis.

1560 (n) If the arbitrator or arbitration panel finds that the action was not brought, pursued,  
1561 or defended in good faith, the arbitrator or arbitration panel may award reasonable attorney fees  
1562 and costs against the party that failed to bring, pursue, or defend the claim in good faith.

1563 (o) An arbitration award issued under this section shall be the final resolution of all  
1564 claims not excluded by Subsection (8)(l) between the parties unless:

1565 (i) the award was procured by corruption, fraud, or other undue means; or

1566 (ii) either party, within 20 days after service of the arbitration award:

1567 (A) files a complaint requesting a trial de novo in the district court; and

1568 (B) serves the nonmoving party with a copy of the complaint requesting a trial de novo  
1569 under Subsection (8)(o)(ii)(A).

1570 (p) (i) Upon filing a complaint for a trial de novo under Subsection (8)(o), the claim  
1571 shall proceed through litigation pursuant to the Utah Rules of Civil Procedure and Utah Rules  
1572 of Evidence in the district court.

1573 (ii) In accordance with Rule 38, Utah Rules of Civil Procedure, either party may  
1574 request a jury trial with a complaint requesting a trial de novo under Subsection (8)(o)(ii)(A).

1575 (q) (i) If the claimant, as the moving party in a trial de novo requested under

1576 Subsection (8)(o), does not obtain a verdict that is at least \$5,000 and is at least 20% greater  
1577 than the arbitration award, the claimant is responsible for all of the nonmoving party's costs.

1578 (ii) If the uninsured motorist carrier, as the moving party in a trial de novo requested  
1579 under Subsection (8)(o), does not obtain a verdict that is at least 20% less than the arbitration  
1580 award, the uninsured motorist carrier is responsible for all of the nonmoving party's costs.

1581 (iii) Except as provided in Subsection (8)(q)(iv), the costs under this Subsection (8)(q)  
1582 shall include:

1583 (A) any costs set forth in Rule 54(d), Utah Rules of Civil Procedure; and

1584 (B) the costs of expert witnesses and depositions.

1585 (iv) An award of costs under this Subsection (8)(q) may not exceed \$2,500.

1586 (r) For purposes of determining whether a party's verdict is greater or less than the  
1587 arbitration award under Subsection (8)(q), a court may not consider any recovery or other relief  
1588 granted on a claim for damages if the claim for damages:

1589 (i) was not fully disclosed in writing prior to the arbitration proceeding; or

1590 (ii) was not disclosed in response to discovery contrary to the Utah Rules of Civil  
1591 Procedure.

1592 (s) If a district court determines, upon a motion of the nonmoving party, that the  
1593 moving party's use of the trial de novo process was filed in bad faith in accordance with  
1594 Section 78B-5-825, the district court may award reasonable attorney fees to the nonmoving  
1595 party.

1596 (t) Nothing in this section is intended to limit any claim under any other portion of an  
1597 applicable insurance policy.

1598 (u) If there are multiple uninsured motorist policies, as set forth in Subsection (7), the  
1599 claimant may elect to arbitrate in one hearing the claims against all the uninsured motorist  
1600 carriers.

1601 (9) (a) Within 30 days after a covered person elects to submit a claim for uninsured  
1602 motorist benefits to binding arbitration or files litigation, the covered person shall provide to  
1603 the uninsured motorist carrier:

1604 (i) a written demand for payment of uninsured motorist coverage benefits, setting forth:

1605 (A) the specific monetary amount of the demand; and

1606 (B) the factual and legal basis and any supporting documentation for the demand;

1607 (ii) a written statement under oath disclosing:

1608 (A) (I) the names and last known addresses of all health care providers who have  
1609 rendered health care services to the covered person that are material to the claims for which  
1610 uninsured motorist benefits are sought for a period of five years preceding the date of the event  
1611 giving rise to the claim for uninsured motorist benefits up to the time the election for  
1612 arbitration or litigation has been exercised; and

1613 (II) whether the covered person has seen other health care providers who have rendered  
1614 health care services to the covered person, which the covered person claims are immaterial to  
1615 the claims for which uninsured motorist benefits are sought, for a period of five years  
1616 preceding the date of the event giving rise to the claim for uninsured motorist benefits up to the  
1617 time the election for arbitration or litigation has been exercised that have not been disclosed  
1618 under Subsection (9)(a)(ii)(A)(I);

1619 (B) (I) the names and last known addresses of all health insurers or other entities to  
1620 whom the covered person has submitted claims for health care services or benefits material to  
1621 the claims for which uninsured motorist benefits are sought, for a period of five years  
1622 preceding the date of the event giving rise to the claim for uninsured motorist benefits up to the  
1623 time the election for arbitration or litigation has been exercised; and

1624 (II) whether the identity of any health insurers or other entities to whom the covered  
1625 person has submitted claims for health care services or benefits, which the covered person  
1626 claims are immaterial to the claims for which uninsured motorist benefits are sought, for a  
1627 period of five years preceding the date of the event giving rise to the claim for uninsured  
1628 motorist benefits up to the time the election for arbitration or litigation have not been disclosed;

1629 (C) if lost wages, diminished earning capacity, or similar damages are claimed, all  
1630 employers of the covered person for a period of five years preceding the date of the event  
1631 giving rise to the claim for uninsured motorist benefits up to the time the election for  
1632 arbitration or litigation has been exercised;

1633 (D) other documents to reasonably support the claims being asserted; and

1634 (E) all state and federal statutory lienholders including a statement as to whether the  
1635 covered person is a recipient of Medicare or Medicaid benefits or Utah Children's Health  
1636 Insurance Program benefits under Title 26, Chapter 40, Utah Children's Health Insurance Act,  
1637 or if the claim is subject to any other state or federal statutory liens; and

1638 (iii) signed authorizations to allow the uninsured motorist carrier to only obtain records  
1639 and billings from the individuals or entities disclosed.

1640 (b) (i) If the uninsured motorist carrier determines that the disclosure of undisclosed  
1641 health care providers or health care insurers under Subsection (9)(a)(ii) is reasonably necessary,  
1642 the uninsured motorist carrier may:

1643 (A) make a request for the disclosure of the identity of the health care providers or  
1644 health care insurers; and

1645 (B) make a request for authorizations to allow the uninsured motorist carrier to only  
1646 obtain records and billings from the individuals or entities not disclosed.

1647 (ii) If the covered person does not provide the requested information within 10 days:

1648 (A) the covered person shall disclose, in writing, the legal or factual basis for the  
1649 failure to disclose the health care providers or health care insurers; and

1650 (B) either the covered person or the uninsured motorist carrier may request the  
1651 arbitrator or arbitration panel to resolve the issue of whether the identities or records are to be  
1652 provided if the covered person has elected arbitration.

1653 (iii) The time periods imposed by Subsection (9)(c)(i) are tolled pending resolution of  
1654 the dispute concerning the disclosure and production of records of the health care providers or  
1655 health care insurers.

1656 (c) (i) An uninsured motorist carrier that receives an election for arbitration or a notice  
1657 of filing litigation and the demand for payment of uninsured motorist benefits under Subsection  
1658 (9)(a)(i) shall have a reasonable time, not to exceed 60 days from the date of the demand and  
1659 receipt of the items specified in Subsections (9)(a)(i) through (iii), to:

1660 (A) provide a written response to the written demand for payment provided for in  
1661 Subsection (9)(a)(i);

1662 (B) except as provided in Subsection (9)(c)(i)(C), tender the amount, if any, of the  
1663 uninsured motorist carrier's determination of the amount owed to the covered person; and

1664 (C) if the covered person is a recipient of Medicare or Medicaid benefits or Utah  
1665 Children's Health Insurance Program benefits under Title 26, Chapter 40, Utah Children's  
1666 Health Insurance Act, or if the claim is subject to any other state or federal statutory liens,  
1667 tender the amount, if any, of the uninsured motorist carrier's determination of the amount owed  
1668 to the covered person less:

1669 (I) if the amount of the state or federal statutory lien is established, the amount of the  
1670 lien; or

1671 (II) if the amount of the state or federal statutory lien is not established, two times the  
1672 amount of the medical expenses subject to the state or federal statutory lien until such time as  
1673 the amount of the state or federal statutory lien is established.

1674 (ii) If the amount tendered by the uninsured motorist carrier under Subsection (9)(c)(i)  
1675 is the total amount of the uninsured motorist policy limits, the tendered amount shall be  
1676 accepted by the covered person.

1677 (d) A covered person who receives a written response from an uninsured motorist  
1678 carrier as provided for in Subsection (9)(c)(i), may:

1679 (i) elect to accept the amount tendered in Subsection (9)(c)(i) as payment in full of all  
1680 uninsured motorist claims; or

1681 (ii) elect to:

1682 (A) accept the amount tendered in Subsection (9)(c)(i) as partial payment of all  
1683 uninsured motorist claims; and

1684 (B) litigate or arbitrate the remaining claim.

1685 (e) If a covered person elects to accept the amount tendered under Subsection (9)(c)(i)  
1686 as partial payment of all uninsured motorist claims, the final award obtained through  
1687 arbitration, litigation, or later settlement shall be reduced by any payment made by the  
1688 uninsured motorist carrier under Subsection (9)(c)(i).

1689 (f) In an arbitration proceeding on the remaining uninsured claims:

1690 (i) the parties may not disclose to the arbitrator or arbitration panel the amount paid  
1691 under Subsection (9)(c)(i) until after the arbitration award has been rendered; and

1692 (ii) the parties may not disclose the amount of the limits of uninsured motorist benefits  
1693 provided by the policy.

1694 (g) If the final award obtained through arbitration or litigation is greater than the  
1695 average of the covered person's initial written demand for payment provided for in Subsection  
1696 (9)(a)(i) and the uninsured motorist carrier's initial written response provided for in Subsection  
1697 (9)(c)(i), the uninsured motorist carrier shall pay:

1698 (i) the final award obtained through arbitration or litigation, except that if the award  
1699 exceeds the policy limits of the subject uninsured motorist policy by more than \$15,000, the

1700 amount shall be reduced to an amount equal to the policy limits plus \$15,000; and  
1701 (ii) any of the following applicable costs:  
1702 (A) any costs as set forth in Rule 54(d), Utah Rules of Civil Procedure;  
1703 (B) the arbitrator or arbitration panel's fee; and  
1704 (C) the reasonable costs of expert witnesses and depositions used in the presentation of  
1705 evidence during arbitration or litigation.  
1706 (h) (i) The covered person shall provide an affidavit of costs within five days of an  
1707 arbitration award.  
1708 (ii) (A) Objection to the affidavit of costs shall specify with particularity the costs to  
1709 which the uninsured motorist carrier objects.  
1710 (B) The objection shall be resolved by the arbitrator or arbitration panel.  
1711 (iii) The award of costs by the arbitrator or arbitration panel under Subsection (9)(g)(ii)  
1712 may not exceed \$5,000.  
1713 (i) (i) A covered person shall disclose all material information, other than rebuttal  
1714 evidence, as specified in Subsection (9)(a).  
1715 (ii) If the information under Subsection (9)(i)(i) is not disclosed, the covered person  
1716 may not recover costs or any amounts in excess of the policy under Subsection (9)(g).  
1717 (j) This Subsection (9) does not limit any other cause of action that arose or may arise  
1718 against the uninsured motorist carrier from the same dispute.  
1719 (k) The provisions of this Subsection (9) only apply to motor vehicle accidents that  
1720 occur on or after March 30, 2010.  
1721 Section 7. Section **31A-22-607** is amended to read:  
1722 **31A-22-607. Grace period.**  
1723 (1) ~~Every~~ (a) An individual or franchise accident and health insurance policy shall  
1724 contain one or more clauses providing for a grace period for premium payment only of:  
1725 (i) at least 15 days for a weekly or monthly premium ~~[policies]~~ policy; and  
1726 (ii) 30 days for ~~[all other policies]~~ a policy that is not a weekly or monthly premium  
1727 policy, for each premium after the first premium payment. ~~[A carrier]~~  
1728 (b) An insurer may elect to include a grace period that is longer than 15 days for a  
1729 weekly or monthly ~~[policies]~~ policy.  
1730 ~~[(a) The]~~ (c) An individual or franchise accident and health insurance policy is not in

1731 force during ~~[the]~~ a grace period.

1732 ~~[(b) If the]~~ (d) If an insurer receives payment before ~~[the]~~ a grace period expires, the  
1733 individual or franchise accident and health insurance policy continues in force with no gap in  
1734 coverage.

1735 ~~[(c) If the]~~ (e) If an insurer does not receive payment before ~~[the]~~ a grace period  
1736 expires, the ~~[policy shall be]~~ individual or franchise accident and health insurance policy is  
1737 terminated as of the last date for which the premium ~~[was]~~ is paid in full.

1738 ~~[(d)]~~ (f) A grace period is not required if the policyholder has requested that the  
1739 individual or franchise accident and health insurance policy be discontinued.

1740 (2) ~~[Every]~~ (a) A group or blanket accident and health insurance policy shall provide  
1741 for a grace period of at least 30 days, unless the policyholder gives written notice of  
1742 discontinuance ~~[prior to]~~ before the date of discontinuance, in accordance with the policy  
1743 terms. ~~[In group or blanket policies, the]~~

1744 (b) A group or blanket accident and health insurance policy is in force during a grace  
1745 period.

1746 (c) If an insurer does not receive payment before a grace period expires, the group or  
1747 blanket accident and health insurance policy is terminated as of the last day of the grace period.

1748 (d) A group or blanket accident and health insurance policy may provide for payment  
1749 of a pro rata premium for the period the group or blanket accident and health insurance policy  
1750 is in effect during ~~[the]~~ a grace period under this Subsection (2).

1751 (3) If ~~[the]~~ an insurer has not guaranteed the insured a right to renew an accident and  
1752 health insurance policy, ~~[any]~~ a grace period beyond the expiration or anniversary date may, if  
1753 provided in the accident and health insurance policy, be cut off by compliance with the notice  
1754 provision under Subsection 31A-21-303(4)(b).

1755 Section 8. Section **31A-22-610.6** is amended to read:

1756 **31A-22-610.6. Special enrollment for individuals receiving premium assistance.**

1757 (1) As used in this section:

1758 (a) "Premium assistance" means assistance under Title 26, Chapter 18, Medical  
1759 Assistance Act, in the payment of premium.

1760 (b) "Qualified beneficiary" means an individual who is approved to receive premium  
1761 assistance.

1762 (2) Subject to the other provisions in this section, an individual may enroll under this  
1763 section at a time outside of an employer health benefit plan open enrollment period, regardless  
1764 of previously waiving coverage, if the individual is:

1765 (a) a qualified beneficiary who is eligible for coverage as an employee under the  
1766 employer health benefit plan; or

1767 (b) a dependent of the qualified beneficiary who is eligible for coverage under the  
1768 employer health benefit plan.

1769 (3) To be eligible to enroll outside of an open enrollment period, an individual  
1770 described in Subsection (2) shall enroll in the employer health benefit plan by no later than 30  
1771 days from the day on which the qualified beneficiary receives initial written notification, after  
1772 July 1, 2008, that the qualified beneficiary is eligible to receive premium assistance.

1773 (4) An individual described in Subsection (2) may enroll under this section only in an  
1774 employer health benefit plan that is available at the time of enrollment to similarly situated  
1775 eligible employees or dependents of eligible employees.

1776 (5) Coverage under an employer health benefit plan for an individual described in  
1777 Subsection (2) may begin as soon as the first day of the month immediately following  
1778 enrollment of the individual in accordance with this section.

1779 (6) This section does not modify any requirement related to premiums that applies  
1780 under an employer health benefit plan to a similarly situated eligible employee or dependent of  
1781 an eligible employee under the employer health benefit plan.

1782 (7) An employer health benefit plan may require an individual described in Subsection  
1783 (2) to satisfy a preexisting condition waiting period that:

1784 (a) is allowed under the Health Insurance Portability and Accountability Act [~~of 1996,~~  
1785 ~~Pub. L. 104-191, 110 Stat. 1936~~]; and

1786 (b) is not longer than 12 months.

1787 Section 9. Section **31A-22-614.5** is amended to read:

1788 **31A-22-614.5. Uniform claims processing -- Electronic exchange of health**  
1789 **information.**

1790 (1) (a) Except as provided in Subsection (1)(c), all insurers offering health insurance  
1791 shall use a uniform claim form and uniform billing and claim codes.

1792 (b) Beginning January 1, 2011, all health benefit plans, and dental and vision plans,

1793 shall provide for the electronic exchange of uniform:

1794 (i) eligibility and coverage information; and

1795 (ii) coordination of benefits information.

1796 (c) For purposes of Subsection (1)(a), "health insurance" does not include a policy or  
1797 certificate that provides benefits solely for:

1798 (i) income replacement; or

1799 (ii) long-term care.

1800 (2) (a) The uniform electronic standards and information required in Subsection (1)  
1801 shall be adopted and approved by the commissioner in accordance with Title 63G, Chapter 3,  
1802 Utah Administrative Rulemaking Act.

1803 (b) When adopting rules under this section the commissioner:

1804 (i) shall:

1805 (A) consult with national and state organizations involved with the standardized  
1806 exchange of health data, and the electronic exchange of health data, to develop the standards  
1807 for the use and electronic exchange of uniform:

1808 (I) claim forms;

1809 (II) billing and claim codes;

1810 (III) insurance eligibility and coverage information; and

1811 (IV) coordination of benefits information; and

1812 (B) meet federal mandatory minimum standards following the adoption of national  
1813 requirements for transaction and data elements in the federal Health Insurance Portability and  
1814 Accountability Act [~~of 1996, Pub. L. 104-191, 110 Stat. 1936~~];

1815 (ii) may not require an insurer or administrator to use a specific software product or  
1816 vendor; and

1817 (iii) may require an insurer who participates in the all payer database created under  
1818 Section 26-33a-106.1 to allow data regarding demographic and insurance coverage information  
1819 to be electronically shared with the state's designated secure health information master person  
1820 index to be used:

1821 (A) in compliance with data security standards established by:

1822 (I) the federal Health Insurance Portability and Accountability Act [~~of 1996, Pub. L.  
1823 104-191, 110 Stat. 1936~~]; and

1824 (II) the electronic commerce agreements established in a business associate agreement;  
1825 and

1826 (B) for the purpose of coordination of health benefit plans.

1827 (3) (a) The commissioner shall coordinate the administrative rules adopted under the  
1828 provisions of this section with the administrative rules adopted by the Department of Health for  
1829 the implementation of the standards for the electronic exchange of clinical health information  
1830 under Section 26-1-37. The department shall establish procedures for developing the rules  
1831 adopted under this section, which ensure that the Department of Health is given the opportunity  
1832 to comment on proposed rules.

1833 (b) (i) The commissioner may provide information to health care providers regarding  
1834 resources available to a health care provider to verify whether a health care provider's practice  
1835 management software system meets the uniform electronic standards for data exchange  
1836 required by this section.

1837 (ii) The commissioner may provide the information described in Subsection (3)(b)(i)  
1838 by partnering with:

1839 (A) a not-for-profit, broad based coalition of state health care insurers and health care  
1840 providers who are involved in the electronic exchange of the data required by this section; or

1841 (B) some other person that the commissioner determines is appropriate to provide the  
1842 information described in Subsection (3)(b)(i).

1843 (c) The commissioner shall regulate any fees charged by insurers to the providers for:

1844 (i) uniform claim forms;

1845 (ii) electronic billing; or

1846 (iii) the electronic exchange of clinical health information permitted by Section  
1847 26-1-37.

1848 Section 10. Section **31A-22-618.5** is amended to read:

1849 **31A-22-618.5. Health benefit plan offerings.**

1850 (1) The purpose of this section is to increase the range of health benefit plans available  
1851 in the small group, small employer group, large group, and individual insurance markets.

1852 (2) A health maintenance organization that is subject to Chapter 8, Health Maintenance  
1853 Organizations and Limited Health Plans:

1854 (a) shall offer to potential purchasers at least one health benefit plan that is subject to

1855 the requirements of Chapter 8, Health Maintenance Organizations and Limited Health Plans;  
1856 and

1857 (b) may offer to a potential purchaser one or more health benefit plans that:

1858 (i) are not subject to one or more of the following:

1859 (A) the limitations on insured indemnity benefits in Subsection 31A-8-105(4);

1860 (B) the limitation on point of service products in Subsections 31A-8-408(3) through

1861 (6);

1862 (C) except as provided in Subsection (2)(b)(ii), basic health care services as defined in  
1863 Section 31A-8-101; or

1864 (D) coverage mandates enacted after January 1, 2009 that are not required by federal  
1865 law, provided that the insurer offers one plan under Subsection (2)(a) that covers the mandate  
1866 enacted after January 1, 2009; and

1867 (ii) when offering a health plan under this section, provide coverage for an emergency  
1868 medical condition as required by Section 31A-22-627 as follows:

1869 (A) within the organization's service area, covered services shall include health care  
1870 services from non-affiliated providers when medically necessary to stabilize an emergency  
1871 medical condition; and

1872 (B) outside the organization's service area, covered services shall include medically  
1873 necessary health care services for the treatment of an emergency medical condition that are  
1874 immediately required while the enrollee is outside the geographic limits of the organization's  
1875 service area.

1876 (3) An insurer that offers a health benefit plan that is not subject to Chapter 8, Health  
1877 Maintenance Organizations and Limited Health Plans:

1878 (a) notwithstanding Subsection 31A-22-617(2), may offer a health benefit plan that  
1879 groups providers into the following reimbursement levels:

1880 (i) tier one contracted providers;

1881 (ii) tier two contracted providers who the insurer must reimburse at least 75% of tier  
1882 one providers; and

1883 (iii) one or more tiers of non-contracted providers; and

1884 (b) notwithstanding Subsection 31A-22-617(9) may offer a health benefit plan that is  
1885 not subject to Section 31A-22-618;

1886 (c) beginning July 1, 2012, may offer [~~products under Subsection (3)(a)~~] health benefit  
1887 plans that:

1888 (i) are not subject to Subsection 31A-22-617(2); and

1889 (ii) are subject to the reimbursement requirements in Section 31A-8-501;

1890 (d) when offering a health plan under this Subsection (3), shall provide coverage of  
1891 emergency care services as required by Section 31A-22-627 by providing coverage at a  
1892 reimbursement level of at least 75% of [~~tier one providers~~] the health benefit plan's highest  
1893 contracted provider category; and

1894 (e) are not subject to coverage mandates enacted after January 1, 2009 that are not  
1895 required by federal law, provided that an insurer offers one plan that covers a mandate enacted  
1896 after January 1, 2009.

1897 (4) Section 31A-8-106 does not prohibit the offer of a health benefit plan under  
1898 Subsection (2)(b).

1899 (5) (a) Any difference in price between a health benefit plan offered under Subsections  
1900 (2)(a) and (b) shall be based on actuarially sound data.

1901 (b) Any difference in price between a health benefit plan offered under Subsections  
1902 (3)(a) and (b) shall be based on actuarially sound data.

1903 (6) Nothing in this section limits the number of health benefit plans that an insurer may  
1904 offer.

1905 Section 11. Section **31A-22-625** is amended to read:

1906 **31A-22-625. Catastrophic coverage of mental health conditions.**

1907 (1) As used in this section:

1908 (a) (i) "Catastrophic mental health coverage" means coverage in a health benefit plan  
1909 that does not impose a lifetime limit, annual payment limit, episodic limit, inpatient or  
1910 outpatient service limit, or maximum out-of-pocket limit that places a greater financial burden  
1911 on an insured for the evaluation and treatment of a mental health condition than for the  
1912 evaluation and treatment of a physical health condition.

1913 (ii) "Catastrophic mental health coverage" may include a restriction on cost sharing  
1914 factors, such as deductibles, copayments, or coinsurance, before reaching a maximum  
1915 out-of-pocket limit.

1916 (iii) "Catastrophic mental health coverage" may include one maximum out-of-pocket

1917 limit for physical health conditions and another maximum out-of-pocket limit for mental health  
1918 conditions, except that if separate out-of-pocket limits are established, the out-of-pocket limit  
1919 for mental health conditions may not exceed the out-of-pocket limit for physical health  
1920 conditions.

1921 (b) (i) "50/50 mental health coverage" means coverage in a health benefit plan that  
1922 pays for at least 50% of covered services for the diagnosis and treatment of mental health  
1923 conditions.

1924 (ii) "50/50 mental health coverage" may include a restriction on:

1925 (A) episodic limits;

1926 (B) inpatient or outpatient service limits; or

1927 (C) maximum out-of-pocket limits.

1928 (c) "Large employer" is as defined in 42 U.S.C. Sec. 300gg-91.

1929 (d) (i) "Mental health condition" means a condition or disorder involving mental illness  
1930 that falls under a diagnostic category listed in the Diagnostic and Statistical Manual, as  
1931 periodically revised.

1932 (ii) "Mental health condition" does not include the following when diagnosed as the  
1933 primary or substantial reason or need for treatment:

1934 (A) a marital or family problem;

1935 (B) a social, occupational, religious, or other social maladjustment;

1936 (C) a conduct disorder;

1937 (D) a chronic adjustment disorder;

1938 (E) a psychosexual disorder;

1939 (F) a chronic organic brain syndrome;

1940 (G) a personality disorder;

1941 (H) a specific developmental disorder or learning disability; or

1942 (I) mental retardation.

1943 (e) "Small employer" is as defined in 42 U.S.C. Sec. 300gg-91.

1944 (2) (a) At the time of purchase and renewal, an insurer shall offer to a small employer  
1945 that it insures or seeks to insure a choice between catastrophic mental health coverage and  
1946 50/50 mental health coverage.

1947 (b) In addition to complying with Subsection (2)(a), an insurer may offer to provide:

1948 (i) catastrophic mental health coverage, 50/50 mental health coverage, or both at levels  
1949 that exceed the minimum requirements of this section; or

1950 (ii) coverage that excludes benefits for mental health conditions.

1951 (c) A small employer may, at its option, choose either catastrophic mental health  
1952 coverage, 50/50 mental health coverage, or coverage offered under Subsection (2)(b),  
1953 regardless of the employer's previous coverage for mental health conditions.

1954 (d) An insurer is exempt from the 30% index rating restriction in Section  
1955 31A-30-106.1 and, for the first year only that catastrophic mental health coverage is chosen, the  
1956 15% annual adjustment restriction in Section 31A-30-106.1, for any small employer with 20 or  
1957 less enrolled employees who chooses coverage that meets or exceeds catastrophic mental  
1958 health coverage.

1959 (3) An insurer shall offer a large employer mental health and substance use disorder  
1960 benefit in compliance with Section 2705 of the Public Health Service Act, 42 U.S.C. Sec.  
1961 ~~[300gg-5]~~ 300gg-26, and federal regulations adopted pursuant to that act.

1962 (4) (a) An insurer may provide catastrophic mental health coverage to a small employer  
1963 through a managed care organization or system in a manner consistent with Chapter 8, Health  
1964 Maintenance Organizations and Limited Health Plans, regardless of whether the insurance  
1965 policy uses a managed care organization or system for the treatment of physical health  
1966 conditions.

1967 (b) (i) Notwithstanding any other provision of this title, an insurer may:

1968 (A) establish a closed panel of providers for catastrophic mental health coverage; and

1969 (B) refuse to provide a benefit to be paid for services rendered by a nonpanel provider  
1970 unless:

1971 (I) the insured is referred to a nonpanel provider with the prior authorization of the  
1972 insurer; and

1973 (II) the nonpanel provider agrees to follow the insurer's protocols and treatment  
1974 guidelines.

1975 (ii) If an insured receives services from a nonpanel provider in the manner permitted by  
1976 Subsection (4)(b)(i)(B), the insurer shall reimburse the insured for not less than 75% of the  
1977 average amount paid by the insurer for comparable services of panel providers under a  
1978 noncapitated arrangement who are members of the same class of health care providers.

1979 (iii) This Subsection (4)(b) may not be construed as requiring an insurer to authorize a  
1980 referral to a nonpanel provider.

1981 (c) To be eligible for catastrophic mental health coverage, a diagnosis or treatment of a  
1982 mental health condition must be rendered:

1983 (i) by a mental health therapist as defined in Section 58-60-102; or

1984 (ii) in a health care facility:

1985 (A) licensed or otherwise authorized to provide mental health services pursuant to:

1986 (I) Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; or

1987 (II) Title 62A, Chapter 2, Licensure of Programs and Facilities; and

1988 (B) that provides a program for the treatment of a mental health condition pursuant to a  
1989 written plan.

1990 (5) The commissioner may prohibit an insurance policy that provides mental health  
1991 coverage in a manner that is inconsistent with this section.

1992 (6) The commissioner shall:

1993 (a) adopt rules, in accordance with Title 63G, Chapter 3, Utah Administrative  
1994 Rulemaking Act, as necessary to ensure compliance with this section; and

1995 (b) provide general figures on the percentage of insurance policies that include:

1996 (i) no mental health coverage;

1997 (ii) 50/50 mental health coverage;

1998 (iii) catastrophic mental health coverage; and

1999 (iv) coverage that exceeds the minimum requirements of this section.

2000 (7) This section may not be construed as discouraging or otherwise preventing an  
2001 insurer from providing mental health coverage in connection with an individual insurance  
2002 policy.

2003 (8) This section shall be repealed in accordance with Section 63I-1-231.

2004 Section 12. Section **31A-22-701** is amended to read:

2005 **31A-22-701. Groups eligible for group or blanket insurance.**

2006 (1) As used in this section, "association group" means a lawfully formed association of  
2007 individuals or business entities that:

2008 (a) purchases insurance on a group basis on behalf of members; and

2009 (b) is formed and maintained in good faith for purposes other than obtaining insurance.

2010 (2) A group [~~or blanket~~] accident and health insurance policy may be issued to:

2011 (a) a group:

2012 (i) to which a group life insurance policy may be issued under Sections 31A-22-502,

2013 31A-22-503, 31A-22-504, 31A-22-506, 31A-22-507, and 31A-22-509; and

2014 (ii) that is formed [~~for a reason other than the purchase of insurance~~] and maintained in

2015 good faith for a purpose other than obtaining insurance;

2016 (b) an association group that:

2017 (i) has been actively in existence for at least five years;

2018 (ii) has a constitution and bylaws;

2019 (iii) is formed and maintained in good faith for purposes other than obtaining

2020 insurance;

2021 (iv) does not condition membership in the association group on any health

2022 status-related factor relating to an individual, including an employee of an employer or a

2023 dependent of an employee;

2024 (v) makes accident and health insurance coverage offered through the association

2025 group available to all members regardless of any health status-related factor relating to the

2026 members or individuals eligible for coverage through a member; [~~and~~]

2027 (vi) does not make accident and health insurance coverage offered through the

2028 association group available other than in connection with a member of the association group;

2029 [~~or~~] and

2030 (vii) is actuarially sound; or

2031 (c) a group specifically authorized by the commissioner under Section 31A-22-509,

2032 upon a finding that:

2033 (i) authorization is not contrary to the public interest;

2034 (ii) the [~~proposed~~] group is actuarially sound;

2035 (iii) formation of the proposed group may result in economies of scale in acquisition,

2036 administrative, marketing, and brokerage costs;

2037 (iv) the insurance policy, insurance certificate, or other indicia of coverage that will be

2038 offered to the proposed group is substantially equivalent to insurance policies that are

2039 otherwise available to similar groups;

2040 (v) the group would not present hazards of adverse selection; [~~and~~]

2041 (vi) the premiums for the insurance policy and any contributions by or on behalf of the  
2042 insured persons are reasonable in relation to the benefits provided[-]; and

2043 (vii) the group is formed and maintained in good faith for a purpose other than  
2044 obtaining insurance.

2045 (3) A blanket accident and health insurance policy:

2046 (a) covers a defined class of persons;

2047 (b) may not be offered or underwritten on an individual basis;

2048 (c) shall cover only a group that is:

2049 (i) actuarially sound; and

2050 (ii) formed and maintained in good faith for a purpose other than obtaining insurance;

2051 and

2052 (d) may [~~also~~] be issued only to:

2053 [~~(a)~~] (i) a common carrier or an operator, owner, or lessee of a means of transportation,  
2054 as policyholder, covering persons who may become passengers as defined by reference to  
2055 [~~their~~] the person's travel status;

2056 [~~(b)~~] (ii) an employer, as policyholder, covering any group of employees, dependents,  
2057 or guests, as defined by reference to specified hazards incident to any activities of the  
2058 policyholder;

2059 [~~(c)~~] (iii) an institution of learning, including a school district, a school jurisdictional  
2060 [~~units~~] unit, or the head, principal, or governing board of [~~any of those units~~] a school  
2061 jurisdictional unit, as policyholder, covering students, teachers, or employees;

2062 [~~(d)~~] (iv) a religious, charitable, recreational, educational, or civic organization, or  
2063 branch of one of those organizations, as policyholder, covering [~~any~~] a group of members or  
2064 participants as defined by reference to specified hazards incident to the activities sponsored or  
2065 supervised by the policyholder;

2066 [~~(e)~~] (v) a sports team, camp, or sponsor of [~~the~~] a sports team or camp, as  
2067 policyholder, covering members, campers, employees, officials, or supervisors;

2068 [~~(f)~~] (vi) a volunteer fire department, first aid, civil defense, or other similar volunteer  
2069 organization, as policyholder, covering [~~any~~] a group of members or participants as defined by  
2070 reference to specified hazards incident to activities sponsored, supervised, or participated in by  
2071 the policyholder;

2072           ~~[(g)]~~ (vii) a newspaper or other publisher, as policyholder, covering its carriers;  
2073           ~~[(h)]~~ (viii) an association, including a labor union, ~~[which]~~ that has a constitution and  
2074 bylaws and ~~[which has been]~~ that is organized in good faith for purposes other than that of  
2075 obtaining insurance, as policyholder, covering ~~[any]~~ a group of members or participants as  
2076 defined by reference to specified hazards incident to the activities or operations sponsored or  
2077 supervised by the policyholder; and

2078           ~~[(i) a health insurance purchasing association, as defined in Section 31A-34-103,~~  
2079 ~~organized and controlled solely by participating employers; and]~~

2080           ~~[(j)]~~ (ix) any other class of risks that, in the judgment of the commissioner, may be  
2081 properly eligible for blanket accident and health insurance.

2082           (4) The judgment of the commissioner may be exercised on the basis of:

2083           (a) individual risks;

2084           (b) a class of risks; or

2085           (c) both Subsections (4)(a) and (b).

2086           Section 13. Section **31A-22-716** is amended to read:

2087           **31A-22-716. Required provision for notice of termination.**

2088           (1) Every policy for group or blanket accident and health coverage issued or renewed  
2089 after July 1, 1990, shall include a provision that obligates the policyholder to give 30 days prior  
2090 written notice of termination to each employee or group member and to notify each employee  
2091 or group member of his rights to continue coverage upon termination.

2092           (2) An insurer's monthly notice to the policyholder of premium payments due shall  
2093 include a statement of the policyholder's obligations as set forth in Subsection (1). Insurers  
2094 shall provide a sample notice to the policyholder at least once a year.

2095           (3) For the purpose of compliance with federal law and the Health Insurance Portability  
2096 and Accountability Act~~[-P.L. No. 104-191, 110 Stat. 1960]~~, all health benefit plans, health  
2097 insurers, and student health plans must provide a certificate of creditable coverage to each  
2098 covered person upon the person's termination from the plan as soon as reasonably possible.

2099           Section 14. Section **31A-22-721** is amended to read:

2100           **31A-22-721. A health benefit plan for a plan sponsor -- Discontinuance and**  
2101 **nonrenewal.**

2102           (1) Except as otherwise provided in this section, a health benefit plan for a plan

- 2103 sponsor is renewable and continues in force:
- 2104 (a) with respect to all eligible employees and dependents; and
- 2105 (b) at the option of the plan sponsor.
- 2106 (2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed:
- 2107 (a) for a network plan, if:
- 2108 (i) there is no longer any enrollee under the group health plan who lives, resides, or
- 2109 works in:
- 2110 (A) the service area of the insurer; or
- 2111 (B) the area for which the insurer is authorized to do business; and
- 2112 (ii) in the case of the small employer market, the insurer applies the same criteria the
- 2113 insurer would apply in denying enrollment in the plan under Subsection 31A-30-108(7); or
- 2114 (b) for coverage made available in the small or large employer market only through an
- 2115 association, if:
- 2116 (i) the employer's membership in the association ceases; and
- 2117 (ii) the coverage is terminated uniformly without regard to any health status-related
- 2118 factor relating to any covered individual.
- 2119 (3) A health benefit plan for a plan sponsor may be discontinued if:
- 2120 (a) a condition described in Subsection (2) exists;
- 2121 (b) the plan sponsor fails to pay premiums or contributions in accordance with the
- 2122 terms of the contract;
- 2123 (c) the plan sponsor:
- 2124 (i) performs an act or practice that constitutes fraud; or
- 2125 (ii) makes an intentional misrepresentation of material fact under the terms of the
- 2126 coverage;
- 2127 (d) the insurer:
- 2128 (i) elects to discontinue offering a particular health benefit product delivered or issued
- 2129 for delivery in this state;
- 2130 (ii) (A) provides notice of the discontinuation in writing:
- 2131 (I) to each plan sponsor, employee, and dependent of a plan sponsor or employee; and
- 2132 (II) at least 90 days before the date the coverage will be discontinued;
- 2133 (B) provides notice of the discontinuation in writing:

- 2134 (I) to the commissioner; and
- 2135 (II) at least three working days prior to the date the notice is sent to the affected plan
- 2136 sponsors, employees, and dependents of plan sponsors or employees;
- 2137 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase any
- 2138 other health benefit products currently being offered:
- 2139 (I) by the insurer in the market; or
- 2140 (II) in the case of a large employer, any other health benefit plan currently being
- 2141 offered in that market; and
- 2142 (D) in exercising the option to discontinue that product and in offering the option of
- 2143 coverage in this section, the insurer acts uniformly without regard to:
- 2144 (I) the claims experience of a plan sponsor;
- 2145 (II) any health status-related factor relating to any covered participant or beneficiary; or
- 2146 (III) any health status-related factor relating to a new participant or beneficiary who
- 2147 may become eligible for coverage; or
- 2148 (e) the insurer:
- 2149 (i) elects to discontinue all of the insurer's health benefit plans:
- 2150 (A) in the small employer market; or
- 2151 (B) the large employer market; or
- 2152 (C) both the small and large employer markets; and
- 2153 (ii) (A) provides notice of the discontinuance in writing:
- 2154 (I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and
- 2155 (II) at least 180 days before the date the coverage will be discontinued;
- 2156 (B) provides notice of the discontinuation in writing:
- 2157 (I) to the commissioner in each state in which an affected insured individual is known
- 2158 to reside; and
- 2159 (II) at least 30 business days prior to the date the notice is sent to the affected plan
- 2160 sponsors, employees, and dependents of a plan sponsor or employee;
- 2161 (C) discontinues and nonrenews all plans issued or delivered for issuance in the
- 2162 market; and
- 2163 (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.
- 2164 (4) A large employer health benefit plan may be discontinued or nonrenewed:

- 2165 (a) if a condition described in Subsection (2) exists; or
- 2166 (b) for noncompliance with the insurer's:
  - 2167 (i) minimum participation requirements; or
  - 2168 (ii) employer contribution requirements.
- 2169 (5) A small employer health benefit plan may be discontinued or nonrenewed:
  - 2170 (a) if a condition described in Subsection (2) exists; or
  - 2171 (b) for noncompliance with the insurer's employer contribution requirements.
- 2172 (6) A small employer health benefit plan may be nonrenewed:
  - 2173 (a) if a condition described in Subsection (2) exists; or
  - 2174 (b) for noncompliance with the insurer's minimum participation requirements.
- 2175 (7) (a) Except as provided in Subsection (7)(d), an eligible employee may be
- 2176 discontinued if after issuance of coverage the eligible employee:
  - 2177 (i) engages in an act or practice that constitutes fraud in connection with the coverage;
  - 2178 or
  - 2179 (ii) makes an intentional misrepresentation of material fact in connection with the
  - 2180 coverage.
- 2181 (b) An eligible employee that is discontinued under Subsection (7)(a) may reenroll:
  - 2182 (i) 12 months after the date of discontinuance; and
  - 2183 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies
  - 2184 to reenroll.
- 2185 (c) At the time the eligible employee's coverage is discontinued under Subsection
- 2186 (7)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is
- 2187 discontinued.
- 2188 (d) An eligible employee may not be discontinued under this Subsection (7) because of
- 2189 a fraud or misrepresentation that relates to health status.
- 2190 (8) (a) Except as provided in Subsection (8)(b), an insurer that elects to discontinue
- 2191 offering a health benefit plan under Subsection (3)(e) shall be prohibited from writing new
- 2192 business in such market in this state for a period of five years beginning on the date of
- 2193 discontinuation of the last coverage that is discontinued.
- 2194 (b) The commissioner may waive the prohibition under Subsection (8)(a) when the
- 2195 commissioner finds that waiver is in the public interest:

2196 (i) to promote competition; or  
2197 (ii) to resolve inequity in the marketplace.  
2198 (9) If an insurer is doing business in one established geographic service area of the  
2199 state, this section applies only to the insurer's operations in that geographic service area.  
2200 (10) An insurer may modify a health benefit plan for a plan sponsor only:  
2201 (a) at the time of coverage renewal; and  
2202 (b) if the modification is effective uniformly among all plans with a particular product  
2203 or service.  
2204 (11) For purposes of this section, a reference to "plan sponsor" includes a reference to  
2205 the employer:  
2206 (a) with respect to coverage provided to an employer member of the association; and  
2207 (b) if the health benefit plan is made available by an insurer in the employer market  
2208 only through:  
2209 (i) an association;  
2210 (ii) a trust; or  
2211 (iii) a discretionary group.  
2212 (12) (a) A small employer that, after purchasing a health benefit plan in the small group  
2213 market, employs on average more than 50 eligible employees on each business day in a  
2214 calendar year may continue to renew the health benefit plan purchased in the small group  
2215 market.  
2216 (b) A large employer that, after purchasing a health benefit plan in the large group  
2217 market, employs on average less than 51 eligible employees on each business day in a calendar  
2218 year may continue to renew the health benefit plan purchased in the large group market.  
2219 (13) An insurer offering employer sponsored health benefit plans shall comply with the  
2220 Health Insurance Portability and Accountability Act, [~~P.L. 104-191, 110 Stat. 1962, Sec. 2701~~  
2221 ~~and 2702~~] 42 U.S.C. Sec. 300gg and 300gg-1.  
2222 Section 15. Section ~~31A-22-723~~ is amended to read:  
2223 **31A-22-723. Conversion from group coverage.**  
2224 (1) Notwithstanding Subsection 31A-1-103(3)(f), and except as provided in Subsection  
2225 (3), [~~all policies~~] a policy of accident and health insurance offered on a group basis under this  
2226 title, or Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act, shall

2227 provide that a person whose insurance under the group policy has been terminated is entitled to  
2228 choose a converted individual policy in accordance with this section and Section 31A-22-724.

2229 (2) A person who has lost group coverage may elect conversion coverage with the  
2230 insurer that provided prior group coverage if the person:

2231 (a) has been continuously covered for a period of three months by the group policy or  
2232 the group's preceding policies immediately prior to termination;

2233 (b) has exhausted either:

2234 (i) Utah mini-COBRA coverage as required in Section 31A-22-722;

2235 (ii) federal COBRA coverage; or

2236 (iii) alternative coverage under Section 31A-22-724;

2237 (c) has not acquired or is not covered under any other group coverage that covers [aH]  
2238 preexisting conditions, including maternity, if the coverage exists; and

2239 (d) resides in the insurer's service area.

2240 (3) This section does not apply if the person's prior group coverage:

2241 (a) is a stand alone policy that only provides one of the following:

2242 (i) catastrophic benefits;

2243 (ii) aggregate stop loss benefits;

2244 (iii) specific stop loss benefits;

2245 (iv) benefits for specific diseases;

2246 (v) accidental injuries only;

2247 (vi) dental; or

2248 (vii) vision;

2249 (b) is an income replacement policy;

2250 (c) was terminated because the insured:

2251 (i) failed to pay any required individual contribution;

2252 (ii) performed an act or practice that constitutes fraud in connection with the coverage;

2253 or

2254 (iii) made intentional misrepresentation of material fact under the terms of coverage; or

2255 (d) was terminated pursuant to Subsection 31A-8-402.3(2)(a), 31A-22-721(2)(a), or  
2256 31A-30-107(2)(a).

2257 (4) (a) The [employer] insurer shall provide written notification of the right to an

2258 individual conversion policy within 30 days of the insurer receiving notice of, the insured's  
2259 termination of coverage to:

2260 (i) the terminated insured;

2261 (ii) the ex-spouse; or

2262 (iii) in the case of the death of the insured:

2263 (A) the surviving spouse; and

2264 (B) the guardian of any dependents, if different from a surviving spouse.

2265 (b) The notification required by Subsection (4)(a) shall:

2266 (i) be sent by first class mail;

2267 (ii) contain the name, address, and telephone number of the insurer that will provide  
2268 the conversion coverage; and

2269 (iii) be sent to the insured's last-known address as shown on the records of the  
2270 employer of:

2271 (A) the insured;

2272 (B) the ex-spouse; and

2273 (C) if the policy terminates by reason of the death of the insured to:

2274 (I) the surviving spouse; and

2275 (II) the guardian of any dependents, if different from a surviving spouse.

2276 (5) (a) An insurer is not required to issue a converted policy [~~which~~] that provides  
2277 benefits in excess of those provided under the group policy from which conversion is made.

2278 (b) Except as provided in Subsection (5)(c), if the conversion is made from a health  
2279 benefit plan, the employee or member shall be offered[~~:(i) at least the basic benefit plan as~~  
2280 ~~provided in Section 31A-22-613.5 through December 31, 2009; and (ii) beginning January 1,~~  
2281 ~~2010, only~~] the alternative coverage as provided in Subsection 31A-22-724(1)(a).

2282 (c) If the benefit levels required under Subsection (5)(b) exceed the benefit levels  
2283 provided under the group policy, the conversion policy may offer benefits [~~which~~] that are  
2284 substantially similar to those provided under the group policy.

2285 (6) Written application for [~~the~~] a converted policy shall be made and the first premium  
2286 paid to the insurer no later than [~~60~~] 30 days after [~~termination of the group accident and health~~  
2287 ~~insurance~~] the date of notice under Subsection (4)(a).

2288 (7) [~~The~~] A converted policy shall be issued without evidence of insurability.

2289 (8) (a) The initial premium for the converted policy for the first 12 months and  
2290 subsequent renewal premiums shall be determined in accordance with premium rates  
2291 applicable to age, class of risk of the person, and the type and amount of insurance provided.

2292 (b) The initial premium for the first 12 months may not be raised based on pregnancy  
2293 of a covered insured.

2294 (c) The premium for converted policies shall be payable monthly or quarterly as  
2295 required by the insurer for the policy form and plan selected, unless another mode or premium  
2296 payment is mutually agreed upon.

2297 (9) ~~[The]~~ A converted policy becomes effective at the time the insurance under the  
2298 group policy terminates.

2299 (10) (a) A newly issued converted policy covers the employee or the member and must  
2300 also cover ~~[all]~~ dependents covered by the group policy at the date of termination of the group  
2301 coverage.

2302 (b) The only dependents that may be added after the policy has been issued are children  
2303 and dependents as required by Section 31A-22-610 and Subsections 31A-22-610.5(6) and (7).

2304 (c) At the option of the insurer, a separate converted policy may be issued to cover  
2305 ~~[any]~~ a dependent.

2306 (11) (a) To the extent ~~[the]~~ a group policy provided maternity benefits, ~~[the]~~ a  
2307 conversion policy shall provide maternity benefits equal to the lesser of the maternity benefits  
2308 of the group policy or the conversion policy until termination of a pregnancy that exists on the  
2309 date of conversion if one of the following is pregnant on the date of the conversion:

2310 (i) the insured;

2311 (ii) a spouse of the insured; or

2312 (iii) a dependent of the insured.

2313 (b) ~~[The requirements of this]~~ This Subsection (11) ~~[do]~~ does not apply to a pregnancy  
2314 that occurs after the date of conversion.

2315 (12) Except as provided in this Subsection (12), a converted policy is renewable with  
2316 respect to ~~[all individuals or dependents]~~ an individual or dependent at the option of the  
2317 insured. An insured may be terminated from a converted policy for the following reasons:

2318 (a) a dependent is no longer eligible under the converted policy;

2319 (b) for a network plan, if the individual no longer lives, resides, or works in:

- 2320 (i) the insured's service area; or
- 2321 (ii) the area for which the covered carrier is authorized to do business;
- 2322 (c) the individual fails to pay premiums or contributions in accordance with the terms
- 2323 of the converted policy, including any timeliness requirements;
- 2324 (d) the individual performs an act or practice that constitutes fraud in connection with
- 2325 the coverage;
- 2326 (e) the individual makes an intentional misrepresentation of material fact under the
- 2327 terms of the coverage; or
- 2328 (f) coverage is terminated uniformly without regard to any health status-related factor
- 2329 relating to any covered individual.

2330 (13) Conditions pertaining to health may not be used as a basis for classification under

2331 this section.

2332 (14) An insurer is only required to offer a conversion policy that complies with

2333 Subsection 31A-22-724(1)(b) and, notwithstanding Sections 31A-8-402.5 and 31A-30-107.1,

2334 may discontinue any other conversion policy if:

2335 (a) the discontinued conversion policy is discontinued uniformly without regard to

2336 ~~any~~ a health related factor;

2337 (b) ~~any affected~~ an affected individual is provided with 90 days' advanced written

2338 notice of the discontinuation of the existing conversion policy;

2339 (c) the ~~policy holder~~ policyholder is offered the insurer's conversion policy that

2340 complies with Subsection 31A-22-724(1)(b); and

2341 (d) the ~~policy holder~~ policyholder is not re-rated for purposes of premium calculation.

2342 (15) This section does not apply to a blanket accident and health insurance policy

2343 issued under Section 31A-22-701.

2344 Section 16. Section **31A-23a-102** is amended to read:

2345 **31A-23a-102. Definitions.**

2346 As used in this chapter:

2347 (1) "Bail bond producer" means a person who:

2348 (a) is appointed by:

2349 (i) a surety insurer that issues bail bonds; or

2350 (ii) a bail bond surety company licensed under Chapter 35, Bail Bond Act;

2351 (b) is designated to execute or countersign undertakings of bail in connection with a  
2352 judicial proceeding; and

2353 (c) receives or is promised money or other things of value for engaging in an act  
2354 described in Subsection (1)(b).

2355 (2) "Escrow" means a license subline of authority in conjunction with the title  
2356 insurance line of authority that allows a person to conduct escrow as defined in Section  
2357 31A-1-301.

2358 (3) "Home state" means a state or territory of the United States or the District of  
2359 Columbia in which an insurance producer:

2360 (a) maintains the insurance producer's principal:

2361 (i) place of residence; or

2362 (ii) place of business; and

2363 (b) is licensed to act as an insurance producer.

2364 (4) "Insurer" is as defined in Section 31A-1-301, except that the following persons or  
2365 similar persons are not insurers for purposes of Part 7, Producer Controlled Insurers:

2366 (a) a risk retention group as defined in:

2367 (i) the Superfund Amendments and Reauthorization Act of 1986, Pub. L. No. 99-499;

2368 (ii) the Risk Retention Act, 15 U.S.C. Sec. 3901 et seq.; and

2369 (iii) Chapter 15, Part 2, Risk Retention Groups Act;

2370 (b) a residual market pool;

2371 (c) a joint underwriting authority or association; and

2372 (d) a captive insurer.

2373 (5) "License" is defined in Section 31A-1-301.

2374 (6) (a) "Managing general agent" means a person that:

2375 (i) manages all or part of the insurance business of an insurer, including the  
2376 management of a separate division, department, or underwriting office;

2377 (ii) acts as an agent for the insurer whether it is known as a managing general agent,  
2378 manager, or other similar term;

2379 (iii) produces and underwrites an amount of gross direct written premium equal to, or  
2380 more than 5% of, the policyholder surplus as reported in the last annual statement of the insurer  
2381 in any one quarter or year:

- 2382 (A) with or without the authority;
- 2383 (B) separately or together with an affiliate; and
- 2384 (C) directly or indirectly; and
- 2385 (iv) (A) adjusts or pays claims in excess of an amount determined by the
- 2386 commissioner; or
- 2387 (B) negotiates reinsurance on behalf of the insurer.
- 2388 (b) Notwithstanding Subsection (6)(a), the following persons may not be considered as
- 2389 managing general agent for the purposes of this chapter:
- 2390 (i) an employee of the insurer;
- 2391 (ii) a United States manager of the United States branch of an alien insurer;
- 2392 (iii) an underwriting manager that, pursuant to contract:
- 2393 (A) manages all the insurance operations of the insurer;
- 2394 (B) is under common control with the insurer;
- 2395 (C) is subject to Chapter 16, Insurance Holding Companies; and
- 2396 (D) is not compensated based on the volume of premiums written; and
- 2397 (iv) the attorney-in-fact authorized by and acting for the subscribers of a reciprocal
- 2398 insurer or inter-insurance exchange under powers of attorney.
- 2399 (7) "Negotiate" means the act of conferring directly with or offering advice directly to a
- 2400 purchaser or prospective purchaser of a particular contract of insurance concerning a
- 2401 substantive benefit, term, or condition of the contract if the person engaged in that act:
- 2402 (a) sells insurance; or
- 2403 (b) obtains insurance from insurers for purchasers.
- 2404 (8) "Reinsurance intermediary" means:
- 2405 (a) a reinsurance intermediary-broker; or
- 2406 (b) a reinsurance intermediary-manager.
- 2407 (9) "Reinsurance intermediary-broker" means a person other than an officer or
- 2408 employee of the ceding insurer, firm, association, or corporation who solicits, negotiates, or
- 2409 places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority
- 2410 or power to bind reinsurance on behalf of the insurer.
- 2411 (10) (a) "Reinsurance intermediary-manager" means a person who:
- 2412 (i) has authority to bind or who manages all or part of the assumed reinsurance

2413 business of a reinsurer, including the management of a separate division, department, or  
2414 underwriting office; and

2415 (ii) acts as an agent for the reinsurer whether the person is known as a reinsurance  
2416 intermediary-manager, manager, or other similar term.

2417 (b) Notwithstanding Subsection (10)(a), the following persons may not be considered  
2418 reinsurance intermediary-managers for the purpose of this chapter with respect to the reinsurer:

2419 (i) an employee of the reinsurer;

2420 (ii) a United States manager of the United States branch of an alien reinsurer;

2421 (iii) an underwriting manager that, pursuant to contract:

2422 (A) manages all the reinsurance operations of the reinsurer;

2423 (B) is under common control with the reinsurer;

2424 (C) is subject to Chapter 16, Insurance Holding Companies; and

2425 (D) is not compensated based on the volume of premiums written; and

2426 (iv) the manager of a group, association, pool, or organization of insurers that:

2427 (A) engage in joint underwriting or joint reinsurance; and

2428 (B) are subject to examination by the insurance commissioner of the state in which the  
2429 manager's principal business office is located.

2430 (11) "Search" means a license subline of authority in conjunction with the title  
2431 insurance line of authority that allows a person to issue title insurance commitments or policies  
2432 on behalf of a title insurer.

2433 (12) "Sell" means to exchange a contract of insurance:

2434 (a) by any means;

2435 (b) for money or its equivalent; and

2436 (c) on behalf of an insurance company.

2437 (13) "Solicit" means:

2438 (a) attempting to sell insurance;

2439 (b) asking or urging a person to apply for:

2440 (i) a particular kind of insurance; and

2441 (ii) insurance from a particular insurance company;

2442 (c) advertising insurance, including advertising for the purpose of obtaining leads for  
2443 the sale of insurance; or

- 2444 (d) holding oneself out as being in the insurance business.
- 2445 (14) "Terminate" means:
- 2446 (a) the cancellation of the relationship between:
- 2447 (i) an individual licensee or agency licensee and a particular insurer; or
- 2448 (ii) an individual licensee and a particular agency licensee; or
- 2449 (b) the termination of:
- 2450 (i) an individual licensee's or agency licensee's authority to transact insurance on behalf
- 2451 of a particular insurance company; or
- 2452 (ii) an individual licensee's authority to transact insurance on behalf of a particular
- 2453 agency licensee.
- 2454 (15) "Title marketing representative" means a person who:
- 2455 (a) represents a title insurer in soliciting, requesting, or negotiating the placing of:
- 2456 (i) title insurance; or
- 2457 (ii) escrow services; and
- 2458 (b) does not have a search or escrow license as provided in Section 31A-23a-106.
- 2459 (16) "Uniform application" means the version of the National Association of Insurance
- 2460 [~~Commissioner's~~] Commissioners' uniform application for resident and nonresident producer
- 2461 licensing at the time the application is filed.
- 2462 (17) "Uniform business entity application" means the version of the National
- 2463 Association of Insurance [~~Commissioner's~~] Commissioners' uniform business entity application
- 2464 for resident and nonresident business entities at the time the application is filed.
- 2465 Section 17. Section **31A-23a-106** is amended to read:
- 2466 **31A-23a-106. License types.**
- 2467 (1) (a) A resident or nonresident license issued under this chapter shall be issued under
- 2468 the license types described under Subsection (2).
- 2469 (b) A license type and a line of authority pertaining to a license type describe the type
- 2470 of licensee and the lines of business that a licensee may sell, solicit, or negotiate. A license type
- 2471 is intended to describe the matters to be considered under any education, examination, and
- 2472 training required of a license applicant under Sections 31A-23a-108, 31A-23a-202, and
- 2473 31A-23a-203.
- 2474 (2) (a) A producer license type includes the following lines of authority:

- 2475 (i) life insurance, including a nonvariable contract;
- 2476 (ii) variable contracts, including variable life and annuity, if the producer has the life  
2477 insurance line of authority;
- 2478 (iii) accident and health insurance, including a contract issued to a policyholder under  
2479 Chapter 7, Nonprofit Health Service Insurance Corporations, or Chapter 8, Health Maintenance  
2480 Organizations and Limited Health Plans;
- 2481 (iv) property insurance;
- 2482 (v) casualty insurance, including a surety or other bond;
- 2483 (vi) title insurance under one or more of the following categories:
- 2484 (A) search, including authority to act as a title marketing representative;
- 2485 (B) escrow, including authority to act as a title marketing representative; and
- 2486 (C) title marketing representative only;
- 2487 (vii) personal lines insurance; and
- 2488 (viii) surplus lines, if the producer has the property or casualty or both lines of  
2489 authority.
- 2490 (b) A limited line producer license type includes the following limited lines of  
2491 authority:
- 2492 (i) limited line credit insurance;
- 2493 (ii) travel insurance;
- 2494 (iii) motor club insurance;
- 2495 (iv) car rental related insurance;
- 2496 (v) legal expense insurance;
- 2497 (vi) crop insurance;
- 2498 (vii) self-service storage insurance; [~~and~~]
- 2499 (viii) bail bond producer[-]; and
- 2500 (ix) guaranteed asset protection waiver.
- 2501 (c) A customer service representative license type includes the following lines of  
2502 authority, if held by the customer service representative's employer producer:
- 2503 (i) life insurance, including a nonvariable contract;
- 2504 (ii) accident and health insurance, including a contract issued to a policyholder under  
2505 Chapter 7, Nonprofit Health Service Insurance Corporations, or Chapter 8, Health Maintenance

- 2506 Organizations and Limited Health Plans;
- 2507 (iii) property insurance;
- 2508 (iv) casualty insurance, including a surety or other bond;
- 2509 (v) personal lines insurance; and
- 2510 (vi) surplus lines, if the employer producer has the property or casualty or both lines of
- 2511 authority.
- 2512 (d) A consultant license type includes the following lines of authority:
- 2513 (i) life insurance, including a nonvariable contract;
- 2514 (ii) variable contracts, including variable life and annuity, if the consultant has the life
- 2515 insurance line of authority;
- 2516 (iii) accident and health insurance, including a contract issued to a policyholder under
- 2517 Chapter 7, Nonprofit Health Service Insurance Corporations, or Chapter 8, Health Maintenance
- 2518 Organizations and Limited Health Plans;
- 2519 (iv) property insurance;
- 2520 (v) casualty insurance, including a surety or other bond; and
- 2521 (vi) personal lines insurance.
- 2522 (e) A managing general agent license type includes the following lines of authority:
- 2523 (i) life insurance, including a nonvariable contract;
- 2524 (ii) variable contracts, including variable life and annuity, if the managing general
- 2525 agent has the life insurance line of authority;
- 2526 (iii) accident and health insurance, including a contract issued to a policyholder under
- 2527 Chapter 7, Nonprofit Health Service Insurance Corporations, or Chapter 8, Health Maintenance
- 2528 Organizations and Limited Health Plans;
- 2529 (iv) property insurance;
- 2530 (v) casualty insurance, including a surety or other bond; and
- 2531 (vi) personal lines insurance.
- 2532 (f) A reinsurance intermediary license type includes the following lines of authority:
- 2533 (i) life insurance, including a nonvariable contract;
- 2534 (ii) variable contracts, including variable life and annuity, if the reinsurance
- 2535 intermediary has the life insurance line of authority;
- 2536 (iii) accident and health insurance, including a contract issued to a policyholder under

2537 Chapter 7, Nonprofit Health Service Insurance Corporations, or Chapter 8, Health Maintenance  
2538 Organizations and Limited Health Plans;

2539 (iv) property insurance;

2540 (v) casualty insurance, including a surety or other bond; and

2541 (vi) personal lines insurance.

2542 (g) A ~~holder of licenses~~ person who holds a license under ~~Subsections~~ Subsection

2543 (2)(a), (d), (e), ~~and~~ or (f) has ~~all~~ the qualifications necessary to act as a holder of a license

2544 under Subsections (2)(b) and (c), except that the person may not act under Subsection

2545 (2)(b)(viii) or (ix).

2546 (3) (a) The commissioner may by rule recognize other producer, limited line producer,

2547 customer service representative, consultant, managing general agent, or reinsurance

2548 intermediary lines of authority as to kinds of insurance not listed under Subsections (2)(a)

2549 through (f).

2550 (b) Notwithstanding Subsection (3)(a), for purposes of title insurance the Title and

2551 Escrow Commission may by rule, with the concurrence of the commissioner and subject to

2552 Section 31A-2-404, recognize other categories for a title insurance producer line of authority

2553 not listed under Subsection (2)(a)(vi).

2554 (4) The variable contracts, including variable life and annuity line of authority requires:

2555 (a) licensure as a registered agent or broker by the ~~National Association of Securities~~

2556 ~~Dealers~~ Financial Industry Regulatory Authority; and

2557 (b) current registration with a securities broker-dealer.

2558 (5) A surplus lines producer is a producer who has a surplus lines line of authority.

2559 Section 18. Section **31A-23a-111** is amended to read:

2560 **31A-23a-111. Revocation, suspension, surrender, lapsing, limiting, or otherwise**

2561 **terminating a license -- Rulemaking for renewal or reinstatement.**

2562 (1) A license type issued under this chapter remains in force until:

2563 (a) revoked or suspended under Subsection (5);

2564 (b) surrendered to the commissioner and accepted by the commissioner in lieu of

2565 administrative action;

2566 (c) the licensee dies or is adjudicated incompetent as defined under:

2567 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

2568 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and  
2569 Minors;

2570 (d) lapsed under Section 31A-23a-113; or

2571 (e) voluntarily surrendered.

2572 (2) The following may be reinstated within one year after the day on which the license  
2573 is no longer in force:

2574 (a) a lapsed license; or

2575 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may  
2576 not be reinstated after the license period in which the license is voluntarily surrendered.

2577 (3) Unless otherwise stated in ~~[the]~~ a written agreement for the voluntary surrender of a  
2578 license, submission and acceptance of a voluntary surrender of a license does not prevent the  
2579 department from pursuing additional disciplinary or other action authorized under:

2580 (a) this title; or

2581 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah  
2582 Administrative Rulemaking Act.

2583 (4) A line of authority issued under this chapter remains in force until:

2584 (a) the qualifications pertaining to a line of authority are no longer met by the licensee;

2585 or

2586 (b) the supporting license type:

2587 (i) is revoked or suspended under Subsection (5);

2588 (ii) is surrendered to the commissioner and accepted by the commissioner in lieu of  
2589 administrative action;

2590 (iii) the licensee dies or is adjudicated incompetent as defined under:

2591 (A) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

2592 (B) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and  
2593 Minors;

2594 (iv) lapsed under Section 31A-23a-113; or

2595 (v) voluntarily surrendered.

2596 (5) (a) If the commissioner makes a finding under Subsection (5)(b), as part of an  
2597 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the  
2598 commissioner may:

- 2599 (i) revoke:
- 2600 (A) a license; or
- 2601 (B) a line of authority;
- 2602 (ii) suspend for a specified period of 12 months or less:
- 2603 (A) a license; or
- 2604 (B) a line of authority;
- 2605 (iii) limit in whole or in part:
- 2606 (A) a license; or
- 2607 (B) a line of authority; or
- 2608 (iv) deny a license application.
- 2609 (b) The commissioner may take an action described in Subsection (5)(a) if the
- 2610 commissioner finds that the licensee:
- 2611 (i) is unqualified for a license or line of authority under Section 31A-23a-104,
- 2612 31A-23a-105, or 31A-23a-107;
- 2613 (ii) violates:
- 2614 (A) an insurance statute;
- 2615 (B) a rule that is valid under Subsection 31A-2-201(3); or
- 2616 (C) an order that is valid under Subsection 31A-2-201(4);
- 2617 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other
- 2618 delinquency proceedings in any state;
- 2619 (iv) fails to pay a final judgment rendered against the person in this state within 60
- 2620 days after the day on which the judgment became final;
- 2621 (v) fails to meet the same good faith obligations in claims settlement that is required of
- 2622 admitted insurers;
- 2623 (vi) is affiliated with and under the same general management or interlocking
- 2624 directorate or ownership as another insurance producer that transacts business in this state
- 2625 without a license;
- 2626 (vii) refuses:
- 2627 (A) to be examined; or
- 2628 (B) to produce its accounts, records, and files for examination;
- 2629 (viii) has an officer who refuses to:

- 2630 (A) give information with respect to the insurance producer's affairs; or
- 2631 (B) perform any other legal obligation as to an examination;
- 2632 (ix) provides information in the license application that is:
  - 2633 (A) incorrect;
  - 2634 (B) misleading;
  - 2635 (C) incomplete; or
  - 2636 (D) materially untrue;
- 2637 (x) violates an insurance law, valid rule, or valid order of another state's insurance
- 2638 department;
- 2639 (xi) obtains or attempts to obtain a license through misrepresentation or fraud;
- 2640 (xii) improperly withholds, misappropriates, or converts money or properties received
- 2641 in the course of doing insurance business;
- 2642 (xiii) intentionally misrepresents the terms of an actual or proposed:
  - 2643 (A) insurance contract;
  - 2644 (B) application for insurance; or
  - 2645 (C) life settlement;
  - 2646 (xiv) is convicted of a felony;
  - 2647 (xv) admits or is found to have committed an insurance unfair trade practice or fraud;
  - 2648 (xvi) in the conduct of business in this state or elsewhere:
    - 2649 (A) uses fraudulent, coercive, or dishonest practices; or
    - 2650 (B) demonstrates incompetence, untrustworthiness, or financial irresponsibility;
  - 2651 (xvii) has an insurance license, or its equivalent, denied, suspended, or revoked in
  - 2652 another state, province, district, or territory;
  - 2653 (xviii) forges another's name to:
    - 2654 (A) an application for insurance; or
    - 2655 (B) a document related to an insurance transaction;
  - 2656 (xix) improperly uses notes or another reference material to complete an examination
  - 2657 for an insurance license;
  - 2658 (xx) knowingly accepts insurance business from an individual who is not licensed;
  - 2659 (xxi) fails to comply with an administrative or court order imposing a child support
  - 2660 obligation;

- 2661 (xxii) fails to:
- 2662 (A) pay state income tax; or
- 2663 (B) comply with an administrative or court order directing payment of state income
- 2664 tax;
- 2665 (xxiii) violates or permits others to violate the federal Violent Crime Control and Law
- 2666 Enforcement Act of 1994, 18 U.S.C. [~~Secs.~~] Sec. 1033 and 1034; or
- 2667 (xxiv) engages in a method or practice in the conduct of business that endangers the
- 2668 legitimate interests of customers and the public.
- 2669 (c) For purposes of this section, if a license is held by an agency, both the agency itself
- 2670 and any individual designated under the license are considered to be the holders of the license.
- 2671 (d) If an individual designated under the agency license commits an act or fails to
- 2672 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,
- 2673 the commissioner may suspend, revoke, or limit the license of:
- 2674 (i) the individual;
- 2675 (ii) the agency, if the agency:
- 2676 (A) is reckless or negligent in its supervision of the individual; or
- 2677 (B) knowingly participates in the act or failure to act that is the ground for suspending,
- 2678 revoking, or limiting the license; or
- 2679 (iii) (A) the individual; and
- 2680 (B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).
- 2681 (6) A licensee under this chapter is subject to the penalties for acting as a licensee
- 2682 without a license if:
- 2683 (a) the licensee's license is:
- 2684 (i) revoked;
- 2685 (ii) suspended;
- 2686 (iii) limited;
- 2687 (iv) surrendered in lieu of administrative action;
- 2688 (v) lapsed; or
- 2689 (vi) voluntarily surrendered; and
- 2690 (b) the licensee:
- 2691 (i) continues to act as a licensee; or

- 2692 (ii) violates the terms of the license limitation.
- 2693 (7) A licensee under this chapter shall immediately report to the commissioner:
- 2694 (a) a revocation, suspension, or limitation of the person's license in another state, the
- 2695 District of Columbia, or a territory of the United States;
- 2696 (b) the imposition of a disciplinary sanction imposed on that person by another state,
- 2697 the District of Columbia, or a territory of the United States; or
- 2698 (c) a judgment or injunction entered against that person on the basis of conduct
- 2699 involving:
- 2700 (i) fraud;
- 2701 (ii) deceit;
- 2702 (iii) misrepresentation; or
- 2703 (iv) a violation of an insurance law or rule.
- 2704 (8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a
- 2705 license in lieu of administrative action may specify a time, not to exceed five years, within
- 2706 which the former licensee may not apply for a new license.
- 2707 (b) If no time is specified in an order or agreement described in Subsection (8)(a), the
- 2708 former licensee may not apply for a new license for five years from the day on which the order
- 2709 or agreement is made without the express approval by the commissioner.
- 2710 (9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of
- 2711 a license issued under this part if so ordered by a court.
- 2712 (10) The commissioner shall by rule prescribe the license renewal and reinstatement
- 2713 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
- 2714 Section 19. Section **31A-23a-202** is amended to read:
- 2715 **31A-23a-202. Continuing education requirements.**
- 2716 (1) Pursuant to this section, the commissioner shall by rule prescribe the continuing
- 2717 education requirements for a producer and a consultant.
- 2718 (2) (a) The commissioner may not state a continuing education requirement in terms of
- 2719 formal education.
- 2720 (b) The commissioner may state a continuing education requirement in terms of
- 2721 [~~classroom hours, or their equivalent,~~] hours of insurance-related instruction received.
- 2722 (c) Insurance-related formal education may be a substitute, in whole or in part, for

2723 [~~classroom hours, or their equivalent,~~] the hours required under Subsection (2)(b).

2724 (3) (a) The commissioner shall impose continuing education requirements in  
2725 accordance with a two-year licensing period in which the licensee meets the requirements of  
2726 this Subsection (3).

2727 (b) (i) Except as provided in this section, the continuing education requirements shall  
2728 require:

2729 (A) that a licensee complete 24 credit hours of continuing education for every two-year  
2730 licensing period;

2731 (B) that 3 of the 24 credit hours described in Subsection (3)(b)(i)(A) be ethics courses;  
2732 and

2733 (C) that the licensee complete at least half of the required hours through classroom  
2734 hours of insurance-related instruction.

2735 (ii) [~~The hours not completed through classroom hours~~] An hour of continuing  
2736 education in accordance with Subsection (3)(b)(i)[~~(C)~~] may be obtained through:

2737 (A) classroom attendance;

2738 [~~(A)~~] (B) home study;

2739 [~~(B)~~] (C) watching a video recording;

2740 [~~(C)~~] (D) experience credit; or

2741 [~~(D)~~] (E) another method provided by rule.

2742 (iii) (A) Notwithstanding Subsections (3)(b)(i)(A) and (B), a title insurance producer is  
2743 required to complete 12 credit hours of continuing education for every two-year licensing  
2744 period, with 3 of the credit hours being ethics courses unless the title insurance producer is  
2745 licensed in this state as a title insurance producer for 20 or more consecutive years.

2746 (B) If a title insurance producer is licensed in this state as a title insurance producer for  
2747 20 or more consecutive years, the title insurance producer is required to complete 6 credit hours  
2748 of continuing education for every two-year licensing period, with 3 of the credit hours being  
2749 ethics courses.

2750 (C) Notwithstanding Subsection (3)(b)(iii)(A) or (B), a title insurance producer is  
2751 considered to have met the continuing education requirements imposed under Subsection  
2752 (3)(b)(iii)(A) or (B) if the title insurance producer:

2753 (I) is an active member in good standing with the Utah State Bar;

2754 (II) is in compliance with the continuing education requirements of the Utah State Bar;  
2755 and

2756 (III) if requested by the department, provides the department evidence that the title  
2757 insurance producer complied with the continuing education requirements of the Utah State Bar.

2758 (c) A licensee may obtain continuing education hours at any time during the two-year  
2759 licensing period.

2760 (d) (i) A licensee is exempt from continuing education requirements under this section  
2761 if:

2762 (A) the licensee was first licensed before April 1, 1978;

2763 (B) the license does not have a continuous lapse for a period of more than one year,  
2764 except for a license for which the licensee has had an exemption approved before May 11,  
2765 2011;

2766 [~~B~~] (C) the licensee requests an exemption from the department; and

2767 [~~C~~] (D) the department approves the exemption.

2768 (ii) If the department approves the exemption under Subsection (3)(d)(i), the licensee is  
2769 not required to apply again for the exemption.

2770 (e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the  
2771 commissioner shall, by rule:

2772 (i) publish a list of insurance professional designations whose continuing education  
2773 requirements can be used to meet the requirements for continuing education under Subsection  
2774 (3)(b);

2775 (ii) authorize a continuing education provider or a state or national professional  
2776 producer or consultant association to:

2777 (A) offer a qualified program for a license type or line of authority on a geographically  
2778 accessible basis; and

2779 (B) collect a reasonable fee for funding and administration of a continuing education  
2780 program, subject to the review and approval of the commissioner; and

2781 (iii) provide that membership by a producer or consultant in a state or national  
2782 professional producer or consultant association is considered a substitute for the equivalent of  
2783 two hours for each year during which the producer or consultant is a member of the  
2784 professional association, except that the commissioner may not give more than two hours of

2785 continuing education credit in a year regardless of the number of professional associations of  
2786 which the producer or consultant is a member.

2787 (f) A fee permitted under Subsection (3)(e)(ii)(B) that is charged for attendance at a  
2788 professional producer or consultant association program may be less for an association  
2789 member, on the basis of the member's affiliation expense, but shall preserve the right of a  
2790 nonmember to attend without affiliation.

2791 (4) The commissioner shall approve a continuing education provider or continuing  
2792 education course that satisfies the requirements of this section.

2793 (5) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the  
2794 commissioner shall by rule set the processes and procedures for continuing education provider  
2795 registration and course approval.

2796 (6) The requirements of this section apply only to a producer or consultant who is an  
2797 individual.

2798 (7) A nonresident producer or consultant is considered to have satisfied this state's  
2799 continuing education requirements if the nonresident producer or consultant satisfies the  
2800 nonresident producer's or consultant's home state's continuing education requirements for a  
2801 licensed insurance producer or consultant.

2802 (8) A producer or consultant subject to this section shall keep documentation of  
2803 completing the continuing education requirements of this section for two years after the end of  
2804 the two-year licensing period to which the continuing education applies.

2805 Section 20. Section **31A-23a-203** is amended to read:

2806 **31A-23a-203. Training period requirements.**

2807 (1) A producer is eligible to add the surplus lines of authority to the person's producer's  
2808 license if the producer:

2809 (a) has passed the applicable examination;

2810 (b) has been a producer with property and casualty lines of authority for at least three  
2811 years during the four years immediately preceding the date of application; and

2812 (c) has paid the applicable fee under Section 31A-3-103.

2813 (2) A person is eligible to become a consultant only if the person has acted in a  
2814 capacity that would provide the person with preparation to act as an insurance consultant for a  
2815 period aggregating not less than three years during the four years immediately preceding the

2816 date of application.

2817 (3) (a) A resident producer with an accident and health line of authority may only sell  
2818 long-term care insurance if the producer:

2819 (i) initially completes a minimum of three hours of long-term care training before  
2820 selling long-term care coverage; and

2821 (ii) after completing the training required by Subsection (3)(a)(i), completes a  
2822 minimum of three hours of long-term care training during each subsequent two-year licensing  
2823 period.

2824 (b) A course taken to satisfy a long-term care training requirement may be used toward  
2825 satisfying a producer continuing education requirement.

2826 (c) Long-term care training is not a continuing education requirement to renew a  
2827 producer license.

2828 (d) An insurer that issues long-term care insurance shall demonstrate to the  
2829 commissioner, upon request, that a producer who is appointed by the insurer and who sells  
2830 long-term care insurance coverage is in compliance with this Subsection (3).

2831 ~~[(3)]~~ (4) The training periods required under this section apply only to an individual  
2832 applying for a license under this chapter.

2833 Section 21. Section **31A-23a-204** is amended to read:

2834 **31A-23a-204. Special requirements for title insurance producers and agencies.**

2835 A title insurance producer, including an agency, shall be licensed in accordance with  
2836 this chapter, with the additional requirements listed in this section.

2837 (1) (a) A person that receives a new license under this title as a title insurance agency,  
2838 shall at the time of licensure be owned or managed by ~~[one or more individuals who are]~~ at  
2839 least one individual who is licensed for at least three of the five years immediately ~~[preceding]~~  
2840 preceding the date on which the title insurance agency applies for a license with both:

2841 (i) a search line of authority; and

2842 (ii) an escrow line of authority.

2843 (b) A title insurance agency subject to Subsection (1)(a) may comply with Subsection  
2844 (1)(a) by having the title insurance agency owned or managed by:

2845 (i) one or more individuals who are licensed with the search line of authority for the  
2846 time period provided in Subsection (1)(a); and

2847 (ii) one or more individuals who are licensed with the escrow line of authority for the  
2848 time period provided in Subsection (1)(a).

2849 (c) A person licensed as a title insurance agency shall at all times during the term of  
2850 licensure be owned or managed by at least one individual who is licensed for at least three  
2851 years within the preceding five-year period with both:

2852 (i) a search line of authority; and

2853 (ii) an escrow line of authority.

2854 [~~(c)~~] (d) The Title and Escrow Commission may by rule, subject to Section 31A-2-404,  
2855 exempt an attorney with real estate experience from the experience requirements in Subsection  
2856 (1)(a).

2857 (2) (a) A title insurance agency or producer appointed by an insurer shall maintain:

2858 (i) a fidelity bond;

2859 (ii) a professional liability insurance policy; or

2860 (iii) a financial protection:

2861 (A) equivalent to that described in Subsection (2)(a)(i) or (ii); and

2862 (B) that the commissioner considers adequate.

2863 (b) The bond, insurance, or financial protection required by this Subsection (2):

2864 (i) shall be supplied under a contract approved by the commissioner to provide  
2865 protection against the improper performance of any service in conjunction with the issuance of  
2866 a contract or policy of title insurance; and

2867 (ii) be in a face amount no less than \$50,000.

2868 (c) The Title and Escrow Commission may by rule, subject to Section 31A-2-404,  
2869 exempt title insurance producers from the requirements of this Subsection (2) upon a finding  
2870 that, and only so long as, the required policy or bond is generally unavailable at reasonable  
2871 rates.

2872 (3) A title insurance agency or producer appointed by an insurer may maintain a  
2873 reserve fund to the extent monies were deposited before July 1, 2008, and not withdrawn to the  
2874 income of the title insurance producer.

2875 (4) An examination for licensure shall include questions regarding the search and  
2876 examination of title to real property.

2877 (5) A title insurance producer may not perform the functions of escrow unless the title

2878 insurance producer has been examined on the fiduciary duties and procedures involved in those  
2879 functions.

2880 (6) The Title and Escrow Commission shall adopt rules, subject to Section 31A-2-404,  
2881 after consulting with the department and the department's test administrator, establishing an  
2882 examination for a license that will satisfy this section.

2883 (7) A license may be issued to a title insurance producer who has qualified:

2884 (a) to perform only searches and examinations of title as specified in Subsection (4);

2885 (b) to handle only escrow arrangements as specified in Subsection (5); or

2886 (c) to act as a title marketing representative.

2887 (8) (a) A person licensed to practice law in Utah is exempt from the requirements of  
2888 Subsections (2) and (3) if that person issues 12 or less policies in any 12-month period.

2889 (b) In determining the number of policies issued by a person licensed to practice law in  
2890 Utah for purposes of Subsection (8)(a), if the person licensed to practice law in Utah issues a  
2891 policy to more than one party to the same closing, the person is considered to have issued only  
2892 one policy.

2893 (9) A person licensed to practice law in Utah, whether exempt under Subsection (8) or  
2894 not, shall maintain a trust account separate from a law firm trust account for all title and real  
2895 estate escrow transactions.

2896 Section 22. Section **31A-23a-406** is amended to read:

2897 **31A-23a-406. Title insurance producer's business.**

2898 (1) A title insurance producer may do escrow involving real property transactions if all  
2899 of the following exist:

2900 (a) the title insurance producer is licensed with:

2901 (i) the title line of authority; and

2902 (ii) the escrow subline of authority;

2903 (b) the title insurance producer is appointed by a title insurer authorized to do business  
2904 in the state;

2905 (c) the title insurance producer issues one or more of the following [~~is to be issued~~] as  
2906 part of the transaction:

2907 (i) an owner's policy of title insurance; or

2908 (ii) a lender's policy of title insurance;

2909 (d) ~~[(i) all funds]~~ money deposited with the title insurance producer in connection with  
 2910 any escrow:

2911 ~~[(A) are]~~ (i) is deposited:

2912 ~~[(F)] (A)~~ in a federally insured financial institution; and

2913 ~~[(H)] (B)~~ in a trust account that is separate from all other trust account ~~[funds that are]~~  
 2914 money that is not related to real estate transactions; ~~[and]~~

2915 ~~[(B) are]~~ (ii) is the property of the one or more persons entitled to ~~[them]~~ the money  
 2916 under the provisions of the escrow; and

2917 ~~[(ii) are]~~ (iii) is segregated escrow by escrow in the records of the title insurance  
 2918 producer;

2919 (e) earnings on ~~[funds]~~ money held in escrow may be paid out of the escrow account to  
 2920 any person in accordance with the conditions of the escrow; ~~[and]~~

2921 (f) the escrow does not require the title insurance producer to hold:

2922 (i) construction ~~[funds]~~ money; or

2923 (ii) ~~[funds]~~ money held for exchange under Section 1031, Internal Revenue Code[-];  
 2924 and

2925 (g) if the title insurance producer with an escrow subline of authority conducts a  
 2926 closing, the title insurance producer is physically present with a borrower, seller, or purchaser  
 2927 involving real estate that is the subject of the real estate transaction.

2928 (2) Notwithstanding Subsection (1), a title insurance producer may engage in the  
 2929 escrow business if:

2930 (a) the escrow involves:

2931 (i) a mobile home;

2932 (ii) a grazing right;

2933 (iii) a water right; or

2934 (iv) other personal property authorized by the commissioner; and

2935 (b) the title insurance producer complies with ~~[all the requirements of]~~ this section  
 2936 except for ~~[the requirement of]~~ Subsection (1)(c).

2937 (3) ~~[Funds]~~ Money held in escrow:

2938 (a) ~~[are]~~ is not subject to any debts of the title insurance producer;

2939 (b) may only be used to fulfill the terms of the individual escrow under which the

2940 [~~funds were~~] money is accepted; and

2941 (c) may not be used until [~~all~~] the conditions of the escrow [~~have been~~] are met.

2942 (4) Assets or property other than escrow [~~funds~~] money received by a title insurance  
2943 producer in accordance with an escrow shall be maintained in a manner that will:

2944 (a) reasonably preserve and protect the asset or property from loss, theft, or damages;  
2945 and

2946 (b) otherwise comply with [~~all~~] the general duties and responsibilities of a fiduciary or  
2947 bailee.

2948 (5) (a) A check from the trust account described in Subsection (1)(d) may not be  
2949 drawn, executed, or dated, or [~~funds~~] money otherwise disbursed unless the segregated escrow  
2950 account from which [~~funds are~~] money is to be disbursed contains a sufficient credit balance  
2951 consisting of collected [~~or~~] and cleared [~~funds~~] money at the time the check is drawn, executed,  
2952 or dated, or [~~funds are~~] money is otherwise disbursed.

2953 (b) As used in this Subsection (5), [~~funds are~~] money is considered to be "collected [~~or~~]  
2954 and cleared," and may be disbursed as follows:

2955 (i) cash may be disbursed on the same day the cash is deposited;

2956 (ii) a wire transfer may be disbursed on the same day the wire transfer is deposited; and

2957 [~~(iii) the following may be disbursed on the day following the date of deposit:]~~

2958 [~~(A) a cashier's check;~~]

2959 [~~(B) a certified check;~~]

2960 [~~(C) a teller's check;~~]

2961 [~~(D) a U.S. Postal Service money order; and]~~

2962 [~~(E) a check drawn on a Federal Reserve Bank or Federal Home Loan Bank; and]~~

2963 [~~(iv) any other check or deposit may be disbursed:]~~

2964 [~~(A) within the time limits provided under the Expedited Funds Availability Act, 12~~  
2965 ~~U.S.C. Section 4001 et seq., as amended, and related regulations of the Federal Reserve~~  
2966 ~~System; or]~~

2967 [~~(B) upon written notification from the financial institution to which the funds have~~  
2968 ~~been deposited, that final settlement has occurred on the deposited item:]~~

2969 [~~(c) Subject to Subsections (5)(a) and (b), any material change to a settlement~~  
2970 ~~statement made after the final closing documents are executed must be authorized or~~

2971 ~~acknowledged by date and signature on each page of the settlement statement by the one or~~  
2972 ~~more persons affected by the change before disbursement of funds.]~~

2973 (iii) the proceeds of one or more of the following financial instruments may be  
2974 disbursed on the same day the financial instruments are deposited if received from a single  
2975 party to the real estate transaction and if the aggregate of the financial instruments for the real  
2976 estate transaction is less than \$10,000:

2977 (A) a cashier's check, certified check, or official check that is drawn on an existing  
2978 account at a federally insured financial institution;

2979 (B) a check drawn on the trust account of a principal broker or associate broker  
2980 licensed under Title 61, Chapter 2f, Real Estate Licensing and Practices Act, if the title  
2981 producer has reasonable and prudent grounds to believe sufficient money will be available  
2982 from the trust account on which the check is drawn at the time of disbursement of proceeds  
2983 from the title producer's escrow account;

2984 (C) a personal check not to exceed \$500 per closing;

2985 (D) a check drawn on the escrow account of another title producer, if the title producer  
2986 in the escrow transaction has reasonable and prudent grounds to believe that sufficient money  
2987 will be available for withdrawal from the account upon which the check is drawn at the time of  
2988 disbursement of money from the escrow account of the title producer in the escrow transaction;  
2989 or

2990 (E) a check issued by a farm credit service authorized under the Farm Credit Act of  
2991 1971, 12 U.S.C. Sec. 2001 et seq., as amended.

2992 (c) Money received from a financial instrument described in Subsection (5)(b)(iii)(B)  
2993 or (C) may be disbursed:

2994 (i) within the time limits provided under the Expedited Funds Availability Act, 12  
2995 U.S.C. Sec. 4001 et seq., as amended, and related regulations of the Federal Reserve System; or

2996 (ii) upon notification from the financial institution to which the money has been  
2997 deposited that final settlement has occurred on the deposited financial instrument.

2998 (6) [The] A title insurance producer shall maintain [~~records of all receipts and~~  
2999 disbursements of escrow funds] a record of a receipt or disbursement of escrow money.

3000 (7) [The] A title insurance producer shall comply with:

3001 (a) Section 31A-23a-409;

3002 (b) Title 46, Chapter 1, Notaries Public Reform Act; and

3003 (c) any rules adopted by the Title and Escrow Commission, subject to Section

3004 31A-2-404, that govern escrows.

3005 (8) If a title insurance producer conducts a search for real estate located in the state, the

3006 title insurance producer shall conduct a minimum mandatory search, as defined by rule made

3007 by the Title and Escrow Commission, subject to Section 31A-2-404.

3008 Section 23. Section **31A-23a-408** is amended to read:

3009 **31A-23a-408. Representations of agency.**

3010 ~~[No]~~ A person may not represent ~~[himself as]~~ that the person is acting in behalf of an

3011 insurer unless a written agency contract is in effect giving the person authority from the insurer

3012 and the insurer ~~[has appointed]~~ appoints that person to act in behalf of the insurer.

3013 Section 24. Section **31A-23a-412** is amended to read:

3014 **31A-23a-412. Place of business and residence address -- Records.**

3015 (1) (a) ~~[All licensees]~~ A licensee under this chapter shall register and maintain with the

3016 commissioner;

3017 (i) the address and telephone numbers of ~~[their]~~ the licensee's principal place of

3018 business[-]; and

3019 (ii) a valid business email address at which the commissioner may contact the licensee.

3020 (b) If ~~[the]~~ a licensee is an individual, in addition to complying with Subsection (1)(a)

3021 the individual shall ~~[provide to]~~ register and maintain with the commissioner the individual's

3022 residence address and telephone number.

3023 (c) A licensee shall notify the commissioner within 30 days of ~~[any]~~ a change of any of

3024 the following required to be registered with the commissioner under this section:

3025 (i) an address ~~[or]~~;

3026 (ii) a telephone number[-]; or

3027 (iii) a business email address.

3028 (2) (a) Except as provided under Subsection (3), ~~[every]~~ a licensee under this chapter

3029 shall keep at the principal place of business address registered under Subsection (1), separate

3030 and distinct books and records of ~~[all]~~ the transactions consummated under the Utah license.

3031 (b) The books and records described in Subsection (2)(a) shall:

3032 (i) be in an organized form;

3033 (ii) be available to the commissioner for inspection upon reasonable notice; and  
3034 (iii) include all of the following:  
3035 (A) if the licensee is a producer, limited line producer, consultant, managing general  
3036 agent, or reinsurance intermediary:  
3037 (I) a record of each insurance contract procured by or issued through the licensee, with  
3038 the names of insurers and insureds, the amount of premium and commissions or other  
3039 compensation, and the subject of the insurance;  
3040 (II) the names of any other producers, limited line producers, consultants, managing  
3041 general agents, or reinsurance intermediaries from whom business is accepted, and of persons  
3042 to whom commissions or allowances of any kind are promised or paid; and  
3043 (III) a record of ~~all~~ the consumer complaints forwarded to the licensee by an  
3044 insurance regulator;  
3045 (B) if the licensee is a consultant, a record of each agreement outlining the work  
3046 performed and the fee for the work; and  
3047 (C) any additional information which:  
3048 (I) is customary for a similar business; or  
3049 (II) may reasonably be required by the commissioner by rule.  
3050 (3) Subsection (2) is satisfied if the books and records specified in Subsection (2) can  
3051 be obtained immediately from a central storage place or elsewhere by on-line computer  
3052 terminals located at the registered address.  
3053 (4) A licensee who represents only a single insurer satisfies Subsection (2) if the  
3054 insurer maintains the books and records pursuant to Subsection (2) at a place satisfying  
3055 Subsections (1) and (5).  
3056 (5) (a) The books and records maintained under Subsection (2) or Section  
3057 31A-23a-413 shall be available for the inspection of the commissioner during all business  
3058 hours for a period of time after the date of the transaction as specified by the commissioner by  
3059 rule, but in no case for less than the current calendar year plus three years.  
3060 (b) Discarding books and records after the applicable record retention period has  
3061 expired does not place the licensee in violation of a later-adopted longer record retention  
3062 period.  
3063 Section 25. Section ~~31A-23a-415~~ is amended to read:

3064           **31A-23a-415. Assessment on title insurance agencies or title insurers -- Account**  
3065 **created.**

3066           (1) For purposes of this section:

3067           (a) "Premium" is as defined in Subsection 59-9-101(3).

3068           (b) "Title insurer" means a person:

3069           (i) making any contract or policy of title insurance as:

3070           (A) insurer;

3071           (B) guarantor; or

3072           (C) surety;

3073           (ii) proposing to make any contract or policy of title insurance as:

3074           (A) insurer;

3075           (B) guarantor; or

3076           (C) surety; or

3077           (iii) transacting or proposing to transact any phase of title insurance, including:

3078           (A) soliciting;

3079           (B) negotiating preliminary to execution;

3080           (C) executing of a contract of title insurance;

3081           (D) insuring; and

3082           (E) transacting matters subsequent to the execution of the contract and arising out of  
3083 the contract.

3084           (c) "Utah risks" means insuring, guaranteeing, or indemnifying with regard to real or  
3085 personal property located in Utah, an owner of real or personal property, the holders of liens or  
3086 encumbrances on that property, or others interested in the property against loss or damage  
3087 suffered by reason of:

3088           (i) liens or encumbrances upon, defects in, or the unmarketability of the title to the  
3089 property; or

3090           (ii) invalidity or unenforceability of any liens or encumbrances on the property.

3091           (2) (a) The commissioner may assess each title insurer and each title insurance agency  
3092 an annual assessment:

3093           (i) determined by the Title and Escrow Commission:

3094           (A) after consultation with the commissioner; and

3095 (B) in accordance with this Subsection (2); and  
3096 (ii) to be used for the purposes described in Subsection (3).  
3097 (b) A title insurance agency shall be assessed up to:  
3098 (i) [~~\$200~~] \$250 for the first office in each county in which the title insurance agency  
3099 maintains an office; and  
3100 (ii) [~~\$100~~] \$150 for each additional office the title insurance agency maintains in the  
3101 county described in Subsection (2)(b)(i).  
3102 (c) A title insurer shall be assessed up to:  
3103 (i) [~~\$200~~] \$250 for the first office in each county in which the title insurer maintains an  
3104 office;  
3105 (ii) [~~\$100~~] \$150 for each additional office the title insurer maintains in the county  
3106 described in Subsection (2)(c)(i); and  
3107 (iii) an amount calculated by:  
3108 (A) aggregating the assessments imposed on:  
3109 (I) title insurance agencies under Subsection (2)(b); and  
3110 (II) title insurers under Subsections (2)(c)(i) and (2)(c)(ii);  
3111 (B) subtracting the amount determined under Subsection (2)(c)(iii)(A) from the total  
3112 costs and expenses determined under Subsection (2)(d); and  
3113 (C) multiplying:  
3114 (I) the amount calculated under Subsection (2)(c)(iii)(B); and  
3115 (II) the percentage of total premiums for title insurance on Utah risk that are premiums  
3116 of the title insurer.  
3117 (d) Notwithstanding Section 31A-3-103 and subject to Section 31A-2-404, the Title  
3118 and Escrow Commission by rule shall establish the amount of costs and expenses described  
3119 under Subsection (3) that will be covered by the assessment, except the costs or expenses to be  
3120 covered by the assessment may not exceed [~~\$75,000~~] \$80,000 annually.  
3121 (3) (a) Money received by the state under this section shall be deposited into the Title  
3122 Licensee Enforcement Restricted Account.  
3123 (b) There is created in the General Fund a restricted account known as the "Title  
3124 Licensee Enforcement Restricted Account."  
3125 (c) The Title Licensee Enforcement Restricted Account shall consist of the money

3126 received by the state under this section.

3127 (d) The commissioner shall administer the Title Licensee Enforcement Restricted  
3128 Account. Subject to appropriations by the Legislature, the commissioner shall use the money  
3129 deposited into the Title Licensee Enforcement Restricted Account only to pay for a cost or  
3130 expense incurred by the department in the administration, investigation, and enforcement of  
3131 this part and Part 5, Compensation of Producers and Consultants, related to:

3132 (i) the marketing of title insurance; and

3133 (ii) audits of agencies.

3134 (e) An appropriation from the Title Licensee Enforcement Restricted Account is  
3135 nonlapsing.

3136 (4) The assessment imposed by this section shall be in addition to any premium  
3137 assessment imposed under Subsection 59-9-101(3).

3138 Section 26. Section **31A-25-208** is amended to read:

3139 **31A-25-208. Revocation, suspension, surrender, lapsing, limiting, or otherwise**  
3140 **terminating a license -- Rulemaking for renewal and reinstatement.**

3141 (1) A license type issued under this chapter remains in force until:

3142 (a) revoked or suspended under Subsection (4);

3143 (b) surrendered to the commissioner and accepted by the commissioner in lieu of  
3144 administrative action;

3145 (c) the licensee dies or is adjudicated incompetent as defined under:

3146 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

3147 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and  
3148 Minors;

3149 (d) lapsed under Section 31A-25-210; or

3150 (e) voluntarily surrendered.

3151 (2) The following may be reinstated within one year after the day on which the license  
3152 is no longer in force:

3153 (a) a lapsed license; or

3154 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may  
3155 not be reinstated after the license period in which the license is voluntarily surrendered.

3156 (3) Unless otherwise stated in ~~the~~ a written agreement for the voluntary surrender of a

3157 license, submission and acceptance of a voluntary surrender of a license does not prevent the  
3158 department from pursuing additional disciplinary or other action authorized under:

3159 (a) this title; or

3160 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah

3161 Administrative Rulemaking Act.

3162 (4) (a) If the commissioner makes a finding under Subsection (4)(b), as part of an  
3163 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the  
3164 commissioner may:

3165 (i) revoke a license;

3166 (ii) suspend a license for a specified period of 12 months or less;

3167 (iii) limit a license in whole or in part; or

3168 (iv) deny a license application.

3169 (b) The commissioner may take an action described in Subsection (4)(a) if the  
3170 commissioner finds that the licensee:

3171 (i) is unqualified for a license under Section 31A-25-202, 31A-25-203, or 31A-25-204;

3172 (ii) has violated:

3173 (A) an insurance statute;

3174 (B) a rule that is valid under Subsection 31A-2-201(3); or

3175 (C) an order that is valid under Subsection 31A-2-201(4);

3176 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other  
3177 delinquency proceedings in any state;

3178 (iv) fails to pay a final judgment rendered against the person in this state within 60  
3179 days after the day on which the judgment became final;

3180 (v) fails to meet the same good faith obligations in claims settlement that is required of  
3181 admitted insurers;

3182 (vi) is affiliated with and under the same general management or interlocking  
3183 directorate or ownership as another third party administrator that transacts business in this state  
3184 without a license;

3185 (vii) refuses:

3186 (A) to be examined; or

3187 (B) to produce its accounts, records, and files for examination;

- 3188 (viii) has an officer who refuses to:
- 3189 (A) give information with respect to the third party administrator's affairs; or
- 3190 (B) perform any other legal obligation as to an examination;
- 3191 (ix) provides information in the license application that is:
- 3192 (A) incorrect;
- 3193 (B) misleading;
- 3194 (C) incomplete; or
- 3195 (D) materially untrue;
- 3196 (x) has violated an insurance law, valid rule, or valid order of another state's insurance
- 3197 department;
- 3198 (xi) has obtained or attempted to obtain a license through misrepresentation or fraud;
- 3199 (xii) has improperly withheld, misappropriated, or converted money or properties
- 3200 received in the course of doing insurance business;
- 3201 (xiii) has intentionally misrepresented the terms of an actual or proposed:
- 3202 (A) insurance contract; or
- 3203 (B) application for insurance;
- 3204 (xiv) has been convicted of a felony;
- 3205 (xv) has admitted or been found to have committed an insurance unfair trade practice
- 3206 or fraud;
- 3207 (xvi) in the conduct of business in this state or elsewhere has:
- 3208 (A) used fraudulent, coercive, or dishonest practices; or
- 3209 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;
- 3210 (xvii) has had an insurance license or its equivalent, denied, suspended, or revoked in
- 3211 any other state, province, district, or territory;
- 3212 (xviii) has forged another's name to:
- 3213 (A) an application for insurance; or
- 3214 (B) a document related to an insurance transaction;
- 3215 (xix) has improperly used notes or any other reference material to complete an
- 3216 examination for an insurance license;
- 3217 (xx) has knowingly accepted insurance business from an individual who is not
- 3218 licensed;

3219 (xxi) has failed to comply with an administrative or court order imposing a child  
3220 support obligation;

3221 (xxii) has failed to:

3222 (A) pay state income tax; or

3223 (B) comply with an administrative or court order directing payment of state income  
3224 tax;

3225 (xxiii) has violated or permitted others to violate the federal Violent Crime Control and  
3226 Law Enforcement Act of 1994, 18 U.S.C. [~~Secs.~~] Sec. 1033 and 1034; or

3227 (xxiv) has engaged in methods and practices in the conduct of business that endanger  
3228 the legitimate interests of customers and the public.

3229 (c) For purposes of this section, if a license is held by an agency, both the agency itself  
3230 and any individual designated under the license are considered to be the holders of the agency  
3231 license.

3232 (d) If an individual designated under the agency license commits an act or fails to  
3233 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,  
3234 the commissioner may suspend, revoke, or limit the license of:

3235 (i) the individual;

3236 (ii) the agency if the agency:

3237 (A) is reckless or negligent in its supervision of the individual; or

3238 (B) knowingly participated in the act or failure to act that is the ground for suspending,  
3239 revoking, or limiting the license; or

3240 (iii) (A) the individual; and

3241 (B) the agency if the agency meets the requirements of Subsection (4)(d)(ii).

3242 (5) A licensee under this chapter is subject to the penalties for acting as a licensee  
3243 without a license if:

3244 (a) the licensee's license is:

3245 (i) revoked;

3246 (ii) suspended;

3247 (iii) limited;

3248 (iv) surrendered in lieu of administrative action;

3249 (v) lapsed; or

- 3250 (vi) voluntarily surrendered; and  
3251 (b) the licensee:  
3252 (i) continues to act as a licensee; or  
3253 (ii) violates the terms of the license limitation.  
3254 (6) A licensee under this chapter shall immediately report to the commissioner:  
3255 (a) a revocation, suspension, or limitation of the person's license in any other state, the  
3256 District of Columbia, or a territory of the United States;  
3257 (b) the imposition of a disciplinary sanction imposed on that person by any other state,  
3258 the District of Columbia, or a territory of the United States; or  
3259 (c) a judgment or injunction entered against the person on the basis of conduct  
3260 involving:  
3261 (i) fraud;  
3262 (ii) deceit;  
3263 (iii) misrepresentation; or  
3264 (iv) a violation of an insurance law or rule.  
3265 (7) (a) An order revoking a license under Subsection (4) or an agreement to surrender a  
3266 license in lieu of administrative action may specify a time, not to exceed five years, within  
3267 which the former licensee may not apply for a new license.  
3268 (b) If no time is specified in the order or agreement described in Subsection (7)(a), the  
3269 former licensee may not apply for a new license for five years from the day on which the order  
3270 or agreement is made without the express approval of the commissioner.  
3271 (8) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of  
3272 a license issued under this part if so ordered by the court.  
3273 (9) The commissioner shall by rule prescribe the license renewal and reinstatement  
3274 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.  
3275 Section 27. Section **31A-26-206** is amended to read:  
3276 **31A-26-206. Continuing education requirements.**  
3277 (1) Pursuant to this section, the commissioner shall by rule prescribe continuing  
3278 education requirements for each class of license under Section 31A-26-204.  
3279 (2) (a) The commissioner shall impose continuing education requirements in  
3280 accordance with a two-year licensing period in which the licensee meets the requirements of

3281 this Subsection (2).

3282 (b) (i) Except as otherwise provided in [~~Subsection (2)(b)(iii)] this section, the  
3283 continuing education requirements shall require:~~

3284 (A) that a licensee complete 24 credit hours of continuing education for every two-year  
3285 licensing period;

3286 (B) that [~~three~~] 3 of the 24 credit hours described in Subsection (2)(b)(i)(A) be ethics  
3287 courses; and

3288 (C) that the licensee complete at least half of the required hours through classroom  
3289 hours of insurance-related instruction.

3290 [~~(ii) The hours not completed through classroom hours]~~

3291 (ii) A continuing education hour completed in accordance with Subsection  
3292 (2)(b)(i)[~~(C)~~] may be obtained through:

3293 (A) classroom attendance;

3294 [~~(A)~~] (B) home study;

3295 [~~(B)~~] (C) watching a video recording;

3296 [~~(C)~~] (D) experience credit; or

3297 [~~(D)~~] (E) other methods provided by rule.

3298 (iii) Notwithstanding Subsections (2)(b)(i)(A) and (B), a title insurance adjuster is  
3299 required to complete 12 credit hours of continuing education for every two-year licensing  
3300 period, with [~~three~~] 3 of the credit hours being ethics courses.

3301 (c) A licensee may obtain continuing education hours at any time during the two-year  
3302 licensing period.

3303 (d) (i) [~~Beginning May 3, 1999, a~~] A licensee is exempt from the continuing education  
3304 requirements of this section if:

3305 (A) the licensee was first licensed before April 1, [~~1970~~] 1978;

3306 (B) the license does not have a continuous lapse for a period of more than one year,  
3307 except for a license for which the licensee has had an exemption approved before May 11,  
3308 2011;

3309 [~~(B)~~] (C) the licensee requests an exemption from the department; and

3310 [~~(C)~~] (D) the department approves the exemption.

3311 (ii) If the department approves the exemption under Subsection (2)(d)(i), the licensee is

3312 not required to apply again for the exemption.

3313 (e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the  
3314 commissioner shall by rule:

3315 (i) publish a list of insurance professional designations whose continuing education  
3316 requirements can be used to meet the requirements for continuing education under Subsection  
3317 (2)(b); and

3318 (ii) authorize a professional adjuster ~~[associations]~~ association to:

3319 (A) offer a qualified ~~[programs for all classes of licenses]~~ program for a classification  
3320 of license on a geographically accessible basis; and

3321 (B) collect a reasonable ~~[fees]~~ fee for funding and administration of ~~[the continuing~~  
3322 ~~education programs]~~ a qualified program, subject to the review and approval of the  
3323 commissioner.

3324 (f) (i) ~~[The fees]~~ A fee permitted under Subsection (2)(e)(ii)(B) that ~~[are]~~ is charged to  
3325 fund and administer a qualified program shall reasonably relate to the ~~[costs]~~ cost of  
3326 administering the qualified program.

3327 (ii) Nothing in this section shall prohibit a provider of a continuing education  
3328 ~~[programs or courses]~~ program or course from charging ~~[fees]~~ a fee for attendance at ~~[courses]~~  
3329 a course offered for continuing education credit.

3330 (iii) ~~[The fees]~~ A fee permitted under Subsection (2)(e)(ii)(B) that ~~[are]~~ is charged for  
3331 attendance at an association program may be less for an association member, ~~[based]~~ on the  
3332 basis of the member's affiliation expense, but shall preserve the right of a nonmember to attend  
3333 without affiliation.

3334 (3) The continuing education requirements of this section apply only to ~~[licensees who~~  
3335 ~~are natural persons]~~ a licensee who is an individual.

3336 (4) The continuing education requirements of this section do not apply to ~~[members]~~ a  
3337 member of the Utah State Bar.

3338 (5) The commissioner shall designate ~~[courses that satisfy]~~ a course that satisfies the  
3339 requirements of this section, including ~~[those]~~ a course presented by ~~[insurers]~~ an insurer.

3340 (6) A nonresident adjuster is considered to have satisfied this state's continuing  
3341 education requirements if:

3342 (a) the nonresident adjuster satisfies the nonresident producer's home state's continuing

3343 education requirements for a licensed insurance adjuster; and

3344 (b) on the same basis the nonresident adjuster's home state considers satisfaction of  
3345 Utah's continuing education requirements for a producer as satisfying the continuing education  
3346 requirements of the home state.

3347 (7) A licensee subject to this section shall keep documentation of completing the  
3348 continuing education requirements of this section for two years after the end of the two-year  
3349 licensing period to which the continuing education requirement applies.

3350 Section 28. Section **31A-26-208** is amended to read:

3351 **31A-26-208. Nonresident jurisdictional agreement.**

3352 (1) (a) If a nonresident license applicant has a valid license from the nonresident  
3353 license applicant's home state and the conditions of Subsection (1)(b) are met, the  
3354 commissioner shall:

- 3355 (i) waive any license requirement for a license under this chapter; and
- 3356 (ii) issue the nonresident license applicant a nonresident adjuster's license.

3357 (b) Subsection (1)(a) applies if:

3358 (i) the nonresident license applicant:

3359 (A) is licensed as a resident in the nonresident license applicant's home state at the time  
3360 the nonresident license applicant applies for a nonresident adjuster license;

3361 (B) has submitted the proper request for licensure;

3362 (C) has submitted to the commissioner:

3363 (I) the application for licensure that the nonresident license applicant submitted to the  
3364 applicant's home state; or

3365 (II) a completed uniform application; and

3366 (D) has paid the applicable fees under Section 31A-3-103;

3367 (ii) the nonresident license applicant's license in the applicant's home state is in good  
3368 standing; and

3369 (iii) the nonresident license applicant's home state awards nonresident adjuster licenses  
3370 to residents of this state on the same basis as this state awards licenses to residents of that home  
3371 state.

3372 (2) A nonresident applicant shall execute in a form acceptable to the commissioner an  
3373 agreement to be subject to the jurisdiction of the commissioner and courts of this state on any

3374 matter related to the adjuster's insurance activities in this state, on the basis of:

3375 (a) service of process under Sections 31A-2-309 and 31A-2-310; or

3376 (b) other service authorized under the Utah Rules of Civil Procedure or Section  
3377 78B-3-206.

3378 (3) The commissioner may verify [~~the third party administrator's~~] an adjuster's  
3379 licensing status through the database maintained by:

3380 (a) the National Association of Insurance Commissioners; or

3381 (b) an affiliate or subsidiary of the National Association of Insurance Commissioners.

3382 (4) The commissioner may not assess a greater fee for an insurance license or related  
3383 service to a person not residing in this state based solely on the fact that the person does not  
3384 reside in this state.

3385 Section 29. Section **31A-26-213** is amended to read:

3386 **31A-26-213. Revocation, suspension, surrender, lapsing, limiting, or otherwise**  
3387 **terminating a license -- Rulemaking for renewal or reinstatement.**

3388 (1) A license type issued under this chapter remains in force until:

3389 (a) revoked or suspended under Subsection (5);

3390 (b) surrendered to the commissioner and accepted by the commissioner in lieu of  
3391 administrative action;

3392 (c) the licensee dies or is adjudicated incompetent as defined under:

3393 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or

3394 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and  
3395 Minors;

3396 (d) lapsed under Section 31A-26-214.5; or

3397 (e) voluntarily surrendered.

3398 (2) The following may be reinstated within one year after the day on which the license  
3399 is no longer in force:

3400 (a) a lapsed license; or

3401 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may  
3402 not be reinstated after the license period in which it is voluntarily surrendered.

3403 (3) Unless otherwise stated in [~~the~~] a written agreement for the voluntary surrender of a  
3404 license, submission and acceptance of a voluntary surrender of a license does not prevent the

3405 department from pursuing additional disciplinary or other action authorized under:  
3406 (a) this title; or  
3407 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah  
3408 Administrative Rulemaking Act.  
3409 (4) A license classification issued under this chapter remains in force until:  
3410 (a) the qualifications pertaining to a license classification are no longer met by the  
3411 licensee; or  
3412 (b) the supporting license type:  
3413 (i) is revoked or suspended under Subsection (5); or  
3414 (ii) is surrendered to the commissioner and accepted by the commissioner in lieu of  
3415 administrative action.  
3416 (5) (a) If the commissioner makes a finding under Subsection (5)(b) as part of an  
3417 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the  
3418 commissioner may:  
3419 (i) revoke:  
3420 (A) a license; or  
3421 (B) a license classification;  
3422 (ii) suspend for a specified period of 12 months or less:  
3423 (A) a license; or  
3424 (B) a license classification;  
3425 (iii) limit in whole or in part:  
3426 (A) a license; or  
3427 (B) a license classification; or  
3428 (iv) deny a license application.  
3429 (b) The commissioner may take an action described in Subsection (5)(a) if the  
3430 commissioner finds that the licensee:  
3431 (i) is unqualified for a license or license classification under Section 31A-26-202,  
3432 31A-26-203, 31A-26-204, or 31A-26-205;  
3433 (ii) has violated:  
3434 (A) an insurance statute;  
3435 (B) a rule that is valid under Subsection 31A-2-201(3); or

- 3436 (C) an order that is valid under Subsection 31A-2-201(4);
- 3437 (iii) is insolvent, or the subject of receivership, conservatorship, rehabilitation, or other
- 3438 delinquency proceedings in any state;
- 3439 (iv) fails to pay a final judgment rendered against the person in this state within 60
- 3440 days after the judgment became final;
- 3441 (v) fails to meet the same good faith obligations in claims settlement that is required of
- 3442 admitted insurers;
- 3443 (vi) is affiliated with and under the same general management or interlocking
- 3444 directorate or ownership as another insurance adjuster that transacts business in this state
- 3445 without a license;
- 3446 (vii) refuses:
- 3447 (A) to be examined; or
- 3448 (B) to produce its accounts, records, and files for examination;
- 3449 (viii) has an officer who refuses to:
- 3450 (A) give information with respect to the insurance adjuster's affairs; or
- 3451 (B) perform any other legal obligation as to an examination;
- 3452 (ix) provides information in the license application that is:
- 3453 (A) incorrect;
- 3454 (B) misleading;
- 3455 (C) incomplete; or
- 3456 (D) materially untrue;
- 3457 (x) has violated an insurance law, valid rule, or valid order of another state's insurance
- 3458 department;
- 3459 (xi) has obtained or attempted to obtain a license through misrepresentation or fraud;
- 3460 (xii) has improperly withheld, misappropriated, or converted money or properties
- 3461 received in the course of doing insurance business;
- 3462 (xiii) has intentionally misrepresented the terms of an actual or proposed:
- 3463 (A) insurance contract; or
- 3464 (B) application for insurance;
- 3465 (xiv) has been convicted of a felony;
- 3466 (xv) has admitted or been found to have committed an insurance unfair trade practice

3467 or fraud;

3468 (xvi) in the conduct of business in this state or elsewhere has:

3469 (A) used fraudulent, coercive, or dishonest practices; or

3470 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;

3471 (xvii) has had an insurance license, or its equivalent, denied, suspended, or revoked in

3472 any other state, province, district, or territory;

3473 (xviii) has forged another's name to:

3474 (A) an application for insurance; or

3475 (B) a document related to an insurance transaction;

3476 (xix) has improperly used notes or any other reference material to complete an

3477 examination for an insurance license;

3478 (xx) has knowingly accepted insurance business from an individual who is not

3479 licensed;

3480 (xxi) has failed to comply with an administrative or court order imposing a child

3481 support obligation;

3482 (xxii) has failed to:

3483 (A) pay state income tax; or

3484 (B) comply with an administrative or court order directing payment of state income

3485 tax;

3486 (xxiii) has violated or permitted others to violate the federal Violent Crime Control and

3487 Law Enforcement Act of 1994, 18 U.S.C. [~~Secs.~~] Sec. 1033 and 1034; or

3488 (xxiv) has engaged in methods and practices in the conduct of business that endanger

3489 the legitimate interests of customers and the public.

3490 (c) For purposes of this section, if a license is held by an agency, both the agency itself

3491 and any individual designated under the license are considered to be the holders of the license.

3492 (d) If an individual designated under the agency license commits an act or fails to

3493 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,

3494 the commissioner may suspend, revoke, or limit the license of:

3495 (i) the individual;

3496 (ii) the agency, if the agency:

3497 (A) is reckless or negligent in its supervision of the individual; or

3498 (B) knowingly participated in the act or failure to act that is the ground for suspending,  
3499 revoking, or limiting the license; or

3500 (iii) (A) the individual; and

3501 (B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).

3502 (6) A licensee under this chapter is subject to the penalties for conducting an insurance  
3503 business without a license if:

3504 (a) the licensee's license is:

3505 (i) revoked;

3506 (ii) suspended;

3507 (iii) limited;

3508 (iv) surrendered in lieu of administrative action;

3509 (v) lapsed; or

3510 (vi) voluntarily surrendered; and

3511 (b) the licensee:

3512 (i) continues to act as a licensee; or

3513 (ii) violates the terms of the license limitation.

3514 (7) A licensee under this chapter shall immediately report to the commissioner:

3515 (a) a revocation, suspension, or limitation of the person's license in any other state, the  
3516 District of Columbia, or a territory of the United States;

3517 (b) the imposition of a disciplinary sanction imposed on that person by any other state,  
3518 the District of Columbia, or a territory of the United States; or

3519 (c) a judgment or injunction entered against that person on the basis of conduct  
3520 involving:

3521 (i) fraud;

3522 (ii) deceit;

3523 (iii) misrepresentation; or

3524 (iv) a violation of an insurance law or rule.

3525 (8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a  
3526 license in lieu of administrative action may specify a time not to exceed five years within  
3527 which the former licensee may not apply for a new license.

3528 (b) If no time is specified in the order or agreement described in Subsection (8)(a), the

3529 former licensee may not apply for a new license for five years without the express approval of  
3530 the commissioner.

3531 (9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of  
3532 a license issued under this part if so ordered by a court.

3533 (10) The commissioner shall by rule prescribe the license renewal and reinstatement  
3534 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

3535 Section 30. Section **31A-26-306** is amended to read:

3536 **31A-26-306. Place of business -- Records.**

3537 (1) (a) An insurance adjuster licensed under this chapter shall~~[(i)]~~ register and  
3538 maintain with the commissioner:

3539 (i) the address and telephone number of the licensee's principal place of business; ~~and~~

3540 (ii) a valid business email address at which the commissioner may contact the licensee;

3541 and

3542 ~~[(ii)]~~ (iii) if the licensee is an individual, ~~[provide]~~ the licensee's residence address and  
3543 telephone number.

3544 (b) A licensee shall notify the commissioner within 30 days of ~~[any change of]~~ a  
3545 change in one of the following required to be registered under Subsection (1)(a):

3546 (i) an address ~~[or]~~;

3547 (ii) a telephone number~~[-];~~ or

3548 (iii) a business email address.

3549 (2) Except as provided under Subsection (3), ~~[every]~~ an insurance adjuster shall keep at  
3550 the address registered under Subsection (1), a record of ~~[all]~~ the transactions consummated  
3551 under the insurance adjuster's license, including a record of:

3552 (a) each investigation or adjustment undertaken or consummated; and

3553 (b) ~~[any]~~ a fee, commission, or other compensation received or to be received by the  
3554 adjuster on account of the investigation or adjustment.

3555 (3) Subsection (2) is satisfied if the records specified in ~~[that subsection]~~ Subsection  
3556 (2) can be obtained immediately from a central storage place elsewhere by on-line computer  
3557 terminals located at the registered address.

3558 (4) (a) ~~[The records]~~ A record maintained as to a transaction under Subsection (2) shall  
3559 be kept available for the inspection of the commissioner during all business hours for a period

3560 of time after the date of the transaction specified by the commissioner by rule, but in no case  
3561 for less than the current calendar year plus three years.

3562 (b) Discarding [~~records~~] a record after the then applicable record retention period is  
3563 passed does not place the licensee in violation of a later-adopted longer record retention period.

3564 Section 31. Section **31A-28-107** is amended to read:

3565 **31A-28-107. Board of directors.**

3566 (1) (a) The board of directors of the association shall consist of:

3567 (i) at least five but not more than nine member insurers who:

3568 (A) subject to Subsection (1)(e), serve terms as established in the plan of operation;

3569 and

3570 (B) are selected by member insurers, subject to the approval of the commissioner; and

3571 (ii) two public representatives appointed by the commissioner.

3572 (b) (i) The commissioner shall make the appointment of a public representative

3573 coincide with the association's annual meeting at which the association's board of directors is  
3574 elected.

3575 (ii) A public representative may not be:

3576 (A) an officer, director, or employee of an insurer; or

3577 (B) a person engaged in the business of insurance.

3578 (iii) Subject to Subsection (1)(e), a public representative shall serve a term of three  
3579 years.

3580 (c) When a vacancy occurs in the membership of the board of directors for any reason:

3581 (i) if the vacancy is of a member insurer, a replacement may be elected for the  
3582 unexpired term by a majority vote of the remaining board members, subject to the approval of  
3583 the commissioner; and

3584 (ii) if the vacancy is of a public representative, the commissioner shall appoint a  
3585 replacement for the unexpired term.

3586 (d) In approving a selection or in appointing a member to the board of directors, the  
3587 commissioner shall consider, among other things, whether all member insurers are fairly  
3588 represented.

3589 (e) Notwithstanding Subsections (1)(a) and (b), the commissioner shall, at the time of  
3590 election, reelection, appointment, or reappointment adjust the length of terms to ensure that the

3591 terms of board members are staggered so that approximately half of the board of directors is  
3592 selected during any two-year period.

3593 (2) (a) A member of the board of directors may be reimbursed from the assets of the  
3594 association for expenses incurred by the member as a member of the board of directors.

3595 (b) A public representative appointed under Subsection (1)(a)(ii) may not receive  
3596 compensation or benefits for the public representative's service, but in addition to  
3597 reimbursement under Subsection (2)(a), a public representative may receive per diem and  
3598 travel expenses established by the board with the approval of the commissioner.

3599 [~~(b)~~] (c) Except as provided in [~~Subsection (2)(a)~~] Subsections (2)(a) and (b), a  
3600 member of the board of directors may not be compensated by the association for the member's  
3601 services.

3602 Section 32. Section **31A-29-103** is amended to read:

3603 **31A-29-103. Definitions.**

3604 As used in this chapter:

3605 (1) "Board" means the board of directors of the pool created in Section 31A-29-104.

3606 (2) (a) "Creditable coverage" has the same meaning as provided in Section 31A-1-301.

3607 (b) "Creditable coverage" does not include a period of time in which there is a  
3608 significant break in coverage, as defined in Section 31A-1-301.

3609 (3) "Domicile" means the place where an individual has a fixed and permanent home  
3610 and principal establishment:

3611 (a) to which the individual, if absent, intends to return; and

3612 (b) in which the individual, and the individual's family voluntarily reside, not for a  
3613 special or temporary purpose, but with the intention of making a permanent home.

3614 (4) "Enrollee" means an individual who has met the eligibility requirements of the pool  
3615 and is covered by a pool policy under this chapter.

3616 (5) "Health benefit plan":

3617 (a) is defined in Section 31A-1-301; and

3618 (b) does not include a plan that:

3619 (i) (A) has a maximum actuarial value less than 100% of the basic health care plan; or

3620 (B) has a maximum annual limit of \$100,000 or less; and

3621 (ii) meets other criteria established by the board.

3622 (6) "Health care facility" means any entity providing health care services which is  
3623 licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act.

3624 (7) "Health care insurance" is defined in Section 31A-1-301.

3625 (8) "Health care provider" has the same meaning as provided in Section 78B-3-403.

3626 (9) "Health care services" means:

3627 (a) any service or product:

3628 (i) used in furnishing to any individual medical care or hospitalization; or

3629 (ii) incidental to furnishing medical care or hospitalization; and

3630 (b) any other service or product furnished for the purpose of preventing, alleviating,  
3631 curing, or healing human illness or injury.

3632 (10) "Health maintenance organization" has the same meaning as provided in Section  
3633 31A-8-101.

3634 (11) "Health plan" means any arrangement by which an individual, including a  
3635 dependent or spouse, covered or making application to be covered under the pool has:

3636 (a) access to hospital and medical benefits or reimbursement including group or  
3637 individual insurance or subscriber contract;

3638 (b) coverage through:

3639 (i) a health maintenance organization;

3640 (ii) a preferred provider prepayment;

3641 (iii) group practice;

3642 (iv) individual practice plan; or

3643 (v) health care insurance;

3644 (c) coverage under an uninsured arrangement of group or group-type contracts  
3645 including employer self-insured, cost-plus, or other benefits methodologies not involving  
3646 insurance;

3647 (d) coverage under a group type contract which is not available to the general public  
3648 and can be obtained only because of connection with a particular organization or group; and

3649 (e) coverage by Medicare or other governmental benefit.

3650 (12) "HIPAA" means the Health Insurance Portability and Accountability Act [~~of 1996;~~  
3651 ~~Pub. L. 104-191, 110 Stat. 1936~~].

3652 (13) "HIPAA eligible" means an individual who is eligible under the provisions of the

3653 Health Insurance Portability and Accountability Act [~~of 1996, Pub. L. 104-191, 110 Stat.~~  
3654 ~~1936~~].

3655 (14) "Insurer" means:

3656 (a) an insurance company authorized to transact accident and health insurance business  
3657 in this state;

3658 (b) a health maintenance organization; or

3659 (c) a self-insurer not subject to federal preemption.

3660 (15) "Medicaid" means coverage under Title XIX of the Social Security Act, 42 U.S.C.  
3661 Sec. 1396 et seq., as amended.

3662 (16) "Medicare" means coverage under both Part A and B of Title XVIII of the Social  
3663 Security Act, 42 U.S.C. Sec. 1395 et seq., as amended.

3664 (17) "Plan of operation" means the plan developed by the board in accordance with  
3665 Section 31A-29-105 and includes the articles, bylaws, and operating rules adopted by the board  
3666 under Section 31A-29-106.

3667 (18) "Pool" means the Utah Comprehensive Health Insurance Pool created in Section  
3668 31A-29-104.

3669 (19) "Pool fund" means the Comprehensive Health Insurance Pool Enterprise Fund  
3670 created in Section 31A-29-120.

3671 (20) "Pool policy" means a health benefit plan policy issued under this chapter.

3672 (21) "Preexisting condition" has the same meaning as defined in Section 31A-1-301.

3673 (22) (a) "Resident" or "residency" means a person who is domiciled in this state.

3674 (b) A resident retains residency if that resident leaves this state:

3675 (i) to serve in the armed forces of the United States; or

3676 (ii) for religious or educational purposes.

3677 (23) "Third-party administrator" has the same meaning as provided in Section  
3678 31A-1-301.

3679 Section 33. Section **31A-29-106** is amended to read:

3680 **31A-29-106. Powers of board.**

3681 (1) The board shall have the general powers and authority granted under the laws of  
3682 this state to insurance companies licensed to transact health care insurance business. In  
3683 addition, the board shall have the specific authority to:

- 3684 (a) enter into contracts to carry out the provisions and purposes of this chapter,  
3685 including, with the approval of the commissioner, contracts with:
- 3686 (i) similar pools of other states for the joint performance of common administrative  
3687 functions; or
- 3688 (ii) persons or other organizations for the performance of administrative functions;
- 3689 (b) sue or be sued, including taking such legal action necessary to avoid the payment of  
3690 improper claims against the pool or the coverage provided through the pool;
- 3691 (c) establish appropriate rates, rate schedules, rate adjustments, expense allowances,  
3692 agents' referral fees, claim reserve formulas, and any other actuarial function appropriate to the  
3693 operation of the pool;
- 3694 (d) issue policies of insurance in accordance with the requirements of this chapter;
- 3695 (e) retain an executive director and appropriate legal, actuarial, and other personnel as  
3696 necessary to provide technical assistance in the operations of the pool;
- 3697 (f) establish rules, conditions, and procedures for reinsuring risks under this chapter;
- 3698 (g) cause the pool to have an annual audit of its operations by the state auditor;
- 3699 (h) coordinate with the Department of Health in seeking to obtain from the Centers for  
3700 Medicare and Medicaid Services, or other appropriate office or agency of government, all  
3701 appropriate waivers, authority, and permission needed to coordinate the coverage available  
3702 from the pool with coverage available under Medicaid, either before or after Medicaid  
3703 coverage, or as a conversion option upon completion of Medicaid eligibility, without the  
3704 necessity for requalification by the enrollee;
- 3705 (i) provide for and employ cost containment measures and requirements including  
3706 preadmission certification, concurrent inpatient review, and individual case management for  
3707 the purpose of making the pool more cost-effective;
- 3708 (j) offer pool coverage through contracts with health maintenance organizations,  
3709 preferred provider organizations, and other managed care systems that will manage costs while  
3710 maintaining quality care;
- 3711 (k) establish annual limits on benefits payable under the pool to or on behalf of any  
3712 enrollee;
- 3713 (l) exclude from coverage under the pool specific benefits, medical conditions, and  
3714 procedures for the purpose of protecting the financial viability of the pool;

- 3715 (m) administer the Pool Fund;
- 3716 (n) make rules in accordance with Title 63G, Chapter 3, Utah Administrative
- 3717 Rulemaking Act, to implement this chapter; and
- 3718 (o) adopt, trademark, and copyright a trade name for the pool for use in marketing and
- 3719 publicizing the pool and its products.
- 3720 (2) (a) The board shall prepare and submit an annual report to the Legislature which
- 3721 shall include:
- 3722 (i) the net premiums anticipated;
- 3723 (ii) actuarial projections of payments required of the pool;
- 3724 (iii) the expenses of administration; and
- 3725 (iv) the anticipated reserves or losses of the pool.
- 3726 (b) The budget for operation of the pool is subject to the approval of the board.
- 3727 (c) The administrative budget of the board and the commissioner under this chapter
- 3728 shall comply with the requirements of Title 63J, Chapter 1, Budgetary Procedures Act, and is
- 3729 subject to review and approval by the Legislature.

3730 (3) (a) The board shall on or before September 1, 2004, require the plan administrator

3731 or an independent actuarial consultant retained by the plan administrator to redetermine the

3732 reasonable equivalent of the criteria for uninsurability required under Subsection

3733 31A-30-106(1)(~~f~~)(h) that is used by the board to determine eligibility for coverage in the pool.

3734 (b) The board shall redetermine the criteria established in Subsection (3)(a) at least

3735 every five years thereafter.

3736 Section 34. Section **31A-30-103** is amended to read:

3737 **31A-30-103. Definitions.**

3738 As used in this chapter:

3739 (1) "Actuarial certification" means a written statement by a member of the American

3740 Academy of Actuaries or other individual approved by the commissioner that a covered carrier

3741 is in compliance with ~~[Section]~~ Sections 31A-30-106 and 31A-30-106.1, based upon the

3742 examination of the covered carrier, including review of the appropriate records and of the

3743 actuarial assumptions and methods used by the covered carrier in establishing premium rates

3744 for applicable health benefit plans.

3745 (2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly

3746 through one or more intermediaries, controls or is controlled by, or is under common control  
3747 with, a specified entity or person.

3748 (3) "Base premium rate" means, for each class of business as to a rating period, the  
3749 lowest premium rate charged or that could have been charged under a rating system for that  
3750 class of business by the covered carrier to covered insureds with similar case characteristics for  
3751 health benefit plans with the same or similar coverage.

3752 (4) "Basic benefit plan" or "basic coverage" means the coverage provided in the Basic  
3753 Health Care Plan under Section 31A-22-613.5.

3754 (5) "Carrier" means any person or entity that provides health insurance in this state  
3755 including:

3756 (a) an insurance company;

3757 (b) a prepaid hospital or medical care plan;

3758 (c) a health maintenance organization;

3759 (d) a multiple employer welfare arrangement; and

3760 (e) any other person or entity providing a health insurance plan under this title.

3761 (6) (a) Except as provided in Subsection (6)(b), "case characteristics" means  
3762 demographic or other objective characteristics of a covered insured that are considered by the  
3763 carrier in determining premium rates for the covered insured.

3764 (b) "Case characteristics" do not include:

3765 (i) duration of coverage since the policy was issued;

3766 (ii) claim experience; and

3767 (iii) health status.

3768 (7) "Class of business" means all or a separate grouping of covered insureds that is  
3769 permitted by the ~~[department]~~ commissioner in accordance with Section 31A-30-105.

3770 (8) "Conversion policy" means a policy providing coverage under the conversion  
3771 provisions required in Chapter 22, Part 7, Group Accident and Health Insurance.

3772 (9) "Covered carrier" means any individual carrier or small employer carrier subject to  
3773 this chapter.

3774 (10) "Covered individual" means any individual who is covered under a health benefit  
3775 plan subject to this chapter.

3776 (11) "Covered insureds" means small employers and individuals who are issued a

3777 health benefit plan that is subject to this chapter.

3778 (12) "Dependent" means an individual to the extent that the individual is defined to be  
3779 a dependent by:

3780 (a) the health benefit plan covering the covered individual; and

3781 (b) Chapter 22, Part 6, Accident and Health Insurance.

3782 (13) "Established geographic service area" means a geographical area approved by the  
3783 commissioner within which the carrier is authorized to provide coverage.

3784 (14) "Index rate" means, for each class of business as to a rating period for covered  
3785 insureds with similar case characteristics, the arithmetic average of the applicable base  
3786 premium rate and the corresponding highest premium rate.

3787 (15) "Individual carrier" means a carrier that provides coverage on an individual basis  
3788 through a health benefit plan regardless of whether:

3789 (a) coverage is offered through:

3790 (i) an association;

3791 (ii) a trust;

3792 (iii) a discretionary group; or

3793 (iv) other similar groups; or

3794 (b) the policy or contract is situated out-of-state.

3795 (16) "Individual conversion policy" means a conversion policy issued to:

3796 (a) an individual; or

3797 (b) an individual with a family.

3798 (17) "Individual coverage count" means the number of natural persons covered under a  
3799 carrier's health benefit products that are individual policies.

3800 (18) "Individual enrollment cap" means the percentage set by the commissioner in  
3801 accordance with Section 31A-30-110.

3802 (19) "New business premium rate" means, for each class of business as to a rating  
3803 period, the lowest premium rate charged or offered, or that could have been charged or offered,  
3804 by the carrier to covered insureds with similar case characteristics for newly issued health  
3805 benefit plans with the same or similar coverage.

3806 (20) "Premium" means [att] money paid by covered insureds and covered individuals  
3807 as a condition of receiving coverage from a covered carrier, including any fees or other

3808 contributions associated with the health benefit plan.

3809 (21) (a) "Rating period" means the calendar period for which premium rates  
3810 established by a covered carrier are assumed to be in effect, as determined by the carrier.

3811 (b) A covered carrier may not have:

3812 (i) more than one rating period in any calendar month; and

3813 (ii) no more than 12 rating periods in any calendar year.

3814 (22) "Resident" means an individual who has resided in this state for at least 12  
3815 consecutive months immediately preceding the date of application.

3816 (23) "Short-term limited duration insurance" means a health benefit product that:

3817 (a) is not renewable; and

3818 (b) has an expiration date specified in the contract that is less than 364 days after the  
3819 date the plan became effective.

3820 (24) "Small employer carrier" means a carrier that provides health benefit plans  
3821 covering eligible employees of one or more small employers in this state, regardless of  
3822 whether:

3823 (a) coverage is offered through:

3824 (i) an association;

3825 (ii) a trust;

3826 (iii) a discretionary group; or

3827 (iv) other similar grouping; or

3828 (b) the policy or contract is situated out-of-state.

3829 (25) "Uninsurable" means an individual who:

3830 (a) is eligible for the Comprehensive Health Insurance Pool coverage under the  
3831 underwriting criteria established in Subsection 31A-29-111(5); or

3832 (b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and

3833 (ii) has a condition of health that does not meet consistently applied underwriting  
3834 criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)~~(f)~~  
3835 ~~and (j)~~(g) and (h) for which coverage the applicant is applying.

3836 (26) "Uninsurable percentage" for a given calendar year equals UC/CI where, for  
3837 purposes of this formula:

3838 (a) "CI" means the carrier's individual coverage count as of December 31 of the

3839 preceding year; and

3840 (b) "UC" means the number of uninsurable individuals who were issued an individual  
3841 policy on or after July 1, 1997.

3842 Section 35. Section **31A-30-105** is amended to read:

3843 **31A-30-105. Establishment of classes of business.**

3844 (1) For [~~policies that go into~~] a policy that takes effect on or after January 1, 2011, a  
3845 covered carrier may not establish a separate class of business unless:

3846 (a) the covered carrier submits an application to the [~~department~~] commissioner to  
3847 establish a separate class of business;

3848 (b) the covered carrier demonstrates to the satisfaction of the [~~department~~]  
3849 commissioner that a separate class of business is justified under the provisions of this section;

3850 and

3851 (c) the [~~department~~] commissioner approves the carrier's application for the use of a  
3852 separate class of business.

3853 (2) (a) The [~~presumption of the department shall be~~] commissioner shall have a  
3854 presumption against the use of a separate class of business by a covered insured, except when  
3855 the covered carrier demonstrates that [~~the provisions of~~] this Subsection (2) [~~apply~~] applies.

3856 (b) The [~~department~~] commissioner may approve the use of a separate class of business  
3857 only if the covered carrier can demonstrate that the use of a separate class of business is  
3858 necessary due to substantial differences in either expected claims experience or administrative  
3859 costs related to the following reasons:

3860 (i) the covered carrier uses more than one type of system for the marketing and sale of  
3861 health benefit plans to covered insureds;

3862 (ii) the covered carrier has acquired a class of business from another covered carrier; or

3863 (iii) the covered carrier provides coverage to one or more association groups.

3864 (3) The commissioner may establish regulations to provide for a period of transition in  
3865 order for a covered carrier to come into compliance with Subsection (2) in the instance of  
3866 acquisition of an additional class of business from another covered carrier.

3867 (4) The commissioner may approve the establishment of up to five classes of business  
3868 per covered carrier upon application to the commissioner and a finding by the commissioner  
3869 that such action would substantially enhance the efficiency and fairness of the health insurance

3870 marketplace subject to this chapter.

3871 (5) A covered carrier may not establish a class of business based solely on the  
3872 marketing or sale of a health benefit plan as a defined contribution arrangement health benefit  
3873 plan, or through the Health Insurance Exchange.

3874 Section 36. Section **31A-30-106** is amended to read:

3875 **31A-30-106. Individual premiums -- Rating restrictions -- Disclosure.**

3876 (1) Premium rates for health benefit plans for individuals under this chapter are subject  
3877 to ~~[the provisions of]~~ this section.

3878 (a) The index rate for a rating period for any class of business may not exceed the  
3879 index rate for any other class of business by more than 20%.

3880 (b) (i) For a class of business, the premium rates charged during a rating period to  
3881 covered insureds with similar case characteristics for the same or similar coverage, or the rates  
3882 that could be charged to the individual under the rating system for that class of business, may  
3883 not vary from the index rate by more than 30% of the index rate ~~[provided in Section~~  
3884 ~~31A-30-106.1]~~ except as provided under Subsection (1)(b)(ii).

3885 (ii) A carrier that offers individual and small employer health benefit plans may use the  
3886 small employer index rates to establish the rate limitations for individual policies, even if some  
3887 individual policies are rated below the small employer base rate.

3888 (c) The percentage increase in the premium rate charged to a covered insured for a new  
3889 rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of  
3890 the following:

3891 (i) the percentage change in the new business premium rate measured from the first day  
3892 of the prior rating period to the first day of the new rating period;

3893 (ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods  
3894 of less than one year, due to the claim experience, health status, or duration of coverage of the  
3895 covered individuals as determined from the rate manual for the class of business of the carrier  
3896 offering an individual health benefit plan; and

3897 (iii) any adjustment due to change in coverage or change in the case characteristics of  
3898 the covered insured as determined from the rate manual for the class of business of the carrier  
3899 offering an individual health benefit plan.

3900 (d) (i) A carrier offering an individual health benefit plan shall apply rating factors,

3901 including case characteristics, consistently with respect to all covered insureds in a class of  
3902 business.

3903 (ii) Rating factors shall produce premiums for identical individuals that:

3904 (A) differ only by the amounts attributable to plan design; and

3905 (B) do not reflect differences due to the nature of the individuals assumed to select  
3906 particular health benefit products.

3907 (iii) A carrier offering an individual health benefit plan shall treat all health benefit  
3908 plans issued or renewed in the same calendar month as having the same rating period.

3909 (e) For the purposes of this Subsection (1), a health benefit plan that uses a restricted  
3910 network provision may not be considered similar coverage to a health benefit plan that does not  
3911 use a restricted network provision, provided that use of the restricted network provision results  
3912 in substantial difference in claims costs.

3913 (f) A carrier offering a health benefit plan to an individual may not, without prior  
3914 approval of the commissioner, use case characteristics other than:

3915 (i) age;

3916 (ii) gender;

3917 (iii) geographic area; and

3918 (iv) family composition.

3919 (g) (i) The commissioner shall establish rules in accordance with Title 63G, Chapter 3,  
3920 Utah Administrative Rulemaking Act, to:

3921 (A) implement this chapter; and

3922 (B) assure that rating practices used by carriers who offer health benefit plans to  
3923 individuals are consistent with the purposes of this chapter.

3924 (ii) The rules described in Subsection (1)(g)(i) may include rules that:

3925 (A) assure that differences in rates charged for health benefit products by carriers who  
3926 offer health benefit plans to individuals are reasonable and reflect objective differences in plan  
3927 design, not including differences due to the nature of the individuals assumed to select  
3928 particular health benefit products;

3929 (B) prescribe the manner in which case characteristics may be used by carriers who  
3930 offer health benefit plans to individuals;

3931 (C) implement the individual enrollment cap under Section 31A-30-110, including

3932 specifying:

3933 (I) the contents for certification;

3934 (II) auditing standards;

3935 (III) underwriting criteria for uninsurable classification; and

3936 (IV) limitations on high risk enrollees under Section 31A-30-111; and

3937 (D) establish the individual enrollment cap under Subsection 31A-30-110(1).

3938 (h) Before implementing regulations for underwriting criteria for uninsurable

3939 classification, the commissioner shall contract with an independent consulting organization to

3940 develop industry-wide underwriting criteria for uninsurability based on an individual's expected

3941 claims under open enrollment coverage exceeding 325% of that expected for a standard

3942 insurable individual with the same case characteristics.

3943 (i) The commissioner shall revise rules issued for Sections 31A-22-602 and

3944 31A-22-605 regarding individual accident and health policy rates to allow rating in accordance

3945 with this section.

3946 (2) For purposes of Subsection (1)(c)(i), if a health benefit product is a health benefit

3947 product into which the covered carrier is no longer enrolling new covered insureds, the covered

3948 carrier shall use the percentage change in the base premium rate, provided that the change does

3949 not exceed, on a percentage basis, the change in the new business premium rate for the most

3950 similar health benefit product into which the covered carrier is actively enrolling new covered

3951 insureds.

3952 (3) (a) A covered carrier may not transfer a covered insured involuntarily into or out of

3953 a class of business.

3954 (b) A covered carrier may not offer to transfer a covered insured into or out of a class

3955 of business unless the offer is made to transfer all covered insureds in the class of business

3956 without regard to:

3957 (i) case characteristics;

3958 (ii) claim experience;

3959 (iii) health status; or

3960 (iv) duration of coverage since issue.

3961 (4) (a) A carrier who offers a health benefit plan to an individual shall maintain at the

3962 carrier's principal place of business a complete and detailed description of its rating practices

3963 and renewal underwriting practices, including information and documentation that demonstrate  
3964 that the carrier's rating methods and practices are:

3965 (i) based upon commonly accepted actuarial assumptions; and

3966 (ii) in accordance with sound actuarial principles.

3967 (b) (i) Each carrier subject to this section shall file with the commissioner, on or before  
3968 April 1 of each year, in a form, manner, and containing such information as prescribed by the  
3969 commissioner, an actuarial certification certifying that:

3970 (A) the carrier is in compliance with this chapter; and

3971 (B) the rating methods of the carrier are actuarially sound.

3972 (ii) A copy of the certification required by Subsection (4)(b)(i) shall be retained by the  
3973 carrier at the carrier's principal place of business.

3974 (c) A carrier shall make the information and documentation described in this  
3975 Subsection (4) available to the commissioner upon request.

3976 (d) Records submitted to the commissioner under this section shall be maintained by  
3977 the commissioner as protected records under Title 63G, Chapter 2, Government Records  
3978 Access and Management Act.

3979 Section 37. Section **31A-30-106.1** is amended to read:

3980 **31A-30-106.1. Small employer premiums -- Rating restrictions -- Disclosure.**

3981 (1) Premium rates for small employer health benefit plans under this chapter are  
3982 subject to ~~[the provisions of]~~ this section for a health benefit plan that is issued or renewed, on  
3983 or after January 1, 2011.

3984 (2) (a) The index rate for a rating period for any class of business may not exceed the  
3985 index rate for any other class of business by more than 20%.

3986 (b) For a class of business, the premium rates charged during a rating period to covered  
3987 insureds with similar case characteristics for the same or similar coverage, or the rates that  
3988 could be charged to an employer group under the rating system for that class of business, may  
3989 not vary from the index rate by more than 30% of the index rate, except when catastrophic  
3990 mental health coverage is selected as provided in Subsection 31A-22-625(2)(d).

3991 (3) The percentage increase in the premium rate charged to a covered insured for a new  
3992 rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of  
3993 the following:

3994 (a) the percentage change in the new business premium rate measured from the first  
3995 day of the prior rating period to the first day of the new rating period;

3996 (b) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods  
3997 of less than one year, due to the claim experience, health status, or duration of coverage of the  
3998 covered individuals as determined from the small employer carrier's rate manual for the class of  
3999 business, except when catastrophic mental health coverage is selected as provided in  
4000 Subsection 31A-22-625(2)(d); and

4001 (c) any adjustment due to change in coverage or change in the case characteristics of  
4002 the covered insured as determined for the class of business from the small employer carrier's  
4003 rate manual.

4004 (4) (a) Adjustments in rates for claims experience, health status, and duration from  
4005 issue may not be charged to individual employees or dependents.

4006 (b) Rating adjustments and factors, including case characteristics, shall be applied  
4007 uniformly and consistently to the rates charged for all employees and dependents of the small  
4008 employer.

4009 (c) Rating factors shall produce premiums for identical groups that:

4010 (i) differ only by the amounts attributable to plan design; and

4011 (ii) do not reflect differences due to the nature of the groups assumed to select  
4012 particular health benefit products.

4013 (d) A small employer carrier shall treat all health benefit plans issued or renewed in the  
4014 same calendar month as having the same rating period.

4015 (5) A health benefit plan that uses a restricted network provision may not be considered  
4016 similar coverage to a health benefit plan that does not use a restricted network provision,  
4017 provided that use of the restricted network provision results in substantial difference in claims  
4018 costs.

4019 (6) The small employer carrier may not use case characteristics other than the  
4020 following:

4021 (a) age of the employee, as determined at the beginning of the plan year, limited to:

4022 (i) the following age bands:

4023 (A) less than 20;

4024 (B) 20-24;

- 4025 (C) 25-29;
- 4026 (D) 30-34;
- 4027 (E) 35-39;
- 4028 (F) 40-44;
- 4029 (G) 45-49;
- 4030 (H) 50-54;
- 4031 (I) 55-59;
- 4032 (J) 60-64; and
- 4033 (K) 65 and above; and
- 4034 (ii) a standard slope ratio range for each age band, applied to each family composition
- 4035 tier rating structure under Subsection (6)(c):
- 4036 (A) as developed by the [department] commissioner by administrative rule;
- 4037 (B) not to exceed an overall ratio of 5:1; and
- 4038 (C) the age slope ratios for each age band may not overlap;
- 4039 (b) geographic area; and
- 4040 (c) family composition, limited to:
- 4041 (i) an overall ratio of 5:1 or less; and
- 4042 (ii) a four tier rating structure that includes:
- 4043 (A) employee only;
- 4044 (B) employee plus spouse;
- 4045 (C) employee plus a dependent or dependents; and
- 4046 (D) a family, consisting of an employee plus spouse, and a dependent or dependents.
- 4047 (7) If a health benefit plan is a health benefit plan into which the small employer carrier
- 4048 is no longer enrolling new covered insureds, the small employer carrier shall use the percentage
- 4049 change in the base premium rate, provided that the change does not exceed, on a percentage
- 4050 basis, the change in the new business premium rate for the most similar health benefit product
- 4051 into which the small employer carrier is actively enrolling new covered insureds.
- 4052 (8) (a) A covered carrier may not transfer a covered insured involuntarily into or out of
- 4053 a class of business.
- 4054 (b) A covered carrier may not offer to transfer a covered insured into or out of a class
- 4055 of business unless the offer is made to transfer all covered insureds in the class of business

4056 without regard to:

- 4057 (i) case characteristics;
- 4058 (ii) claim experience;
- 4059 (iii) health status; or
- 4060 (iv) duration of coverage since issue.

4061 (9) (a) Each small employer carrier shall maintain at the small employer carrier's  
4062 principal place of business a complete and detailed description of its rating practices and  
4063 renewal underwriting practices, including information and documentation that demonstrate that  
4064 the small employer carrier's rating methods and practices are:

- 4065 (i) based upon commonly accepted actuarial assumptions; and
- 4066 (ii) in accordance with sound actuarial principles.

4067 (b) (i) Each small employer carrier shall file with the commissioner on or before April  
4068 1 of each year, in a form and manner and containing information as prescribed by the  
4069 commissioner, an actuarial certification certifying that:

- 4070 (A) the small employer carrier is in compliance with this chapter; and
- 4071 (B) the rating methods of the small employer carrier are actuarially sound.

4072 (ii) A copy of the certification required by Subsection (9)(b)(i) shall be retained by the  
4073 small employer carrier at the small employer carrier's principal place of business.

4074 (c) A small employer carrier shall make the information and documentation described  
4075 in this Subsection (9) available to the commissioner upon request.

4076 (10) (a) The commissioner shall, by July 1, 2010, establish rules in accordance with  
4077 Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to:

- 4078 (i) implement this chapter; and
- 4079 (ii) assure that rating practices used by small employer carriers under this section and  
4080 carriers for individual plans under Section 31A-30-106, [~~as effective~~] in effect on January 1,  
4081 2011, are consistent with the purposes of this chapter.

4082 (b) The rules may:

- 4083 (i) assure that differences in rates charged for health benefit plans by carriers are  
4084 reasonable and reflect objective differences in plan design, not including differences due to the  
4085 nature of the groups or individuals assumed to select particular health benefit plans; and
- 4086 (ii) prescribe the manner in which case characteristics may be used by small employer

4087 and individual carriers.

4088 (11) Records submitted to the commissioner under this section shall be maintained by  
4089 the commissioner as protected records under Title 63G, Chapter 2, Government Records  
4090 Access and Management Act.

4091 Section 38. Section **31A-30-106.5** is amended to read:

4092 **31A-30-106.5. Conversion policy -- Premiums -- Rating restrictions.**

4093 (1) [~~All provisions of Section 31A-30-106.1 apply~~] Section 31A-30-106 applies to  
4094 conversion policies.

4095 (2) Conversion policy premium rates may not exceed by more than 35% the index rate  
4096 for [~~small employers~~] individuals with similar case characteristics for any class of business in  
4097 which the policy form has been [~~approved~~] filed.

4098 (3) An insurer may not consider pregnancy of a covered insured in determining its  
4099 conversion policy premium rates.

4100 Section 39. Section **31A-30-108** is amended to read:

4101 **31A-30-108. Eligibility for small employer and individual market.**

4102 (1) (a) Small employer carriers shall accept residents for small group coverage as set  
4103 forth in the Health Insurance Portability and Accountability Act, [~~P.L. 104-191, 110 Stat.~~  
4104 ~~1962,~~] Sec. 2701(f) and 2711(a).

4105 (b) Individual carriers shall accept residents for individual coverage pursuant to:

4106 (i) [~~to P.L. 104-191, 110 Stat. 1979~~] Health Insurance Portability and Accountability  
4107 Act, Sec. 2741(a)-(b); and

4108 (ii) Subsection (3).

4109 (2) (a) Small employer carriers shall offer to accept all eligible employees and their  
4110 dependents at the same level of benefits under any health benefit plan provided to a small  
4111 employer.

4112 (b) Small employer carriers may:

4113 (i) request a small employer to submit a copy of the small employer's quarterly income  
4114 tax withholdings to determine whether the employees for whom coverage is provided or  
4115 requested are bona fide employees of the small employer; and

4116 (ii) deny or terminate coverage if the small employer refuses to provide documentation  
4117 requested under Subsection (2)(b)(i).

4118 (3) Except as provided in Subsections (5) and (6) and Section 31A-30-110, individual  
4119 carriers shall accept for coverage individuals to whom all of the following conditions apply:  
4120 (a) the individual is not covered or eligible for coverage:  
4121 (i) (A) as an employee of an employer;  
4122 (B) as a member of an association; or  
4123 (C) as a member of any other group; and  
4124 (ii) under:  
4125 (A) a health benefit plan; or  
4126 (B) a self-insured arrangement that provides coverage similar to that provided by a  
4127 health benefit plan as defined in Section 31A-1-301;  
4128 (b) the individual is not covered and is not eligible for coverage under any public  
4129 health benefits arrangement including:  
4130 (i) the Medicare program established under Title XVIII of the Social Security Act;  
4131 (ii) any act of Congress or law of this or any other state that provides benefits  
4132 comparable to the benefits provided under this chapter; or  
4133 (iii) coverage under the Comprehensive Health Insurance Pool Act created in Chapter  
4134 29, Comprehensive Health Insurance Pool Act;  
4135 (c) unless the maximum benefit has been reached the individual is not covered or  
4136 eligible for coverage under any:  
4137 (i) Medicare supplement policy;  
4138 (ii) conversion option;  
4139 (iii) continuation or extension under COBRA; or  
4140 (iv) state extension;  
4141 (d) the individual has not terminated or declined coverage described in Subsection  
4142 (3)(a), (b), or (c) within 93 days of application for coverage, unless the individual is eligible for  
4143 individual coverage under [~~P.L. 104-191, 110 Stat. 1979~~] Health Insurance Portability and  
4144 Accountability Act, Sec. 2741(b), in which case, the requirement of this Subsection (3)(d) does  
4145 not apply; and  
4146 (e) the individual is certified as ineligible for the Health Insurance Pool if:  
4147 (i) the individual applies for coverage with the Comprehensive Health Insurance Pool  
4148 within 30 days after being rejected or refused coverage by the covered carrier and reapplies for

4149 coverage with that covered carrier within 30 days after the date of issuance of a certificate  
4150 under Subsection 31A-29-111(5)(c); or

4151 (ii) the individual applies for coverage with any individual carrier within 45 days after:  
4152 (A) notice of cancellation of coverage under Subsection 31A-29-115(1); or  
4153 (B) the date of issuance of a certificate under Subsection 31A-29-111(5)(c) if the  
4154 individual applied first for coverage with the Comprehensive Health Insurance Pool.

4155 (4) (a) If coverage is obtained under Subsection (3)(e)(i) and the required premium is  
4156 paid, the effective date of coverage shall be the first day of the month following the individual's  
4157 submission of a completed insurance application to that covered carrier.

4158 (b) If coverage is obtained under Subsection (3)(e)(ii) and the required premium is  
4159 paid, the effective date of coverage shall be the day following the:

4160 (i) cancellation of coverage under Subsection 31A-29-115(1); or  
4161 (ii) submission of a completed insurance application to the Comprehensive Health  
4162 Insurance Pool.

4163 (5) (a) An individual carrier is not required to accept individuals for coverage under  
4164 Subsection (3) if the carrier issues no new individual policies in the state after July 1, 1997.

4165 (b) A carrier described in Subsection (5)(a) may not issue new individual policies in  
4166 the state for five years from July 1, 1997.

4167 (c) Notwithstanding Subsection (5)(b), a carrier may request permission to issue new  
4168 policies after July 1, 1999, which may only be granted if:

4169 (i) the carrier accepts uninsurables as is required of a carrier entering the market under  
4170 Subsection 31A-30-110; and

4171 (ii) the commissioner finds that the carrier's issuance of new individual policies:  
4172 (A) is in the best interests of the state; and  
4173 (B) does not provide an unfair advantage to the carrier.

4174 (6) (a) If the Comprehensive Health Insurance Pool, as set forth under [~~Title 31A~~],  
4175 Chapter 29, Comprehensive Health Insurance Pool Act, is dissolved or discontinued, or if  
4176 enrollment is capped or suspended, an individual carrier may decline to accept individuals  
4177 applying for individual enrollment, other than individuals applying for coverage as set forth in  
4178 [~~P.L. 104-191, 110 Stat. 1979~~] Health Insurance Portability and Accountability Act, Sec. 2741  
4179 (a)-(b).

4180 (b) Within two calendar days of taking action under Subsection (6)(a), an individual  
4181 carrier will provide written notice to the [~~Utah Insurance Department~~] department.

4182 (7) (a) If a small employer carrier offers health benefit plans to small employers  
4183 through a network plan, the small employer carrier may:

4184 (i) limit the employers that may apply for the coverage to those employers with eligible  
4185 employees who live, reside, or work in the service area for the network plan; and

4186 (ii) within the service area of the network plan, deny coverage to an employer if the  
4187 small employer carrier has demonstrated to the commissioner that the small employer carrier:

4188 (A) will not have the capacity to deliver services adequately to enrollees of any  
4189 additional groups because of the small employer carrier's obligations to existing group contract  
4190 holders and enrollees; and

4191 (B) applies this section uniformly to all employers without regard to:

4192 (I) the claims experience of an employer, an employer's employee, or a dependent of an  
4193 employee; or

4194 (II) any health status-related factor relating to an employee or dependent of an  
4195 employee.

4196 (b) (i) A small employer carrier that denies a health benefit product to an employer in  
4197 any service area in accordance with this section may not offer coverage in the small employer  
4198 market within the service area to any employer for a period of 180 days after the date the  
4199 coverage is denied.

4200 (ii) This Subsection (7)(b) does not:

4201 (A) limit the small employer carrier's ability to renew coverage that is in force; or

4202 (B) relieve the small employer carrier of the responsibility to renew coverage that is in  
4203 force.

4204 (c) Coverage offered within a service area after the 180-day period specified in  
4205 Subsection (7)(b) is subject to the requirements of this section.

4206 Section 40. Section **31A-30-110** is amended to read:

4207 **31A-30-110. Individual enrollment cap.**

4208 (1) The commissioner shall set the individual enrollment cap at .5% on July 1, 1997.

4209 (2) The commissioner shall raise the individual enrollment cap by .5% at the later of  
4210 the following dates:

- 4211 (a) six months from the last increase in the individual enrollment cap; or  
4212 (b) the date when CCI/TI is greater than .90, where:  
4213 (i) "CCI" is the total individual coverage count for all carriers certifying that their  
4214 uninsurable percentage has reached the individual enrollment cap; and  
4215 (ii) "TI" is the total individual coverage count for all carriers.
- 4216 (3) The commissioner may establish a minimum number of uninsurable individuals  
4217 that a carrier entering the market who is subject to this chapter must accept under the individual  
4218 enrollment provisions of this chapter.
- 4219 (4) Beginning July 1, 1997, an individual carrier may decline to accept individuals  
4220 applying for individual enrollment under Subsection 31A-30-108(3), other than individuals  
4221 applying for coverage as set forth in P.L. 104-191, 110 Stat. 1979, Sec. 2741 (a)-(b), if:  
4222 (a) the uninsurable percentage for that carrier equals or exceeds the cap established in  
4223 Subsection (1); and  
4224 (b) the covered carrier has certified on forms provided by the commissioner that its  
4225 uninsurable percentage equals or exceeds the individual enrollment cap.
- 4226 (5) The department may audit a carrier's records to verify whether the carrier's  
4227 uninsurable classification meets industry standards for underwriting criteria as established by  
4228 the commissioner in accordance with Subsection 31A-30-106(1)~~(f)~~(h).
- 4229 (6) (a) If the commissioner determines that individual enrollment is causing a  
4230 substantial adverse effect on premiums, enrollment, or experience, the commissioner may  
4231 suspend, limit, or delay further individual enrollment for up to 12 months.  
4232 (b) The commissioner shall adopt rules to establish a uniform methodology for  
4233 calculating and reporting loss ratios for individual policies for determining whether the  
4234 individual enrollment provisions of Section 31A-30-108 should be waived for an individual  
4235 carrier experiencing significant and adverse financial impact as a result of complying with  
4236 those provisions.
- 4237 Section 41. Section **31A-30-112** is amended to read:  
4238 **31A-30-112. Employee participation levels.**  
4239 (1) (a) Except as provided in Subsection (2) and Section 31A-30-206, a requirement  
4240 used by a covered carrier in determining whether to provide coverage to a small employer,  
4241 including a requirement for minimum participation of eligible employees and minimum

4242 employer contributions, shall be applied uniformly among all small employers with the same  
4243 number of eligible employees applying for coverage or receiving coverage from the covered  
4244 carrier.

4245 (b) In addition to applying Subsection 31A-1-301~~[(121)]~~(123), a covered carrier may  
4246 require that a small employer have a minimum of two eligible employees to meet participation  
4247 requirements.

4248 (2) A covered carrier may not increase a requirement for minimum employee  
4249 participation or a requirement for minimum employer contribution applicable to a small  
4250 employer at any time after the small employer is accepted for coverage.

4251 Section 42. Section **31A-31-108** is amended to read:

4252 **31A-31-108. Assessment of insurers.**

4253 (1) For purposes of this section:

4254 (a) The commissioner shall by rule made in accordance with Title 63G, Chapter 3,  
4255 Utah Administrative Rulemaking Act, define:

- 4256 (i) "annuity consideration";
- 4257 (ii) "membership fees";
- 4258 (iii) "other fees";
- 4259 (iv) "deposit-type contract funds"; and
- 4260 (v) "other considerations in Utah."

4261 (b) "Utah consideration" means:

- 4262 (i) the total premiums written for Utah risks;
- 4263 (ii) annuity consideration;
- 4264 (iii) membership fees collected by the insurer;
- 4265 (iv) other fees collected by the insurer;
- 4266 (v) deposit-type contract funds; and
- 4267 (vi) other considerations in Utah.

4268 (c) "Utah risks" means insurance coverage on the lives, health, or against the liability  
4269 of persons residing in Utah, or on property located in Utah, other than property temporarily in  
4270 transit through Utah.

4271 (2) To implement this chapter, Section 34A-2-110, and Section 76-6-521, the  
4272 commissioner may assess each admitted insurer and each nonadmitted insurer transacting

4273 insurance under Chapter 15, Parts 1, Unauthorized Insurers and Surplus Lines, and 2,  
4274 [~~Unauthorized Insurers~~] Risk Retention Groups Act, an annual fee as follows:

4275 (a) \$150 for an insurer, if the sum of the Utah consideration for that insurer is less than  
4276 or equal to \$1,000,000;

4277 (b) \$400 for an insurer, if the sum of the Utah consideration for that insurer is greater  
4278 than \$1,000,000 but is less than or equal to \$2,500,000;

4279 (c) \$700 for an insurer, if the sum of the Utah consideration for that insurer is greater  
4280 than \$2,500,000 but is less than or equal to \$5,000,000;

4281 (d) \$1,350 for an insurer, if the sum of the Utah consideration for that insurer is greater  
4282 than \$5,000,000 but less than or equal to \$10,000,000;

4283 (e) \$5,150 for an insurer, if the sum of the Utah consideration for that insurer is greater  
4284 than \$10,000,000 but less than \$50,000,000; and

4285 (f) \$12,350 for an insurer, if the sum of the Utah consideration for that insurer equals  
4286 or exceeds \$50,000,000.

4287 (3) [~~All money~~] Money received by the state under this section shall be deposited [~~in~~  
4288 ~~the General Fund as a dedicated credit of the department for the purpose of providing funds to~~  
4289 ~~pay for any costs and expenses incurred by the department in the administration, investigation,~~  
4290 ~~and enforcement of this chapter, Section 34A-2-110, and Section 76-6-521.] into the Insurance  
4291 Fraud Investigation Restricted Account created in Subsection (4).~~

4292 (4) (a) There is created in the General Fund a restricted account known as the  
4293 "Insurance Fraud Investigation Restricted Account."

4294 (b) The Insurance Fraud Investigation Restricted Account shall consist of the money  
4295 received by the commissioner under this section and Section 31A-31-109.

4296 (c) The commissioner shall administer the Insurance Fraud Investigation Restricted  
4297 Account. Subject to appropriations by the Legislature, the commissioner shall use the money  
4298 deposited into the Insurance Fraud Investigation Restricted Account to pay for a cost or  
4299 expense incurred by the commissioner in the administration, investigation, and enforcement of  
4300 this chapter, Section 34A-2-110, and Section 76-6-521.

4301 Section 43. Section **31A-31-109** is amended to read:

4302 **31A-31-109. Civil penalties.**

4303 (1) In addition to other penalties provided by law, a person who violates this chapter:

4304 (a) is subject to the following civil penalties:

4305 (i) the person shall make full restitution; and

4306 (ii) the person shall pay the costs of enforcement of this chapter for the case in which  
4307 the person is found to have violated this chapter:

4308 (A) as determined by the one or more authorized agencies involved; and

4309 (B) including costs of:

4310 (I) investigators;

4311 (II) attorneys; and

4312 (III) other public employees; and

4313 (b) in the discretion of the court, may be required to pay to the state a civil penalty not  
4314 to exceed three times that amount of value improperly sought or received from the fraudulent  
4315 insurance act.

4316 (2) (a) Money paid under Subsection (1)(a)(i) shall be paid to the person damaged by  
4317 the fraudulent insurance act.

4318 (b) Money paid under Subsection (1)(a)(ii) shall be paid to each applicable authorized  
4319 agency in the following order:

4320 (i) to the [~~General Fund as a dedicated credit of the department~~] Insurance Fraud  
4321 Investigation Restricted Account created in Section 31A-31-108 for the costs of enforcement  
4322 incurred by the [~~department~~] commissioner;

4323 (ii) to the General Fund for the costs of enforcement incurred by a state agency other  
4324 than the [~~department~~] commissioner;

4325 (iii) to the applicable political subdivision for the costs of enforcement incurred by the  
4326 political subdivision; and

4327 (iv) to the applicable criminal investigative department or agency of the United States  
4328 for the costs of enforcement incurred by the department or agency.

4329 (c) Money paid under Subsection (1)(b) shall be paid into the General Fund.

4330 (3) (a) A civil penalty assessed under Subsection (1) shall be awarded by the court as  
4331 part of its judgment in both criminal and civil actions.

4332 (b) A criminal action need not be brought against a person in order for that person to be  
4333 civilly liable under this section.

4334 Section 44. Section ~~31A-35-202~~ is amended to read:

4335 **31A-35-202. Board responsibilities.**4336 (1) The board shall:4337 [~~(1)~~] (a) meet:4338 [~~(a)~~] (i) at least quarterly; and4339 [~~(b)~~] (ii) at the call of the chair;4340 [~~(2)~~] (b) make written recommendations to the commissioner for rules governing the

4341 following aspects of the bail bond surety insurance business:

4342 [~~(a)~~] (i) qualifications, applications, and fees for obtaining:4343 [~~(i)~~] (A) a license required by this Section 31A-35-401; or4344 [~~(ii)~~] (B) a certificate;4345 [~~(b)~~] (ii) limits on the aggregate amounts of bail bonds;4346 [~~(c)~~] (iii) unprofessional conduct;4347 [~~(d)~~] (iv) procedures for hearing and resolving allegations of unprofessional conduct;

4348 and

4349 [~~(e)~~] (v) sanctions for unprofessional conduct;4350 [~~(3)~~] (c) screen:4351 [~~(a)~~] (i) bail bond surety company license applications; and4352 [~~(b)~~] (ii) persons applying for a bail bond surety company license; and4353 [~~(4)~~] (d) recommend to the commissioner action regarding the granting, renewing,4354 suspending, revoking, and reinstating of bail bond surety company license~~[-and]~~.4355 (2) The board may:4356 [~~(5)~~] (a) conduct investigations of allegations of unprofessional conduct on the part of  
4357 persons or bail bond sureties involved in the business of bail bond surety insurance; and4358 (b) provide the results of the investigations described in Subsection [~~(5)~~] (2)(a) to the  
4359 commissioner with recommendations for:4360 (i) action; and4361 (ii) any appropriate sanctions.4362 Section 45. Section **31A-35-406** is amended to read:4363 **31A-35-406. Renewal and reinstatement.**4364 (1) (a) A license under this chapter expires annually on August 14. To renew its4365 license under this chapter, on or before [~~the last day of the month in which the license expires]~~

4366 July 15 a bail bond surety company shall:

- 4367 (i) complete and submit a renewal application to the department; and
- 4368 (ii) pay the department the applicable renewal fee established in accordance with
- 4369 Section 31A-3-103.

4370 (b) A bail bond surety company shall renew its license under this chapter annually as

4371 established by department rule, regardless of when the license is issued.

4372 (2) A bail bond surety company may apply for reinstatement of an expired bail bond

4373 surety company license within one year following the expiration of the license under

4374 Subsection (1) by:

- 4375 (a) submitting the renewal application required by Subsection (1); and
- 4376 (b) paying a license reinstatement fee established in accordance with Section
- 4377 31A-3-103.

4378 (3) If a bail bond surety company license has been expired for more than one year, the

4379 person applying for reinstatement of the bail bond surety license shall:

- 4380 (a) submit a new application form to the commissioner; and
- 4381 (b) pay the application fee established in accordance with Section 31A-3-103.

4382 (4) If a bail bond surety company license is suspended, the applicant may not submit an

4383 application for a bail bond surety company license until after the end of the period of

4384 suspension.

4385 (5) A fee collected under this section shall be deposited in the restricted account created

4386 in Section 31A-35-407.

4387 Section 46. Section **31A-35-602** is amended to read:

4388 **31A-35-602. Place of business -- Records to be kept there.**

4389 (1) (a) ~~Every~~ A bail bond surety company shall have and maintain in this state a place

4390 of business:

- 4391 (i) accessible to the public; and
- 4392 (ii) where the bail bond surety company principally conducts transactions authorized by
- 4393 its bail bond surety company license.

4394 (b) The address of the place of business described in Subsection (1)(a) shall appear

4395 upon:

- 4396 (i) the application for a bail bond surety company license; and

4397 (ii) ~~[the]~~ a bail bond surety company license issued under this chapter.

4398 (c) In addition to complying with Subsection (1)(b), a bail bond surety company shall  
4399 register and maintain with the commissioner the following at which the commissioner may  
4400 contact the bail bond surety company:

4401 (i) a telephone number; and

4402 (ii) a business email address.

4403 ~~[(c)]~~ (d) A bail bond surety company shall notify the commissioner ~~[of any change in~~  
4404 ~~the address required by this Subsection (1) within 20 days after the change.]~~ within 20 days of a  
4405 change in the bail bond surety company's:

4406 (i) place of business address;

4407 (ii) telephone number; or

4408 (iii) business email address.

4409 ~~[(d)]~~ (e) This section does not prohibit a bail bond surety company from maintaining  
4410 the place of business required under this section in the licensee's residence, if the residence is  
4411 in Utah.

4412 (2) The bail bond surety company shall keep at the place of business described in  
4413 Subsection (1)(a) the records required under Section 31A-35-604.

4414 Section 47. Section **31A-37-103** is amended to read:

4415 **31A-37-103. Chapter exclusivity.**

4416 (1) Except as provided in ~~[Subsection]~~ Subsections (2) and (3) or otherwise provided  
4417 in this chapter, a provision of this title other than this chapter does not apply to a captive  
4418 insurance company.

4419 (2) To the extent that a provision of the following does not contradict this chapter, the  
4420 provision applies to a captive insurance company that receives a certificate of authority under  
4421 this chapter:

4422 (a) Chapter 2, Administration of the Insurance Laws;

4423 (b) Chapter 4, Insurers in General;

4424 (c) Chapter 5, Domestic Stock and Mutual Insurance Corporations;

4425 (d) Chapter 14, Foreign Insurers;

4426 (e) Chapter 16, Insurance Holding Companies;

4427 (f) Chapter 17, Determination of Financial Condition;

- 4428            (g) Chapter 18, Investments;
- 4429            (h) Chapter 19a, Utah Rate Regulation Act;
- 4430            (i) Chapter 27, Delinquency Administrative Action Provisions; and
- 4431            (j) Chapter 27a, Insurer Receivership Act.
- 4432            [~~2~~] (3) In addition to this chapter, and subject to Section 31A-37a-103:
- 4433            (a) Chapter 37a, Special Purpose Financial Captive Insurance Company Act, applies to
- 4434 a special purpose financial captive insurance company; and
- 4435            (b) for purposes of a special purpose financial captive insurance company, a reference
- 4436 in this chapter to "this chapter" includes a reference to Chapter 37a, Special Purpose Financial
- 4437 Captive Insurance Company Act.
- 4438            Section 48. Section **31A-37-202** is amended to read:
- 4439            **31A-37-202. Permissive areas of insurance.**
- 4440            (1) (a) Except as provided in Subsection (1)(b), when permitted by its articles of
- 4441 incorporation or charter, a captive insurance company may apply to the commissioner for a
- 4442 certificate of authority to do all insurance authorized by this title except workers' compensation
- 4443 insurance.
- 4444            (b) Notwithstanding Subsection (1)(a):
- 4445            (i) a pure captive insurance company may not insure a risk other than a risk of:
- 4446            (A) its parent or affiliate;
- 4447            (B) a controlled unaffiliated business; or
- 4448            (C) a combination of Subsections (1)(b)(i)(A) and (B);
- 4449            (ii) an association captive insurance company may not insure a risk other than a risk of:
- 4450            (A) an affiliate;
- 4451            (B) a member organization of its association; and
- 4452            (C) an affiliate of a member organization of its association;
- 4453            (iii) an industrial insured captive insurance company may not insure a risk other than a
- 4454 risk of:
- 4455            (A) an industrial insured that is part of the industrial insured group;
- 4456            (B) an affiliate of an industrial insured that is part of the industrial insured group; and
- 4457            (C) a controlled unaffiliated business of:
- 4458            (I) an industrial insured that is part of the industrial insured group; or

- 4459 (II) an affiliate of an industrial insured that is part of the industrial insured group;
- 4460 (iv) a special purpose captive insurance company may only insure a risk of its parent;
- 4461 (v) a captive insurance company may not provide:
- 4462 (A) personal motor vehicle insurance coverage;
- 4463 (B) homeowner's insurance coverage; or
- 4464 (C) a component of a coverage described in this Subsection (1)(b)(v); and
- 4465 (vi) a captive insurance company may not accept or cede reinsurance except as
- 4466 provided in Section 31A-37-303.
- 4467 (c) Notwithstanding Subsection (1)(b)(iv), for a risk approved by the commissioner a
- 4468 special purpose captive insurance company may provide:
- 4469 (i) insurance;
- 4470 (ii) reinsurance; or
- 4471 (iii) both insurance and reinsurance.
- 4472 (2) To conduct insurance business in this state a captive insurance company shall:
- 4473 (a) obtain from the commissioner a certificate of authority authorizing it to conduct
- 4474 insurance business in this state;
- 4475 (b) hold at least once each year in this state:
- 4476 (i) a board of directors meeting; or
- 4477 (ii) in the case of a reciprocal insurer, a subscriber's advisory committee meeting;
- 4478 (c) maintain in this state:
- 4479 (i) the principal place of business of the captive insurance company; or
- 4480 (ii) in the case of a branch captive insurance company, the principal place of business
- 4481 for the branch operations of the branch captive insurance company; and
- 4482 (d) except as provided in Subsection (3), appoint a resident registered agent to accept
- 4483 service of process and to otherwise act on behalf of the captive insurance company in this state.
- 4484 (3) Notwithstanding Subsection (2)(d), in the case of a captive insurance company
- 4485 formed as a corporation or a reciprocal insurer, if the registered agent cannot with reasonable
- 4486 diligence be found at the registered office of the captive insurance company, the commissioner
- 4487 is the agent of the captive insurance company upon whom process, notice, or demand may be
- 4488 served.
- 4489 (4) (a) Before receiving a certificate of authority, a captive insurance company:

- 4490 (i) formed as a corporation shall file with the commissioner:  
4491 (A) a certified copy of:  
4492 (I) articles of incorporation or the charter of the corporation; and  
4493 (II) bylaws of the corporation;  
4494 (B) a statement under oath of the president and secretary of the corporation showing  
4495 the financial condition of the corporation; and  
4496 (C) any other statement or document required by the commissioner under Section  
4497 31A-37-106;  
4498 (ii) formed as a reciprocal shall:  
4499 (A) file with the commissioner:  
4500 (I) a certified copy of the power of attorney of the attorney-in-fact of the reciprocal;  
4501 (II) a certified copy of the subscribers' agreement of the reciprocal;  
4502 (III) a statement under oath of the attorney-in-fact of the reciprocal showing the  
4503 financial condition of the reciprocal; and  
4504 (IV) any other statement or document required by the commissioner under Section  
4505 31A-37-106; and  
4506 (B) submit to the commissioner for approval a description of the:  
4507 (I) coverages;  
4508 (II) deductibles;  
4509 (III) coverage limits;  
4510 (IV) rates; and  
4511 (V) any other information the commissioner requires under Section 31A-37-106.  
4512 (b) (i) If there is a subsequent material change in an item in the description required  
4513 under Subsection (4)(a)(ii)(B) for a reciprocal captive insurance company, the reciprocal  
4514 captive insurance company shall submit to the commissioner for approval an appropriate  
4515 revision to the description required under Subsection (4)(a)(ii)(B).  
4516 (ii) A reciprocal captive insurance company that is required to submit a revision under  
4517 Subsection (4)(b)(i) may not offer any additional types of insurance until the commissioner  
4518 approves a revision of the description.  
4519 (iii) A reciprocal captive insurance company shall inform the commissioner of a  
4520 material change in a rate within 30 days of the adoption of the change.

4521 (c) In addition to the information required by Subsection (4)(a), an applicant captive  
4522 insurance company shall file with the commissioner evidence of:

4523 (i) the amount and liquidity of the assets of the applicant captive insurance company  
4524 relative to the risks to be assumed by the applicant captive insurance company;

4525 (ii) the adequacy of the expertise, experience, and character of the person who will  
4526 manage the applicant captive insurance company;

4527 (iii) the overall soundness of the plan of operation of the applicant captive insurance  
4528 company;

4529 (iv) the adequacy of the loss prevention programs for the following of the applicant  
4530 captive insurance company:

4531 (A) a parent;

4532 (B) a member organization; or

4533 (C) an industrial insured; and

4534 (v) any other factor the commissioner:

4535 (A) adopts by rule under Section 31A-37-106; and

4536 (B) considers relevant in ascertaining whether the applicant captive insurance company  
4537 will be able to meet the policy obligations of the applicant captive insurance company.

4538 (d) In addition to the information required by Subsections (4)(a), (b), and (c), an  
4539 applicant sponsored captive insurance company shall file with the commissioner:

4540 (i) a business plan at the level of detail required by the commissioner under Section  
4541 31A-37-106 demonstrating:

4542 (A) the manner in which the applicant sponsored captive insurance company will  
4543 account for the losses and expenses of each protected cell; and

4544 (B) the manner in which the applicant sponsored captive insurance company will report  
4545 to the commissioner the financial history, including losses and expenses, of each protected cell;

4546 (ii) a statement acknowledging that the applicant sponsored captive insurance company  
4547 will make all financial records of the applicant sponsored captive insurance company,  
4548 including records pertaining to a protected cell, available for inspection or examination by the  
4549 commissioner;

4550 (iii) a contract or sample contract between the applicant sponsored captive insurance  
4551 company and a participant; and

4552 (iv) evidence that expenses will be allocated to each protected cell in an equitable  
4553 manner.

4554 (5) (a) Information submitted pursuant to Subsection (4) is classified as a protected  
4555 record under Title 63G, Chapter 2, Government Records Access and Management Act.

4556 (b) Notwithstanding Title 63G, Chapter 2, Government Records Access and  
4557 Management Act, the commissioner may disclose information submitted pursuant to  
4558 Subsection (4) to a public official having jurisdiction over the regulation of insurance in  
4559 another state if:

4560 (i) the public official receiving the information agrees in writing to maintain the  
4561 confidentiality of the information; and

4562 (ii) the laws of the state in which the public official serves require the information to be  
4563 confidential.

4564 (c) This Subsection (5) does not apply to information provided by an industrial insured  
4565 captive insurance company insuring the risks of an industrial insured group.

4566 (6) (a) A captive insurance company shall pay to the department the following  
4567 nonrefundable fees established by the department under Sections 31A-3-103, 31A-3-304, and  
4568 63J-1-504:

4569 (i) a fee for examining, investigating, and processing, by a department employee, of an  
4570 application for a certificate of authority made by a captive insurance company;

4571 (ii) a fee for obtaining a certificate of authority for the year the captive insurance  
4572 company is issued a certificate of authority by the department; and

4573 (iii) a certificate of authority renewal fee.

4574 (b) The commissioner may:

4575 (i) assign a department employee or retain legal, financial, and examination services  
4576 from outside the department to perform the services described in:

4577 (A) Subsection (6)(a); and

4578 (B) Section 31A-37-502; and

4579 (ii) charge the reasonable cost of services described in Subsection (6)(b)(i) to the  
4580 applicant captive insurance company.

4581 (7) If the commissioner is satisfied that the documents and statements filed by the  
4582 applicant captive insurance company comply with this chapter, the commissioner may grant a

4583 certificate of authority authorizing the company to do insurance business in this state.

4584 (8) A certificate of authority granted under this section expires annually and must be  
4585 renewed by July 1 of each year.

4586 Section 49. Section **31A-37-504** is amended to read:

4587 **31A-37-504. Examinations for branch and alien captive insurance companies.**

4588 [~~(1) This section applies to all business written by a captive insurance company.~~]

4589 [~~(2) Notwithstanding this section, the~~]

4590 (1) The examination for a branch captive insurance company shall be of branch

4591 business and branch operations only, if the branch captive insurance company:

4592 (a) provides annually to the commissioner a certificate of compliance, or an equivalent,  
4593 issued by or filed with the licensing authority of the jurisdiction in which the branch captive  
4594 insurance company is formed; and

4595 (b) demonstrates to the commissioner's satisfaction that the branch captive insurance  
4596 company is operating in sound financial condition in accordance with ~~[aH]~~ the applicable laws  
4597 and regulations of the jurisdiction in which the branch captive insurance company is formed.

4598 [~~(3)~~] (2) As a condition of obtaining a certificate of authority, an alien captive  
4599 insurance company shall grant authority to the commissioner to examine the affairs of the alien  
4600 captive insurance company in the jurisdiction in which the alien captive insurance company is  
4601 formed.

4602 [~~(4) To the extent that the provisions of Chapters 2, 4, 5, 14, 16, 17, 18, 19a, 27, and~~  
4603 ~~27a do not contradict this section, these chapters apply to captive insurance companies that~~  
4604 ~~have received a certificate of authority under this chapter.~~]

4605 Section 50. Section **31A-40-308** is enacted to read:

4606 **31A-40-308. Material changes.**

4607 A professional employer organization shall notify the commissioner within 30 days of a  
4608 change in:

4609 (1) ownership;

4610 (2) an address or telephone number;

4611 (3) a contact person; or

4612 (4) business email address at which the commissioner may contact the professional  
4613 employer organization.

4614 Section 51. Section **59-9-105** is amended to read:

4615 **59-9-105. Tax on certain insurers to pay for relative value study and other**  
4616 **publications or services.**

4617 (1) ~~[Each]~~ An insurer ~~[providing]~~ that provides coverage for motor vehicle liability,  
4618 uninsured motorist, and personal injury protection shall pay to the State Tax Commission on or  
4619 before March 31 of each year, a tax of .01% on the total premiums received for these coverages  
4620 during the preceding calendar year from policies covering motor vehicle risks in this state.

4621 (2) The taxable premium under this section shall be reduced by ~~[all]~~ the premiums  
4622 returned or credited to policyholders on direct business subject to tax in this state.

4623 (3) ~~[All money]~~ Money received by the state under this section shall be deposited ~~[in~~  
4624 ~~the General Fund as a dedicated credit for the purpose of providing funds]~~ into the Relative  
4625 Value Study Restricted Account created in Subsection (4).

4626 (4) (a) There is created in the General Fund a restricted account known as the "Relative  
4627 Value Study Restricted Account."

4628 (b) The Relative Value Study Restricted Account shall consist of the money received  
4629 by the insurance commissioner under:

4630 (i) Section 31A-2-208; and

4631 (ii) this section.

4632 (c) The insurance commissioner shall administer the Relative Value Study Restricted  
4633 Account. Subject to appropriations by the Legislature, the insurance commissioner shall use  
4634 the money deposited into the Relative Value Study Restricted Account to pay for [any] costs  
4635 and expenses incurred by the [Insurance Department] insurance commissioner:

4636 ~~[(a)]~~ (i) in conducting, maintaining, and administering the relative value study referred  
4637 to in Section 31A-22-307;

4638 ~~[(b)]~~ (ii) to prepare, publish, and distribute publications relating to insurance and  
4639 consumers of insurance as provided in Section 31A-2-208; and

4640 ~~[(c)]~~ (iii) in providing the services of the ~~[Insurance Department]~~ insurance  
4641 commissioner through the use of:

4642 ~~[(i)]~~ (A) electronic commerce; and

4643 ~~[(ii)]~~ (B) other information technology.

4644 Section 52. Section **63I-2-231** is amended to read:

4645           **63I-2-231. Repeal dates, Title 31A.**

4646           ~~[(1) Section 31A-23a-415 is repealed July 1, 2011.]~~

4647           ~~[(2)]~~ Title 31A, Chapter 42, Defined Contribution Risk Adjuster Act, is repealed  
4648 January 1, 2013.

4649           Section 53. Section **63J-1-602.2** is amended to read:

4650           **63J-1-602.2. List of nonlapsing funds and accounts -- Title 31 through Title 45.**

4651           (1) Appropriations from the Technology Development Restricted Account created in  
4652 Section 31A-3-104.

4653           (2) Appropriations from the Criminal Background Check Restricted Account created in  
4654 Section 31A-3-105.

4655           (3) Appropriations from the Captive Insurance Restricted Account created in Section  
4656 31A-3-304, except to the extent that Section 31A-3-304 makes the money received under that  
4657 section free revenue.

4658           (4) Appropriations from the Title Licensee Enforcement Restricted Account created in  
4659 Section 31A-23a-415.

4660           (5) Appropriations from the Insurance Fraud Investigation Restricted Account created  
4661 in Section 31A-31-108.

4662           ~~[(5)]~~ (6) The fund for operating the state's Federal Health Care Tax Credit Program, as  
4663 provided in Section 31A-38-104.

4664           ~~[(6)]~~ (7) The Special Administrative Expense Account created in Section 35A-4-506.

4665           ~~[(7)]~~ (8) Funding for a new program or agency that is designated as nonlapsing under  
4666 Section 36-24-101.

4667           ~~[(8)]~~ (9) The Oil and Gas Conservation Account created in Section 40-6-14.5.

4668           ~~[(9)]~~ (10) The Off-Highway Access and Education Restricted Account created in  
4669 Section 41-22-19.5.

4670           Section 54. Section **63J-1-602.3** is amended to read:

4671           **63J-1-602.3. List of nonlapsing funds and accounts -- Title 46 through Title 60.**

4672           (1) Certain funds associated with the Law Enforcement Operations Account, as  
4673 provided in Section 51-9-411.

4674           (2) The Public Safety Honoring Heroes Restricted Account created in Section  
4675 53-1-118.

4676 (3) Funding for the Search and Rescue Financial Assistance Program, as provided in  
4677 Section 53-2-107.

4678 (4) Appropriations made to the Department of Public Safety from the Department of  
4679 Public Safety Restricted Account, as provided in Section 53-3-106.

4680 (5) Appropriations to the Motorcycle Rider Education Program, as provided in Section  
4681 53-3-905.

4682 (6) The DNA Specimen Restricted Account created in Section 53-10-407.

4683 (7) Appropriations to the State Board of Education, as provided in Section  
4684 53A-17a-105.

4685 (8) Certain funds appropriated from the Uniform School Fund to the State Board of  
4686 Education for new teacher bonus and performance-based compensation plans, as provided in  
4687 Section 53A-17a-148.

4688 (9) Certain funds appropriated from the Uniform School Fund to the State Board of  
4689 Education for implementation of proposals to improve mathematics achievement test scores, as  
4690 provided in Section 53A-17a-152.

4691 (10) The School Building Revolving Account created in Section 53A-21-401.

4692 (11) Money received by the State Office of Rehabilitation for the sale of certain  
4693 products or services, as provided in Section 53A-24-105.

4694 (12) The State Board of Regents, as provided in Section 53B-6-104.

4695 (13) Certain funds appropriated from the General Fund to the State Board of Regents  
4696 for teacher preparation programs, as provided in Section 53B-6-104.

4697 (14) A certain portion of money collected for administrative costs under the School  
4698 Institutional Trust Lands Management Act, as provided under Section 53C-3-202.

4699 (15) Certain surcharges on residence and business telecommunications access lines  
4700 imposed by the Public Service Commission, as provided in Section 54-8b-10.

4701 (16) Certain fines collected by the Division of Occupational and Professional Licensing  
4702 for violation of unlawful or unprofessional conduct that are used for education and enforcement  
4703 purposes, as provided in Section 58-17b-505.

4704 (17) The Nurse Education and Enforcement Account created in Section 58-31b-103.

4705 (18) The Certified Nurse Midwife Education and Enforcement Account created in  
4706 Section 58-44a-103.

4707 (19) Certain fines collected by the Division of Occupational and Professional Licensing  
4708 for use in education and enforcement of the Security Personnel Licensing Act, as provided in  
4709 Section 58-63-103.

4710 (20) The Professional Geologist Education and Enforcement Account created in  
4711 Section 58-76-103.

4712 (21) Appropriations from the Relative Value Study Restricted Account created in  
4713 Section 59-9-105.

4714 [~~21~~] (22) Certain money in the Water Resources Conservation and Development  
4715 Fund, as provided in Section 59-12-103.

4716 Section 55. **Intent language regarding lapsing of money.**

4717 It is the intent of the Legislature that money received by the Insurance Department  
4718 during fiscal year 2010-11 under the following shall be considered dedicated credits and in  
4719 closing out fiscal year 2010-11 the unspent dedicated credits shall lapse to the appropriate  
4720 restricted account created by the amendments made by this bill:

4721 (1) Section 31A-2-208;

4722 (2) Section 31A-31-108;

4723 (3) Section 31A-31-109; and

4724 (4) Section 59-9-105.

4725 Section 56. **Effective date.**

4726 This bill takes effect on May 10, 2011, except that the amendments to Section  
4727 31A-3-304 in this bill take effect on July 1, 2013.

4728 Section 57. **Retrospective operation.**

4729 The amendments to the following sections in this bill have retrospective operation to  
4730 January 1, 2011:

4731 (1) Section 31A-22-701;

4732 (2) Section 31A-30-103; and

4733 (3) Section 31A-30-106.